Support and recovery in a therapeutic community

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Support and recovery in a therapeutic community

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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DECLARATION

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Selma Ingeborg Macfarlane

12 July 2007
Abstract

This research project began from an interest in ‘what happened’ at a residential psychiatric disability support service (therapeutic community) where I had previously worked as a social worker, or, as it was termed in the program, support worker. My approach to data collection was, as for many social work researchers, qualitative. As my work on the project developed over time, I was consistently informed and re-informed not only by ideas arising from my engagement with participants and relevant literature, but also by new concepts and areas of interest that opened up as a result of my teaching in a progressive Bachelor of Social Work course. Gradually, as my understanding of critical and reflective postmodern social work theory and practice evolved, new interpretations crept into my thinking and writing on my thesis. Some of the tensions that arose as a result of this continual overlaying of new conceptual frameworks are evident in the thesis that resulted. While I have tried to create reasonable internal coherence, the layers of different approaches and understandings that informed me are sometimes evident, like the sides of a canyon that display evidence of its historical and ongoing formation. This may not be dissimilar to social work itself in the new millennium, as new ideas continue to variously challenge, consolidate, destabilize and/or reshape theory and practice. While this thesis began as an exploration of the experiences of individuals in a therapeutic community and the role of support workers in that process, it became, additionally, an exploration of ways in which the role and practice of social work is constructed. However, the stories of participants remain a central feature. Chapters include: the professional gaze and the construction of subjects; problematising worker power and professionalism; boundaries, vulnerability and authority; therapeutic community; sensemaking, meaning ascription and the creation of culture; change and turning points; and problematising and exploring outcomes.
This thesis is dedicated to my three children: Freyja, Anna and Alex who provided unconditional support during the years that I’ve been working on this project (comprising much of their childhood/youth),
and my mother Denny Bjornaraa, sister Thora Abarca,
and friends Julie Wells and Jane Wexler, who encouraged me to believe I could complete it. Thanks also to my colleagues and friends, Christine Morley and Jane Maidment for their continuous (and tactful) support.

This thesis is also dedicated to the individuals who generously shared their stories with me: may you travel well.
And to the memory of my father, whose passing last year reminded me again that the heart and the spirit are as important as the head.

Thanks also to my supervisors Bill Healy and Gary Hough who assisted me in the early stages of this project, and especially to Bob Pease who supervised me through the final stages, and Jenny Martin, who agreed to be a co-supervisor.
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A Note to the Reader…

This research project began from my interest in ‘what happened’ at a residential psychiatric disability support service where I had previously worked as a social worker, or, as it was termed in the program, support worker. My approach to data collection was, as for many social work researchers, qualitative. As my work on the project developed over time, I was consistently informed and re-informed not only by ideas arising from my engagement with participants and relevant literature, but also by new concepts and areas of interest that opened up as a result of my teaching in a progressive Bachelor of Social Work course. Gradually, as my understanding of critical and reflective postmodern social work theory and practice evolved, new interpretations crept into my thinking and writing on my thesis. Some of the tensions that arose as a result of this continual overlaying of new conceptual frameworks are evident in the thesis that resulted. While I have tried to create reasonable internal coherence, the layers of different approaches and understandings that informed me are sometimes evident, like the sides of a canyon that display evidence of its historical and ongoing formation. This may not be dissimilar to social work itself in the new millennium, as new ideas continue to variously challenge, consolidate, destabilize and/or reshape theory and practice. While this thesis began as an exploration of the experiences of individuals in a therapeutic community and the role of support workers in that process, it became, additionally, an exploration of ways in which the role and practice of social work is constructed. However, the stories of participants remain a central feature.
Chapter 1

Setting the context

“Your research is determined by your own quest ... it’s not just knowledge for curiosity...It’s knowledge for the sake of relating to people in different ways... [the] key purpose of human inquiry is to heal our relationships with each other and the world…” (Reason, 1996, p.17)

When I began my research, it was with the desire to understand more about the ‘something powerful’ that seemed to occur for everyone (including staff) in the psychiatric disability support program where I had worked. The program, at that time, was described as a therapeutic community: today it would more likely be referred to as a residential psychiatric disability support service. The program was available to persons aged twenty to thirty-five who had been involved in the psychiatric system after experiencing psychosis or mental distress and receiving a psychiatric diagnosis (see Appendix A for program description); residents were able to stay up to two years, with a minimum recommended stay of 6-12 months. My initial research question – composed largely for writing up a proposal and providing a brief explanation of what I was doing – was ‘How does living in a residential psychiatric disability support service impact on an individual’s life?’ I wondered how the intensive experience of living in the program affected people: what their needs were when they entered the program, what actually ‘happened’ for people during their stay, what it was about the program that was useful and the role of staff in that process, and what people took with them when they left. I proposed to explore these questions by engaging in loosely structured interviews with service users, former service users and staff. Rather than seeking to include a number of services or programs, I sensed that the depth and richness of this particular program and the people connected to it, offered enough material for any number of theses, and I was not disappointed.

Beginning with a naturalistic or qualitative approach to gathering material, I moved progressively towards a narrative, sensemaking and postmodern critical frame of reference in terms of my interpretations of and responses toward the material that I collected. As I gathered and engaged with material from the literature and the stories of participants, gaining insights into their experiences of support and recovery in the
program, some traditional social work concepts and assumptions also seemed to ‘present themselves’ for closer inspection and problematising. As my thesis journey unfolded, an additional – almost subterranean – exploration began to form and find expression, around the power of social work practice itself (and academic research, for that matter) to trespass and emancipate and the need for workers to reflect critically, honestly and courageously on their practice in specific contexts. It seemed that workers and clients were in a continuous and dynamic process of co-creation: of culture, of meaning, of relationship and (inter)action. Thus my own unfolding story began to take its place alongside the stories of other participants.

As my understanding of critical social work and postmodern thinking developed through my reading, thinking and teaching, additional layers of interpretation also developed. While the content of interviews and literature remained largely focused on exploring experiences within the program, my return to academia during the research period began also to lead to attempts to locate this thesis within critical social work practice more broadly. My work as a support worker in the program had seemed, in some ways, disconnected to my identity and ‘training’ as a social worker: not only did I have a different position title, but the theories upon which practice in the therapeutic community was based, were quite new to me. My return to academia brought me back, quite sharply, to my social work background, and invited me to contextualise my practice experience within the current social work traditions I was propounding in the classroom, and which resonated with my commitment to anti-oppressive practice.

In recent years, the term, ‘critical social work’ has accumulated a range of somewhat varying definitions and uses. Arguably, critical social work seems to have become synonymous with an approach that incorporates older critical theories, such as structural, radical or feminist theory, with emancipatory aspects of postmodern thinking and critically reflective practice. Many recent social work texts (see for example, Carniol, 2005; Hick, Fook & Pozzuto, 2005; Allan, Briskman & Pease, 2003; Adams, Dominelli & Payne, 2002) contain the word ‘critical’ in their title, however various authors use and understand the word in slightly different ways, which incorporate or draw on particular postmodern ideas to varying extents. Whilst the radical or critical social work of previous recent decades focused on patterns of inequality, disempowerment and oppression based on class, gender, race, sexual orientation, age and ability, postmodern thinking opened some challenging new
avenues for social workers’ (and others’) consideration. Understandably, the ‘anything goes’ approach of postmodernism appeared potentially threatening to the emancipatory goals of (modernist) critical theory and practice in which the material reality of oppression based on social structures and the significance of collective identity in challenging privilege and power was vital. However, the emancipatory potential of postmodern thinking has presented social work with new opportunities to extend their analysis to create a critical social work that retains its crucial focus on structural inequalities whilst embracing those aspects of postmodern thinking that open out critical practice to new ideas and understandings. This will be explored in some detail as the thesis unfolds, in relation to specific aspects of practice and (inter)action, such as critical reflection on the impact of (modernist) binary oppositional thinking, for example around micro/macro, radical /therapeutic, progress/regress, and psychiatric discourse/experiential narrative. Indeed, my own critical reflection on these oppositional constructions began before I knew the word ‘deconstruction’ existed. (To be honest, my process at the time was experienced more as ‘internal confusion,’ than ‘critical reflection.’)

A definition or description of critical social work that appeals to me, as it is both broad and insightful, is that critical social work “has something to do with making the world we live in…with looking at something and not taking it solely as a given but also imagining what it could be… expand[ing] the possible through the process of social dialog and the act of doing in the present” (Pozzuto, 2000, pp.1-2). Burkett and McDonald (2005, p.175) suggest that critical social work attempts to deconstruct the “social work project” through engaging with it as discursive practice subject to reformulation. Along these same lines, Adams et al. (2002, p.xxi) suggest that criticality provides a key grounding component for social work practice that “enables us to question the knowledge we have and our own involvement with clients – including our taken for granted understandings.” They equate critical practice with ongoing and dynamic engagement with critical reflection and an “open-minded… appraisal that takes account of different perspectives, experiences and assumptions.”

In exploring the experiences of service users and problematising the role of social workers in a specific localised context, this thesis can be positioned within the critical social work framework in that it creates a space for a range of alternative voices to be heard, and calls assumed knowledge and (inter)action into productive questioning. My own simple view is that criticality embodies the problematising of taken for
granted assumptions, along with a commitment to anti-oppressive practice, whatever form that may take.

In the preceding discussion I have tried to position myself within a critical social work theory base before (re)turning to the actual essence of my research endeavour – i.e. an exploration of experiences of recovery and support in a therapeutic community. In some ways this mirrors or exemplifies the ongoing tensions I experienced throughout my years of involvement in this project, which became more intense as my participation in academia grew, and my connection with ‘practice’ became more distant. The demands of academia for theoretical rigour often seem to be positioned (and experienced) as at odds with real on-the-ground needs, responses and lived experience. Now, I am somewhat more skilled in critically interrogating the potentially false distinction between engagement with academia and engagement in ‘practice.’ The need to embed narratives of lived experience – my own or others - within academic theory has continually vexed me and presented me with paradoxes. In my teaching I constantly reiterate the importance of theory (‘it’s not just about doing - it’s about knowing and being able to articulate why you’re doing it’); at the same time, however, my rebellious propensity is to resist theoretical overlays and anything else that is demanded in order to conform to academia! In any case, I now make what is hopefully not too jarring a ‘u-turn’ and refocus on my project more specifically, beginning with a discussion of where my research sits in the context of similar qualitative research in the mental health field.

**Contextualising the area of inquiry**

As I began my literature review, I realised that my general area of inquiry resonated strongly with suggestions by others in the field of psychiatric disability support, as useful areas for further research. Since the inception of community support services in mental health, attempts have been made to understand the diverse nature of individual experience and how (what are now referred to as psychiatric disability support) programs might respond to these needs. This research has highlighted the significance of the individual’s immediate environment in relation to well being and the importance of consumer perspectives and program-specific studies in developing an understanding of the process of recovery from psychiatric disturbance and the role of professional support in that process.
The significance of the environment

In the late 1970s, it was suggested, as a result of considerable time and effort put into the evaluation of the burgeoning movement of therapeutic communities in the UK, that small-scale studies of specific programs could be particularly revealing in terms of how the various components of a program combined to be effective (Hinshelwood, 1979). Some years later Bloor et al. also spent considerable time and energy exploring the work of therapeutic communities. They concluded that conventional evaluation studies claiming a “general applicability of findings” were not viable and that only descriptive studies of a range of programs were appropriate (1988, p. 206). Services, they pointed out, could not be studied as if they were drugs being administered; services, they observed, varied enormously “in their approach to treatment [sic], in their clientele, in their typical length of resident careers [sic] and in their views of success and failure” (1988, p. 205). They also problematised universalised definitions of the ‘success’ or ‘failure’ of a service, for example in relation to hospital readmission, as some programs and/or service-users might consider hospital readmission and subsequent return to the service as part of a continuing process of recovery.

Hatfield and Lefley, who have written extensively about mental health and illness, highlighted both the impact of the individual’s environment on well-being, and the need for workers to be attentive to peak moments when change may be most possible. They proposed what is needed is to know “what kinds of environments are most supportive of [recovery oriented] efforts and what kinds of interventions may prove effective at key points along the way.” They asked a series of important questions: “Are there approaches in … rehabilitation that can effectively shift a patient [sic] away from a sense of being a victim of his or her symptoms and toward a sense of control over them?” What are the vulnerabilities and barriers “that interfere with relatedness,” and - what they refer to as the major question for the century - “to what extent can [individual] improvement be brought about by timely interventions?” (1993, p. 187). These questions resonated strongly with my own, and with the opportunities for learning that might be available through in-depth interview conversations with residents, former residents and staff in the program.

Moos (1996) also focused on the significance of the environment to ‘outcomes’ in mental health services. He suggested that it was important to understand the processes that link environment to outcomes and to explore what
actually characterises powerful environments. Similarly to Hatfield and Lefley’s attention to peak moments, he suggested that developing better understanding of what makes individuals more or less amenable to environment influences – the individual’s ‘maturational ripeness’ - was important. He went on to question to what extent the individual’s experiences in one environment influenced their mood and behaviour, and in other/future environments that they might be or become part of. He referred to this as the power and evanescence of the environment. This was an area I hoped to explore through dialogue with former residents, who had left the program anywhere from two weeks to two years before.

Other writers have also suggested that exploring the health inducing (or inhibiting) aspects of the environment is useful in understanding what might assist a recovery process. Taylor’s (1997) conceptual framework around social niches that were enabling or entrapping for persons recovering from psychiatric upheaval or other difficult life experiences is of particular interest. A social niche, according to Taylor, is the space or environment a person inhabits, including the resources accessible to them and the people they interact with. Entrapping niches are generally stigmatised and restricted: they are settings that hold few expectations for personal progress, where little constructive feedback is received, and where there are few incentives, sparse resources and low levels of support. Enabling niches are basically the opposite; many niches are combinations of varying degrees of the two characterisations. Niche differences, he suggests, may play an important role in recovery from psychiatric disturbance, as well as providing fertile ground for exploration of what might draw an individual to seek out or remain in a particular type of social niche. He observed that there was “as yet no form of program development, nor of macro practice, that draws on niche ideas” (1997, p.225). Taylor also drew attention to the importance in the recovery process of what he calls “support pods” (created when people come together as a group to collaborate, pool resources and learn from each other) – some of which, he says, are effective in facilitating greater well being, and some of which are not. Russell (1995, p.162) echoes this emphasis on supportive relationships, proposing that an exploration of “which relations promote human flourishing” is vital to any discussion of how an individual’s well-being can be enhanced. In this sense, the relationships between workers and service users, as well as other relationships in the client’s life, becomes a crucial focus of exploration. (The nature of relationships between staff members in a program is also an important facet of work in human
services or therapeutic environments that unfortunately, in many settings, receives inadequate attention). In exploring the significance of social relationships and environments to psychological and mental health, it has been suggested – in ways that resonate with a critical approach to social work practice – that those involved in the giving and receiving of support services be considered crucially important to the construction of knowledge and understanding.

Service users’ perspectives

Mohr (1999, p.284) suggests that in order to explore successful interventions, research should focus on “what it is that they [service recipients] find helpful or not helpful and under what circumstances.” This view resonates with that expressed by VICSERV (1998), peak body of the psychiatric disability support sector in Victoria, who suggest that useful research in the sector would engage consumer perspectives on the benefits of psychiatric disability support services, particularly worker and consumer narratives of their experiences of giving and receiving support in such services. Greene (1994, p.531), discussing program evaluation more generally, suggests that the question, “How is the program experienced by various stakeholders?” is a significant and crucial one. This echoes Anthony’s view that research attempting to “understand the experience of recovery from mental illness from those who are experiencing it themselves” (1993, p.20) is vital to the creation of service systems and environments that facilitate a recovery process. This necessitates critical reflection on how services are conceptualised, implemented and experienced at a local level.

Patton (1980, p.57) further suggests that program aims or outcomes like ‘personal growth’ and ‘increased awareness,’ desirable as they are, are generally vague and require further exploration. He suggests that researchers try to “describe what actually happens to people in the program and what they say about what happens to them,” as well as asking how program participants link any personal changes to specific program processes. These suggestions, although I had not read them when I began my interviews, resonated strongly with areas of discussion explored with participants (see Interview Guides, Appendix C). At the same time, Patton (1980) cautions researchers to remain wary of linking program processes to participant outcomes, suggesting that any causal linkages must be understood as conjecture, and clearly identified as speculative and grounded in the researcher’s (inherently subjective) frame of reference as well as the local and historical context. He observes
that case studies can be particularly useful in capturing the uniqueness of individual clients and illuminating the internal dynamics of a program, using “research methods that are humanistic so that participants are not labeled, numbered” (Patton, 1980, pp.88-89). This resonates well with the psychiatric disability support sector philosophy, critical social work practice, and the ethos of the program under study.

**Recovery literature**

Cheryl Gagne, a leading spokesperson within the recovery movement, observed in her keynote address to the 1996 Recovery Conference in Melbourne, that the purpose of psychiatric disability support programs is to “meet a person where he is and help him get to where he wants to go.” The key question to explore then becomes how the service has assisted the service recipient to become an expert in their own recovery or “an agent on [their] own behalf” (1996, p.5). Indeed, recovery, rather than management or maintenance has become a powerful concept in psychiatric disability support services. Sullivan (1997) stresses that research must proceed from an understanding that recovery is an interactive and complex process. One way of determining some of the key factors involved in recovery, he goes on, is to learn from consumers, particularly those who feel they are moving along a path toward greater well-being; not only does this provide useful insight and knowledge but also “elevates informants from the role of subject to expert” (Sullivan, 1997, p.184) – a premise consistent with empowerment perspectives and postmodern problematising of who is allowed to produce valid knowledge or ‘truth’.

Finally, it is useful to look at what is suggested in an article put out by VICSERV (2000), entitled *Research Agenda for Psychiatric Disability Support Services 2000-2003*. They propose that the type of in-depth inquiry which is needed to explore how people experience the community support services that are meant to assist them, is something which is not easily amenable to the sorts of cause-and-effect measuring instruments which generally attract funding, and which are considered to be less ‘biased,’ and more ‘scientific’ and ‘objective.’ The principles for psychiatric disability support sector research that they put forward are that participants must be respected and listened to as experts, that studies should be “grounded in actual practice and consumer experience,” and that projects should involve a “collaborative relationship that advances the rehabilitation process” (p.7). Major priorities identified for research in the sector are questions that clearly resonate with critical postmodern social work theory and practice: “What works and for whom and when?”, “What
models help consumers’ health and well-being?”, “What are the long term outcomes for current users of psychiatric disability support services – including those who leave the service?”, and “How effective, efficient and appropriate are current psychosocial rehabilitation models?”. These types of questions, which I came upon in the literature, before, during and after my interview process, appeared to support the general direction of my project. In relation to these suggestions, put forward by the sector, my basic research question – ‘How does living in a residential psychiatric disability support service impact on an individual’s life’ – still seemed relevant, although the simple nature of the question belied the complexity of the questions and experiences bound up within it. As I continued to develop my thinking, through interaction with participants and other events I was involved in, such as my university teaching, the complexities deepened. Gradually, the influence of new ideas from my teaching and engagement with new literature and concepts crept into my questioning and my discussion, adding layers that began to problematise various taken for granted assumptions around social work practice. Material from the interview texts added to my growing awareness of the need for scrutiny of modernist assumptions around mental health and illness and the understandings and subject positions they engendered. While my basic research question remained the driving force of the research, additional concepts crept into my writing, as my own critical thinking developed; these conceptual overlays can be seen in the multi-layered approach to the literature, the research process and the interview material that developed.

Problematisation of the role of social/support workers and a postmodern critical exploration of practice assumptions came to occupy my thinking, based on the material raised in interviews, and my own new learning. This exploration came to include a problematisation of the professional gaze, worker power, authority and vulnerability, and the powerful nature of sensemaking, culture creation and meaning ascription in a program setting. Although rudimentary, and something, in retrospect, I acknowledge I could have engaged with more deeply and consciously, critical reflection was almost unavoidable as I struggled with authorship, the researcher role, relationships with participants and my own standpoint. For now, though, I return to the initial contextualising of this research project, describing my approach to the literature review.
Chapter 1        Setting the context

Reviewing and engaging with ‘the literature’

Having mentioned ‘the literature’ a number of times now, it is timely to engage in some problematisation of the term generally and in relation to this thesis. My literature review could be described as an exercise underpinned by postmodern thinking, for a number of reasons, which are discussed below. Having said that, however, I must admit that the approach I took to exploring previously written material was a fairly organic or intuitive one that I only later realised could be labeled ‘postmodern,’ or, less academically: a combination of serendipity, subjective choice and interest, as well as resonance with my favoured theoretical frameworks and the stories of participants as they unfolded.

What literature is ‘the literature’?

Traditional modernist versions of ‘the literature’ and perhaps even the assumption that such a thing exists as we enter the new millennium, are challengeable. It could be argued that in some areas of study, for example research into the effects of tobacco smoking on physical health, a boundaried and cumulatively progressive set of literature with direct relevance exists. However, in relation to areas of study such as mental and emotional well-being, the highly subjective act of deciding what texts, concepts or interpretations are relevant comes into play. Diverse knowledge-makers might suggest very different sources of knowledge as relevant: what a psychiatrist might find seminal to an understanding of mental health or illness may differ from what an elder Aboriginal woman might consider relevant, or a social worker (and here there would potentially be a myriad of understandings within the one profession), or a Buddhist monk. Thus the unavoidable situatedness – the standpoint – of the literature accumulator and reviewer must be acknowledged, along with the resultant diversity of texts (in the broad sense of the word) that may be considered relevant to an area of inquiry.

Critical social work practice, informed by postmodern thinking, encourages the deconstruction of taken for granted norms and assumptions around what is considered ‘valid’ knowledge and how and by whom it is produced. The sheer amount of potentially relevant and accessible literature is also overwhelming: in what is truly the information age, the limits are almost endless and the boundaries constantly expanding. Critical postmodern thinking leads us to resist meta-narratives that suggest literature, like civilisation, necessarily progresses towards greater enlightenment. For
me, what this meant was that contrary to advice that I not bother reading anything more than five years old, I did not assume the date of publication necessarily positioned a text within a continuum of legitimacy, where newer meant better. Hence literature that was written in the 1970s and 1980s is considered, in my literature review, just as potentially valuable as something published more recently. Indeed I often found these older works equally valuable to more recent texts in terms of their capacity to illuminate human experience, and resonate with participants’ narratives. This may have something to do with the wave of alternative voices (including the anti-psychiatry movement) that swept through Western countries during that time, in the form of emancipatory new social movements.

Each researcher/reviewer will more or less consciously choose to include some literature over others; the sort of synthesising that goes on as a researcher selects or rejects various types and pieces of literature is highly subjective, despite claims to objectivity. The scientist’s claim to objectivity in choosing only medical model literature is, from a critical postmodern perspective, a subjective choice that excludes large bodies of other knowledge.

For example, in the article entitled “100 Years of Schizophrenia” (Hegarty et al., 1994) – an overview of outcome studies – not only were studies of non-pharmacological interventions excluded, several hundred other studies that did not meet the criteria of the researchers were also discarded. Of course, selectivity is always required to contain the amount of material engaged with – and it is to the researchers’ credit that they acknowledged certain material had been excluded – however, the choice to exclude material must be noted, and noted as having come from somewhere and someone, i.e. the subjective and situated opinion of the researchers (and/or their discipline) about what was purposeful. Similarly, in an article by Scott & Dixon (1995) concerning the efficacy of psychological interventions, although their literature search produced a number of relevant studies/articles, they discarded some for not being ‘rigorous enough’ or failing to meet their criteria in other ways. Of the studies they included, many were criticised for not being methodologically sound or for paying inadequate attention to certain variables. Again, there are decisions being made about what is worth taking note of, even in studies that claim objectivity. (The notion that it is actually possible to include all potential variables in looking at something as complex as mental health/illness is problematic in itself.)
Chapter 1        Setting the context

The reviewer/researcher, no matter what their orientation, also chooses how much of any given text, including interview transcripts, to use or present – I might have written one line about Podvoll’s work, rather than quoting from it substantially and consistently. As Hazel neatly puts it, “[t]he circumstances of the space provided will constrain when and how many voices appear, as well as what they say and the silences and exclusions they produce…” (1996, p.312). This, she says is unavoidable, indeed this is the “very condition of any kind of voice” (p.313). Fine concurs, suggesting that researchers, necessarily, “wear a mask of openness but without doing justice to all the ways in which a setting might be understood…”; we are, he says, “by nature, an ‘interested party’” (1993, p.86). What modernist conceptions of ‘the literature’ may miss is “how the individual characteristics of the social scientist shape the way theoretical meaning is imposed on everyday experience” (Daly, 1997, p.335).

The motivation behind choices made in the literature review is also variable: is one reviewing the literature in order to find support for an argument, to express a range of divergent views, to discover theoretical gaps, to critique the work of others, or – which is more what I have done – to find interesting possibilities to expand or illuminate the words of participants and to position alongside their stories, in the hopes they might be useful to various individuals on their own journeys, whether academics, practitioners, or people trying to make sense of their own experience. My way of working seems to resonate with what Eisner (1991, p.172) describes as “closer to the creation of a collage than to the construction of a building.” Lincoln & Denzin (1994, p.584) suggest that the key commitment of qualitative researchers is to study “human experience from the ground up, from the point of interacting individuals;” Theory, then, becomes a set of “contested, localised, conjectural knowledges that have to be debated in a dialogic way” (Daly, 1997, p.359). This fits well with critical postmodern social work practice emphasising multiple perspectives, contextuality, relatedness and open-mindedness.

The final form of such a collage, Eisner suggests, “depends upon in-process decisions made because of the look of the configuration as it unfolds” (1991, p.172). While I started my research with certain ideas, experiences, observations and potential research questions in mind, the methodology of naturalistic inquiry that I adopted (described in more detail in Chapter Two) encouraged continual openness to new directions and understanding. As I continued to actively engage in interviewing, I continued to read continually, so that as new ideas entered my thinking via the
literature I was drawn to, new awareness was incorporated into my questions and conceptual horizon. Because my literature review was ongoing, rather than a discrete phase that ended when I began to interview, it continually informed, changed, challenged and widened my thinking. Due to the simplistic nature of my initial research question, it remained viable despite the nomadic nature of my reading and thinking.

Yin (1994), who has written extensively about case studies, states that the purpose of engaging in a literature review is to determine your questions, not your answers; the more ongoing the literature review, the more flexible and dynamic (and sometimes worryingly slippery) your research questions become. Often something said by a participant (or a theme which I seemed to be hearing, from my own standpoint and through my own filters) would trigger a new line of thinking and reading, or heighten my attention to particular cues in what I read, as the significance of other cues receded. Participants were very much, as Polkinghorne (1997, p.16) puts it, “co-actors… [who affected and contributed] to the unfolding research process…”; indeed, they often provided prime directives that I had not anticipated (for example, around the experience of what a former program resident named as a staff-client power differential).

Turner (1988, p.109) comments that alternating field work with analysis makes it possible to adjust one’s thinking and call into productive question one’s “botanising” of the shapes, experiences and stories being collected. As new ideas arise, he says, new questions can be formed about the inter-relationships between them; he refers to Bulmer’s notion of “preserving plasticity” – funnily enough I often thought of my research material (interview transcripts and other literature) as wet clay that I was continuously working with. I was intrigued by Peshkin’s idea (referred to in Stake, 1995, p.22) of tracing the “evolution” of research by re-titling a project every few months. Certainly if I went back through my field notes and index cards of literature that I noted as ‘seminal’ at various times, my project would have borne many titles, which I wish now I had recorded.

There is absolutely no doubt I have privileged some discourses over others, and that I have very much chosen, in a subjective fashion, the literature I refer to. I was drawn to humanistic, non-medical model, recovery-oriented and consumer accounts of ‘mental illness,’ qualitative approaches to research inquiry, and critical and postmodern approaches to analysis that question taken for granted assumptions.
around knowledge production and social work practice. This thesis is my story – or synthesis, or ordering - of the stories of others, whether those others are participants in the research project (people I interviewed), or “second-order stories” (Daly, 1997, p.350) from written texts, often called theories. Theory, says Daly (1997, p.350), “reflects the interests and puzzles of the theory teller.” Others would certainly have told the story differently or told a different story altogether. I would no doubt have written the thesis differently myself five years ago, or several years hence, as my subjectivity and even my presence would, like everything, have changed somewhat. (Indeed, the fact that it has taken nearly eight years to complete this thesis is evidenced by the range of different theses contained within it!) By saying this, I am locating what Daly refers to as “the missing person” – myself – the researcher / writer who has subjectively construed the raw material in a way particular to myself.

The story I have produced, perhaps, is no more or less an “act of imagination” than any other (Daly, 1997, p.350). Coles (1989) observes that the Latin root of ‘theory’ is, in fact, ‘I behold’. By putting ourselves into the picture, rather than claiming a disembodied third-person stance, we sacrifice (or are liberated from) a position of ‘objectivity’ and its attendant claim to empirical truth (DeLois, 1998). This is not simply a challenge to writing conventions (or positivist research paradigms) but a critical act. One of many great debts to feminism is the awareness that, as De Lois states, the situatedness of the researcher/writer “does matter” as research is always done from a political position (1998, p.2). Bert and Smith comment, in their discussion of the positioning of the self in social inquiry, that no matter what methods we use, we have to position our self somewhere, shaping what we choose to look at, what we see and “what we encode” (1988, p.9). My approach resonates strongly with Stake’s suggestion that the function of research (particularly case studies) is “not where with the primary criterion in selecting text/data/literature is the opportunity to learn.

**Connecting literature with data: melding of theory-stories**

Rather than presenting a separate chapter entitled literature review, my approach in this thesis has been to integrate an exploration of the literature with interview material in an effort to closely interweave stories and ideas and to present both as legitimate and valued theory/knowledge from diverse but equally valued standpoints. This seemed ‘natural’ to me, but has also been affirmed by experienced and respected qualitative researchers such as Wolcott (1990) who propose that the
best place to examine the literature is in consort with analyses of data. More recently, Hansen and Lavery presented a paper entitled “Why literature should be merged with qualitative data” at an international conference on qualitative research. They observed that generally researchers complete their literature review as a discrete research phase at the outset of their project, then shelve it and later resurrect it to reinforce and discuss their findings (2001). They propose that a more integrative approach is an ongoing and continuous engagement with literature, allowing key phrases and concepts to be ever-present in one’s mind, continuously modified and used in one’s interactions and analysis. I found that as I came across new theories or concepts in literature, I could – rather than keeping them to myself – ask participants what they thought about them: this way we could engage furthering sharing knowledge, views and insights.

Chambon (1999, p.72) observes that Foucault’s approach to knowledge making and writing in the social sciences combined a number of genres in one text: “alternating between the rational exposition of arguments, the language of immediate experience, poetic expression, and the language of revolt.” He points out that this stylistic mix is at odds with conventional social work writing norms that distinguish between emotional expression and academic reason. “Vignettes and analysis,” in social work texts, he suggests, “are spatially set apart, their respective styles generally contrasted.” this practice, according to Chambon serves to reinforce the divide between clients’ lived experience, and the theoretical and ‘expert’ knowledge of practitioners. In some small way, by positioning the stories of participants alongside material from the literature, I have attempted to acknowledge and bridge this divide. I have presented the words of other writers and texts to engage them in dialogue with the ideas, stories and observations of other living, breathing people. Goodchild (writing about the “politics of desire”) refers evocatively to theoretical “nomadism… wandering along a multiplicity of lines of flight that lead away from centres of power” (1996, p.2).

By merging the literature review with ‘the data’, “differences between kinds of knowledge (e.g. lay/professional), between narratives (e.g. anecdote/scientific paper), arise from their various occasions of production and use, not from any of the factual adequacy of different narratives and knowledges” (Curt, 1994, p.10). Importantly, according to Curt (1994, p.10), such integration also makes redundant the need to “establish truth claims for any given text, by treating each text as the product of a
field of motivated and local knowledge.” As such, all forms of social reality – be they scientific, sociological, psychological, anecdotal, narrative – are treated as textual and thus open to critical exploration around their production and legitimation; readers are encouraged to be attentive to interplays amongst texts and the power dynamics of these interplays, and sensitive to the constructed nature of knowledge.

Richardson (1992, p.136), as part of her “feminist mission,” describes how she continuously struggles “with ways to unite people’s subjective experiences with [her] sociological utterances” to create an “effective and affecting discourse.” Similarly, Manning (1997) makes what, to me, is a very liberating proposal: to write in a way that “leaves latitude for [readers] to compose his or her interpretations…” creating a document that still has a faint pulse even after it becomes frozen in textual time – something that’s “never complete, only finished” (p.110). If something that has been frozen in textual time still has a pulse, even a faint one, there is a potential to energise ideas in others. This presence of ‘pulse’ or life in a text was something I became aware of in my search amongst potentially relevant literature in the mental health field, as it gradually dawned on me that some texts seemed much more dynamic, dialogical and alive than others. Those I was drawn to contained, in my reading, possibilities for growth and empowerment on the part of both workers and clients, a clear sense of the individual and human reality of client’s lives, and a resonance with, in Roszak’s words, with “our [shared human] experience of freedom, originality and meaning” that may be overlooked by reductionist science (1979, p. 56). I have tried, as Bochner (1997, p.434) puts it so succinctly, to privilege “the story which longs to be used, not analysed” (p.434). “There is nothing as theoretical as a good story,” he goes on, particularly when the activity becomes one of “ theorising from a process of thinking about to one of thinking with” (pp.435-36). As I wrote – presenting material from interviews interwoven with insights and ideas from the literature – I hoped that anyone who might eventually read this thesis would be thinking with me and the various other voices in the text, engaging in dialogue and whatever forms of problematisation resonated with their experience.

**Problematising medical model/psychiatric literature**

Overall, I found the scientific/medical model/psychiatric literature, held in row after row of great tomes in the university libraries, not only mind numbing and draining, but non-dialogical, spirit deadening and *unhelpful*. Undoubtedly, this had something to do with my own standpoint, but suffice to say, little of it will be found in
this thesis. Heilbrun’s words echoed my feelings closely, as she described “more a sense of accumulation than learning” (1997, p.51) in relation to her research into an area of study she had thought would be stimulating and meaningful. ‘Knowing’ that individuals of a particular gender, age and set of ‘pre-morbid’ conditions were ‘x’ number of times more likely to experience re-admission to hospital than some other category of persons had some usefulness (although the next study might come up with contradictory findings), however this usefulness to support workers or recovering individuals seemed severely limited. Bochner observes that even when science improves “our predictions, it doesn’t tell us what to do” (1997, p.423) (my italics).

Rotov (1991, p.184) observes that statistical studies often engender the kind of essentialisation (averaging out individual human characteristics) that leads to stereotyping and stigmatisation; psychiatrists, he suggests, lag embarrassingly behind others inquiring into mental health/illness, and are still tied to the “idols of the laboratory” – physicalism, methodology, jargon, objectivity, and mathematisation. This is what Janesick (1994, p.215) evocatively refers to as “methodolatory” – a preoccupation with “selecting and defending methods to the exclusion of the actual substance of the story being told.” Indeed, the distrust of personal experience and narrative shown by positivist researchers towards ‘non-scientific’ material has been one of the “hallmarks of both the modern (academic) attitude and the scientific method” (Reinharz, 1988, p.154). For the past several hundred years, writing has been divided into scientific and literary writing, with “truth value” being denied to literary writing because it “invented” reality, rather than observing [and reflecting] it the way science presumably did” (Richardson, 1992, p.119).

Notable in scientific writing is the grammatical and symbolic split between subject and object. Also notable is the use of a metaphorical framework that constructs the messiness of human life as something to be ‘controlled;’ where ‘problems’ must be ‘managed,’ where variables are ‘manipulated’ and research questions and methods are ‘designed’. While this metaphorical construction, Richardson suggests, may not necessarily be worse than another, it does shape the “activities of the researcher and eliminates other dimensions of knowledge” (1992, p.123); indeed, “facts,” she suggests, only make sense “in terms of their place within a metaphoric structure,” constructed largely through particular literary practices and devices. In an earlier writing (1990), Richardson gives the example of the American Psychological Association’s Publication Manual, in which some 200 pages of rules
about material that would be accepted for publication dramatically narrowed the scope and style of research material. While abiding by these rules (for example, deductive reporting, abstractable to 150 words, parenthesised publication dates for citations, explicit identification of the writer with theoretical/methodological label) will, Richardson confirms, certainly assist one’s chances of having an article published, they are not “prima facie evidence of greater – or lesser – truth value or significance than social science writing using other conventions” (1992, pp.16-17). Agger (1991) suggests we “read science [and, I would argue, academic writing] not as a mirror of the world, but a strong, imaginative…literary intervention…” Methodology,” he suggests, “tells a story in spite of itself” (p.115). He suggests “the unquestioned belief in value-freedom [presumed by scientific inquiry] is no less problematic than the belief in God or spirit” (p.119); however, by claiming objectivity, a particular “version of the world” is built that “comes to stand in for the actuality it claims to represent” (p.75).

Indeed, this is precisely the type of account that maintains what Smith calls “the relations of ruling,” reliant on objectified bodies of knowledge and unquestioned social organisation (1990, p.84). While order is actually produced “out of chaos” (a messy, diverse, constantly changing and indefinite real world), according to Smith, it is made to appear as if it is discovered, and presented in ways that make routine, generalisable responses actionable and reasonable (1990, p.126). The notion that mental illness is discovered by the mental health practitioner is in direct contradiction to the principles of psychosocial rehabilitation which guide practice in the psychiatric disability support sector, and emphasise self-determination, empowerment, acknowledgment of diverse needs and experiences, and the demystification of professional interactions (see Robson, 1997; McDonnell & Clarke, 1997; see also Appendix B – Principles of Psychosocial Rehabilitation). Smith (1990) relates this obsession with ‘rationality’ to the wider patriarchal society in which scientific inquiry is embedded.

Along this line, Epstein (cited in Sorger, 1995, p.36) creates an evocative image of “unwrapping the cloth” from medical model/patriarchal structures based on “man-science’s definitions of seriousness.” McMahon (1990, p.26), as a result of her research in the nursing field, observed that typical medical model analysis evoked “closure,” which, through its emphasis on the production of “air tight knowledge…couldn’t heal what needed to be healed.” While national planners and
research councils continue to restrict their standards to positivist findings, Professor Beverley Raphael, herself a psychiatrist, comments that “any of us who have been involved in scientific research for a long time know the terrible failures of the randomised control trial” (cited in Sorger, 1995 p.27). Somewhat scathingly, Smith, critiquing medical model formulations of mental illness, suggests that the pursuit of objectivity actually makes it possible for people “to be paid to pursue a knowledge to which they are otherwise indifferent” (1990, p.16), which may help explain the lack of pulse and sense of dialogue of much psychiatric/medical model material. It is in stark contrast to the “empathic stance” suggested by Josselson, which aims to transform research into “a process of overcoming distance rather than creating it,” where the particulars of lived experience are attended to “rather than logical, positivist constructs about variables and classes” (1995, p.31). This latter form of inquiry has led me, on the whole, to largely reject medical model/psychiatric literature in favour of the wealth of material that has been written by mental health practitioners and consumers since the 1970s, and to interweave those materials alongside the stories of participants.

One of the challenges, then, in selecting useful literature and in writing up qualitative social work research is to “help practitioners deal with choices” about their interpretations and (inter)actions, inspiring and creating opportunities for “local and personal experimentation” with approaches to critical practice (Lomas, 1993, cited in McWilliam, 1996, p.153). Summarised findings about variables and measurable outcomes, McWilliam (1996, p.161) says, often do not suggest what either workers or service users might engage with; indeed, the depersonalised nature of the writing may hinder motivation to use the material. Stake puts it succinctly: research, he says, can certainly improve knowledge, “however knowledge production (i.e. research reports) and knowledge utilisation are often not enjoined” (p.94). It can be more useful, he observes, for research to be designed and written up in such a way that it evokes “vicarious experience which leads to improved practice” (1986, p.94), and/or, I would add, new understanding of self and experience for practitioners and non-practitioners alike. McWilliam suggests that qualitative research findings can “stimulate individuals to contemplate change and often clearly illuminate what may be changed and how that change may be implemented” (1996, p.161); in other words, they contribute to dynamic processes, and herein, perhaps, beats the pulse. Skilfully done, interpretive research, she observes, can build motivation for criticality and change on
the part of practitioners; holistic interpretations aligned with the values which motivate practitioners (for example, empowerment) may be much more accessible, engaging and useful. This fits well with the emancipatory nature of critical social practice – emancipatory not only for service users but for workers as well – by expanding, as Pozzuto puts it, the possible, through dialogue and action (2000, p.2).

The validity of the range of literature I have included in this thesis is to be found in its usefulness to critical practice, and its capacity to stimulate thought and criticality, and to illuminate experience in ways that are at least non-oppressive. Goodchild suggests that “knowledge is no longer a question of being able to repeat the main points of as many books as possible in a library, nor is it a question of being able to criticise their weaknesses and failings; knowledge is more like the capacity to direct oneself, through encounters with others, towards the most interesting and profound books in that library. Only through this knowledge can one awaken desire...aiming to include as much multiplicity and creation as possible in the work; the theoretical work then becomes a product capable of lying alongside other products, affecting them, interacting with them, leading off on new trails...” (1996, pp.4-5) (my italics).

Marris, writing before postmodern theories came into vogue, expressed that the value of his research into experiences of grief and loss, and the texts that he chose to present, depended on whether or not they facilitated people to “understand better and see more” (1974, p.3). Ideas, then, are presented as “candidates for others to entertain, not necessarily as truth, let alone Truth, but as positions about the nature and meaning of a phenomenon… that may fit their sensibility and shape their thinking about their own inquiries…” (Peshkin, 1988, p.280). Stake puts it well, suggesting that the aim of naturalistic case study research is to facilitate a vicarious experience for readers, which may impact on their own continually developing knowledge and practice. This is a form of validity – or groundedness - that sits well with me, and seems conceptually and practically aligned with critical approaches to social work practice.

**Problematising academic writing**

“Social science education did not prepare me to write from the heart, touch other people, or improve social conditions. My education taught me to write in a way...
that would bring respect from a small, elite group of colleagues. If I had not suffered losses early in my life, losses that traditional social science did not help me understand or cope with, then I might never have explored writing in other ways for other purposes…” (Ellis, 1997, p.135)

The language of academia, as Childress puts it, is something of a double-edged sword: it can serve as “a passport to credibility and advancement” within academic circles, while at the same time feel like a form of betrayal as we “talk knowingly behind the backs of our participants” (1998, p.256). This was something I consistently struggled with. Bochner suggests that by choosing “snippets of stories to exemplify our frameworks,” authorial power can be used to transform narrative into an exposition of theory, in which the researcher is positioned as distant and disconnected, in a world devoid of “spirituality, emotion and poetry… [where there is] no place for human feelings, motives or consciousness…” (Bochner, 1997, p.422). In relation to developing a greater understanding of mental health and well being, and the role of social workers in the mental health system, human feelings, motives and consciousness seem far too important to sideline. Powerful scientific/medical model knowledge and forms of speaking have historically objectified those experiencing psychiatric or mental distress, in ways that are not only inappropriate and damaging, but also not necessarily effective in developing insight into what might assist an individual’s recovery.

Josselson (1995) describes feeling guilt – as I did – when she took herself out of relationship with her participants to write about them, thus entering into a different sort of relationship with her readers instead (1996, p.70). (This does imply that participants and readers are not the same people, which is worth considering also.) Whereas in her interviews she had been responsive to and engaged with her participants, when she began to write she felt as if she was “using their lives” for her own purposes, to display her intellectual prowess and advance her career (p.70). As I sometimes felt similarly - like I was literally carrying away parts of people in my briefcase as I left an interview and went home to ‘process’ and reassemble them - I was relieved to read her words and her conclusion that, “To be uncomfortable with this work… protects us from going too far. It is with our anxiety, dread, guilt and shame that we honour our participants” (p.70).
Lather also discusses this appropriation of narrative in relation to her research project on the lives of women with HIV/AIDS, but she takes a slightly different approach. Her interviews progressively leave her with a feeling which she described as more akin to bearing “witness” to the experiences of the women, than intervening as an expert interpreter of data (1995, p.42). She refers to the “violence of objectification” which occurs when one turns another person’s life into “information for academic trade” (51). She suggests four intriguing types of validity for postmodern inquiry: ironic validity (which produces “truth as a problem”), paralogic validity (“concerned with undecidables, limits, paradoxes and complexities”), rhizomatic validity (which problematises the way we organise and communicate knowledge) and voluptuous validity (that embodies a tentative, engaged and self-reflexive approach) (pp.54-55), all of which are perhaps demonstrated to some degree in my research and in this thesis. These types problematise modernist notions of, for example, ‘progress,’ or ‘illness’ having singular meanings that are taken for granted and generalisable across contexts.

Research can be framed, Richardson (1990, pp.50-52) suggests, to express an open-ended and “in-progress state,” where final truths are neither sought nor claimed. This, for me, resonated with own intuitive approach, but caused some consternation when trying, as my supervisor sagely challenged me to do, to articulate what my ‘argument’ was. I related more to the idea of, as Richardson says, offering themes, which are clearly grounded in the ‘raw data’, and from which continuums of experience can be proffered alongside ambiguity, uncertainty and difference. For Richardson, writing is a “moral issue…a site of intentionality” (1990, p.39) in which the tone that the writer uses reveals their moral attitude toward the material they are writing about. It can be used to reduce one’s authority over the experiences of others: by increasing the presence of the participants as speakers, the writer’s own credibility as a social scientist can be increased as a result of consciously de-centring oneself. While I struggled to reduce my presence in the text of this thesis and let the wise and insightful words of others speak for themselves I also remained bound up in academic conventions of authorship; to compensate, at times I no doubt have receded too far behind the material as I felt it spoke for itself. At the same time, my presence as previously discussed, was already deeply entrenched by my choice and synthesis of material, and despite my reluctance to embrace author-ity, I have also been constantly drawn into traditional academic writing styles.
Chapter 1  Setting the context

The problem of representation, much debated in postmodern circles, has created dilemmas that I never fully resolved. When I read the book written by the Melbourne Consumer Consultants’ Group – *Do you mind?… the ultimate exit survey* (1997), I was struck by the absence of an authorial voice-over amongst the conversations of contributors that were presented verbatim. An academic authorial voice-over would have siphoned participants’ words through ‘the literature’ and overlaid them with authorial interpretations based on more or less explicitly stated theoretical premises. This may indeed have provided different insights that were of value: the end result would certainly have been different.

Opie, who characterises the textual appropriation of the other as a relationship between the “coloniser” and “colonised,” discusses how “textual authority is constituted,” often by the filtering of the new through the old (1992, p.55), a well entrenched academic writing tradition. This is not inherently ‘good’ or ‘bad,’ however, it does place somewhat arbitrary limitations on what can be considered useful knowledge. Articles such as that written by Walsh (1996), a short (five-page) unreferenced article on supports to recovery written from his own experience, provides a wealth of ideas about how to support an individual’s recovery process. Similarly, the four-page chapter at the end of the Melbourne Consumer Consultant Group’s book, (entitled *What Every New Worker Should Know*) provides enough information to digest and ‘apply’ to practice to keep a support worker productively engaged for quite some time. There may be something liberating for practitioners in coming to the end of something very informative, sitting with the ideas presented, and reflecting on them without the potentially deadening weight of ‘scholarly rigour’. An overload of information may actually negate the possibility of translating theory or narrative into meaningful thought or (inter)action: a form of paralysis can ensue in which the pursuit or ‘creation’ of knowledge, however obscure, becomes an end-point in itself. At the same time, particularly in the current economic rationalist environment, it appears to be a feature of contemporary academia that research output is crucial to ongoing university funding and credible academic performance.

Without apology, Lincoln suggests that academic writing is something to be “exorcised” or, at the minimum, viewed as only one of a number of “languages of the self” (1997, p.51). The group of contributors – qualitative researchers – to the book “Representation and the Text” (Tierney & Lincoln, eds, 1997) categorically states that they are committed to breaking “the science habit” (Tierney & Lincoln, 1997, p.viii).
They subscribe, they say, to an “ideology of doubt” (p.ix), which makes them actively suspicious of discourses that limit views of reality and exclude or silence those who are outside professional jargon and language. Along similar lines, Tompkins writes, in her article ‘Me and My Shadow’ about the “two voices” within her – one that writes for professional journals, using words like ‘context’ and ‘intelligibility,’ and the other that writes in diaries, sees psychiatrists, likes coffee and worries about her soul (1989, p.122). She goes on to suggest that the personal/professional dichotomy is “false and not-false:” that while there are arguments suggesting they must be kept separate, their arrangement as not only different but unequal - with one capable/acceptable of contributing to the production of (or the process of obtaining) useful knowledge, and the other not - is questionable. At times I wondered if the ‘me’ that engaged in dialogue with the wonderful people I interviewed, and the ‘me’ that sat at the computer integrating participants’ words with those from the literature, and the ‘me’ that had to present papers at postgraduate research conferences was – or should be – different.

Again, Laurel Richardson provides some useful insights into these ethical dilemmas of representation, relationship and power. She suggests that the question to ask ourselves is around the type of social relationships our writing is conveying: “How does our writing reproduce a system of domination, and how does it challenge that system?” (1990, p. 27). This resonates well with critical social work practice, and provides clear grounding for critical reflection. Indeed, writing about some people as ‘service users’ itself is an act and a product worthy of deconstruction to uncover the underlying assumptions and resultant (inter)actions made possible by its use. This includes its potential to create a fixed rather than dynamic identity, its potential to infer a complete rather than partial view of an individual, the context in which the label is created, the power dynamic involved and maintained through its use, and its potential for oppression and/or empowerment. A reconstructed (critical or postmodern) view would acknowledge not only the temporal, contextual and partial nature of this label, but also draw attention to ways in which power relations are being constructed and their impact on emancipatory practice. In our writing, as in our practice, Richardson says, “there is no way to avoid deploying one’s power if one chooses to act/write in this world” (1990, p.27), what Guba & Lincoln refer to as the “value-ladeness of facts” (1994, p.107).
The consequential nature of language must be acknowledged in relation to categorising individuals as ‘staff’/‘workers’, or ‘residents’/‘former residents’ in this thesis, as identities are being constructed in a particular way that does not necessarily acknowledge the partial, contextual and fluid nature of such labels. For example, a worker may at times be a client or a patient, may experience disempowerment in other aspects of their life related to gender, sexual orientation etc; a resident may also be a supportive sister, a future (or former) staff member, or a thoughtful student. An uncritical fixed use of labels can convey a particular positioning within hierarchical orderings of status and entitlement to speak ‘truth’ which impacts on all involved. One resident in the program commented that she did not like the way staff used the word ‘resident’ as it sounded “too institutional”. She preferred, instead, ‘flatmate’: “I’m not prepared to put myself in the institutional category of being a resident. I don’t see myself that way. And I don’t see people around me that way either” (AK74).

Worker and client identities are undeniably partial and contextual: they are created and sustained within a particular environment, such as the program, and are subject to change: indeed these identities have been different in the past and will continue to evolve into the future, for all parties. Despite the problematic nature of such labels, communication requires language, so, rather uncreatively, I have used these and other consequential labels throughout this thesis, for lack of generating an alternative. Rather than continually putting them in single quotes to acknowledge their problematic nature, it is hoped that both the reader and I will continue to engage in critical reflection on the consequential nature of such labels in various settings and texts.

**Acknowledging standpoint(s)**

The inherent subjectivity of the researcher informs every aspect of a research project from its inception (Parker 1995); even the researcher’s conception of ‘the field’ is a consequential act that can be conceived of as an *attitude* or position rather than an objective act. “Far from being neutral or inert, it is itself the product of disciplinary technologies” (Turner, 1989, p.13). The way we interpret who are to be valid informers, how much we control the scope of their responses, the sorts of relationships we foster, and how we identify themes are all highly consequential. The
constructs, hypotheses, and theories that we overlay on what we observe or gather (observation and gathering also being highly selective acts), according to Miles and Huberman, depend on “arbitrary” decisions “as to how, conceptually, we prefer to carve up the social universe…” (1988, p.352).

Even if we are reflexive in analysing our motivations, subjectivity and positionality, unconscious material will also be influential, playing a part in how and what we consider as data and theory (Alderfer, 1988). Our family history and context, the time we are living in, our professional training and identification, our biases and beliefs will all be part of the self we bring to our research. The researcher/writer’s search for patterns or themes in the interview material is shaped by their experience; experience which is, as Clandinin and Connelly suggest, composed of internal and existential conditions, and the researcher’s relationship not only to the inquiry itself but also to the participants. “Who the researchers are,” they posit, “makes a difference at all levels of the research” (1994, p.423) and who we present ourselves to be is also a choice that is made: the same person might variously describe themselves, or be described by others, as expert in a particular area of knowledge and hopeless in sustaining relationships: both may, to some extent influence both the field of enquiry and the methods used to engage in it.

I am currently a lecturer in social work at a regional university; however, I was shaped as a person long before I entered academia (or, from a Buddhist perspective, over the course of many lifetimes). Growing up in northern California in the days of the Vietnam War moratoriums and the burgeoning women’s movement, drawn to alternative hippy lifestyles and an explosion of new ideas, may have laid the groundwork for a future worker in a therapeutic community who would be open to particular ways of understanding human experience. It may not be a coincidence that the mental health theorists I resonated most strongly with were part of the anti-psychiatry movement of the 1970s.

My writing and thinking might also demonstrate that, despite my postmodern inclinations, I still engage in modernist dichotomous thinking that positions certain discourses as ‘the enemy’ to rebel against, as the social movements I identified with had pitted themselves against the American war machine or the conservative restrictions of the older generation. Perhaps this is where the ‘critical’ part of critical postmodernism becomes important. Still, I need to keep reminding myself of the potentially destructive nature of binary oppositional thinking as I tend to demonise
certain forms of knowledge even as I argue for the validity of a wide range of knowledges. My structural roots, highlighting oppression and patterns of inequality in society, are still strong and I believe valid ways of understanding experience. To some extent, my vacillation between the injection of postmodern theory into my discussion and a more modernist political/radical meaning frame is evident in my writing, and remains, to some extent, unresolved; if indeed resolve is required. From a postmodern critical perspective, it is possible to embrace therapeutic approaches and emancipatory practice. Similarly, there is no ultimate truth that says a piece of writing, a rendition, a theory or a conceptual framework must be used either for political purposes or slip into a nebulous realm of postmodern miasma: navel gazing and action can co-exist - in fact, one might enable the other.

The tensions I experienced between theoretical frameworks, along with an ongoing questioning of the usefulness of academic conventions (while still often resorting to them), produced a struggle to find and hold an authorial voice. On the bright side, rather than seeing this tension and movement as problematic, it may be more fruitful to frame these incongruities as part of an active search for expression. In some ways, the tone of the thesis reflects my own ongoing debates, puzzlements and movement between discourses, as my research and writing journey moved into more narrative, critically reflective or postmodern territory. My search for an authorial voice remained, to some extent, unresolved, and my approach to knowledge building eclectic, fluctuating between modernist and postmodernist tendencies. This may in fact mirror life, and social work practice, in the new millennium. On a more personal level, it also mirrors my general reluctance to assert an opinion in a range of public and private settings: euphemistically this could be described as open-mindedness, or astrologically, as a partial result of being composed entirely of water, thus producing a fluid approach to life. Being open to diverse forms of knowledge and the significance of narrative construction and meaning making, these explanations are as valid as any.

In drawing this chapter to a close, it is useful to return to the quote with which it began, in which Reason (1996) suggests that research is determined by one’s own quest, and is, in his view, a way of healing relationships with “each other and the world” (p. 17). While my desire in this research was to illuminate some of the processes occurring in the program and in individual experience, my quest was also – initially at least – partly about personal healing or closure. In a sense, my continued
involvement with the program, as a researcher after having been a worker, has been something of a ‘long goodbye’ that reflects my pattern of leave-taking in other areas of my life, as well as my fears around not doing a ‘good enough’ job even though I’ve ‘tried hard.’ I have never been very good at saying goodbyes – whether it’s leaving a party, a marriage, or a country. It may be that I felt my connection to the program and its people was unfinished, or not properly left, or that I hadn’t done well enough as a support worker and maybe I could ‘do better’ as a researcher. An alternative (and perhaps more empowering interpretation) may be that long goodbyes are a result of something that was significantly begun, and will never actually end although it is sure to change (Pease, personal communication, May 2005). As a worker, the program had challenged and confronted me on every level – from personal to professional; my attempts to make sense of my experience in the program and the experiences of others was ongoing and powerful. Our experiences as a team of workers were powerful; all around me I observed and felt the dynamic processes of the community and the individuals within it. After I left, these powerful impressions stayed with me, as something I didn’t fully understand, or rather – accepting that understanding is always partial and situated – I wished to understand more deeply.

Along with (wisely) telling me that one’s ‘psychological musculature’ as a worker was crucial to survival in the field, my supervisor had told me early on that a very important skill for workers in the program to possess was the capacity to live with loose ends. Indeed, loose ends were ever-present in the work, and often extremely uncomfortable – people feeling better, people feeling worse, people with deep struggles and suicidal tendencies that seemed to emerge just as you were clocking off, where there were no easy answers. As I began work on my research project, I was constantly, as a woman and a mother, also surrounded by loose ends – the unfinished, the messy – the unfolded laundry, the unswept floor, the dirty dishes, the unraked leaves – all of which would be loose again as soon as they were (temporarily) tied. My work – my reading, my writing, my preparing an interview guide – was accomplished amidst the clutter of children’s toys and dirty clothes, the sounds of Saturday morning cartoons and grunge music blaring. Maybe this wearing of different hats – of operating from and speaking to one world (academia) from the midst of another (the messy, the domestic, the world of sick children and unpaid bills) – this inhabiting of different worlds – had its impact on the way I conducted my research and the way I have ‘created knowledge’ as well. As I read through interview
material eye to eye with a grazing guinea pig, still wearing my pyjamas, I wondered if my thinking would have been different had I been wearing a suit (and perhaps being male as well) and sitting in an office lined with medical journals. Lewis comments on how her “commitment to working as an intellectual woman” was marked by the contradictory realities of public and private worlds/selves, but that it was in their fusion that she found “the rich tapestry” she wrote from (1993, p.221). The rich tapestry of which she speaks is a wonderfully positive way of framing what might also be described as a frenetic compulsion to be a good mother/house-holder as well as a credible academic/income earner and social justice advocate, while feeling like a tired middle-aged rebel/social misfit (surprisingly, not an entirely uncomfortable position).

All inquiry is, as Reason (1996) puts it, “directly connected to our lives and the questions we bring to our lives,” whether we acknowledge this or not; he contends that by “working on the edge of something in their lives” researchers are able to put their heart into their inquiry and seek out knowledge not just for curiosity “but for the sake of relating to people in different ways” (p.23) that are emancipatory. Richardson echoes this sentiment, suggesting that the most relevant task for researchers is to use their skills and privileges to affect public discourse and facilitate diverse voices to be heard, thereby generating a richer and more empowering field of narratives that people – including themselves - might identify with (1990). The idea of narrative identity, according to Fook (2003) carries with it possibilities for both coherence and change, allowing social workers and those they connect with, the possibility of constructing their own narratives, infused with the discourses of their choice, even if contradictory. Thus workers can both ‘know’ and ‘not know;’ service users can be both vulnerable and empowered; and credible research can be subjective and legitimate, contradictory and useful, partial and illuminating.

When I left the field of direct practice in community mental health and moved into academia, loose ends, change, ‘contradiction,’ and uncertainty followed me, although their forms changed somewhat. Each year I taught brought new ways of thinking and questions about what was previously ‘known.’ This destabilising of knowledge was both stimulating and challenging, and it was impossible to keep these new ideas from creeping into my interpretation of the research material I was collecting. While my research topic remained basically the same in relation to exploring experiences of living in a therapeutic community and what that might mean
in relation to support and recovery, my academic pursuits around critical reflection, postmodernism and critical social work contributed their own perceptual lens through which I viewed the material I was collecting.

In the following chapter, Chapter Two, I wind back the clock to discuss my process of engagement with the field, how I conducted my interviews and their subsequent use and interpretation. In the first part of the chapter, I discuss the researcher-researched relationship and my concerns around the power imbalances inherent in such relationships, as well as my own group membership in relation to the program. I go on to discuss my approach to interviews as mutually growthful dialogues, and my subsequent struggle with issues of accountability and authorship as I somewhat reluctantly ‘analysed’ the interview material. Chapter Two concludes with an exploration of methodological and theoretical underpinnings of the thesis.

Chapters Three, Four and Five ‘problematis’ notions of the professional gaze and the construction of subjects (Chapter Three), worker power and professionalism (Chapter Four), and explore worker boundaries, vulnerability and authority (Chapter Five). These chapters draw heavily on the words of program participants and former participants – workers, residents and former residents – as well as material from relevant literature. Chapter Three explores various constructions of what it might mean for service users to be the focus of a professional gaze, beginning with a discussion of what might be called a modernist gaze and its function, and concluding with a discussion of what might be considered a more empowering gaze.

Chapter Four problematises concepts of professionalism in social work practice, and examines worker power from a postmodern perspective. Again, the discussion is generated from a range of perspectives of program participants as well as relevant literature. The chapter begins with a discussion of the inherent inequalities of the worker-client relationship and the ambivalent nature of professionalism, and moves on to explore a critical and postmodern approach to professional power. Chapter Five further explores various constructions of worker practice and professionalism, in particular, worker-client boundaries, worker vulnerability and worker authority, with research participants’ stories interacting with theory-stories from literature.

In Chapter Six, I focus on the program itself, exploring the nature and notion of community and the significance of the environment to well-being, as conceptualised in mental health literature and as perceived and experienced by
program participants. In particular, I reflect on the construction and experience of therapeutic community. Chapter Seven identifies and explores the role of ‘sensemaking’, culture creation and meaning ascription – their relevance to social work practice and, specifically, within the program setting. Workers are identified as powerful agents in these processes. A range of examples of sensemaking in the program are identified.

Chapter Eight explores and problematises the role of program staff as change agents in the lives of service users. It begins with a discussion of recovery and hope in relation to mental and emotional well-being and goes on to look at what might be described as turning point experiences for service users. Some of the difficulties and complexities of personal growth or change are discussed, from the point of view of program participants. The chapter concludes with an exploration of the role of workers, and the program itself, in contributing to a recovery-oriented experience and environment. Following on from this chapter about change and turning points, Chapter Nine problematises and explores the notion of ‘outcomes’ in relation to mental health, beginning with some history around the development of outcome measures in mental health services. The non-linear, subtle and ongoing nature of recovery is then discussed, again drawing heavily on the voices of program participants. The chapter concludes with program participants’ views on the measurement of outcomes. Finally, Chapter Ten discusses participants’ experiences of leaving the program, and the mixed feelings that created for individuals. In this concluding chapter I also reflect on my own experience of coming to the end of my research project: also an experience of mixed emotions, after years of engagement, learning, and change.
Chapter 2

Developing an approach

“*I feel that I SHOULD be asked what my reflections are, because I lived there for two years! What do YOU know, you only worked there nine to five!*” (former resident, NA)

In this chapter I explore the relationship between the researcher and other research participants, the interview process, and the interpretation of interview material. In these discussions, I relate my approach and experience to qualitative research literature. My approach was aimed at exploring the experiences of diverse individuals whose voices might not usually be heard in traditional psychiatric (or, for that matter, social work) discourse, but who had many and diverse insights to share. Despite the inherent power inequalities of the researcher-researched positions, my aim was to foster an environment in which interviewees were co-collaborators in the construction of knowledge. This meant a number of things in practice, which are discussed in this chapter, concluding with a discussion of the main methodological and theoretical underpinnings of this thesis, and locating the study within naturalistic or constructivist approaches to inquiry.

In this chapter, and throughout the thesis, reflections on my own life and experience are interwoven with the other voices, to convey some of the personal learning which, I believe, is intrinsically linked to whatever work we engage in. As I wrote and thought, it became increasingly clear that many of the struggles, challenges and experiences of program participants mirrored my own, in relation to such things as fear of change and agency, the meaning of well being, ongoing recovery from loss, and the creation of (dis)empowering self stories. Thus the diverse individuals whose stories I hoped to convey came to include some parts of my own: this can be located within traditions of critical reflection, experiential research or even autoethnography, although at the time, they may have been experienced more as confusion and struggle.

The researcher-researched relationship

As Clandinin and Connelly (1994, p.422) suggest, researchers enter the field – and hence develop *relationships* with participants – with “certain intentions and
purposes, and as the one most often initiating the research relationship”; as such, they go on, it is the researcher’s responsibility to put the well-being of participants as a primary concern. While these authors were not writing particularly about research in relation to mental health/illness, it may be particularly important to take this responsibility seriously when initiating dialogue about stressful, traumatic or vulnerable times in a person’s life, which the individual may still be in the process of coming to terms with and achieving some sense of recovery from. In a wider sense, it is also important to critical social work practice, that disempowering, pathologising and objectifying practices and experiences (such as some forms of medical/psychiatric models or positivist research) are not reproduced. As feminist sociologist Lynda Glennon iterates, face-to-face situations such as interviews have the capacity to create and sustain dominant and potentially oppressive social arrangements (1983, p.270), or something more consciously engendered from an anti-oppressive stance. This requires honest and ongoing critical reflection on what sort of social arrangements their research interactions are (re)producing. Critical social work practice would suggest, at the minimum, a dialogical and anti-oppressive relationship, but what this means in practice is potentially more difficult to ascertain and to embody. Through critical reflection on specific moments and forms of (inter)action, and listening to the experiences of a range of people involved, praxis (the linking of theory and practice) can perhaps become more possible. This takes courage and a willingness to change and grow.

**Power and collaboration**

When looking back over my field log, I remembered my own concerns, particularly at a specific point in time – indeed, during and after a particular interview – where my unease in my role confronted me. I felt, in this interview, that I was replicating the sort of unequal power dynamics the person I was interviewing was raising: she described her dislike, during her time in the program, of the experience of feeling not only ‘inferior’ to staff in the program, but also forever cut off from any reciprocity of relationship. And here I was, in her house (in possession of not only her home phone number but her address), asking her to talk about some very painful and personal experiences, while she had no idea of where my house was or what my experiences and indeed the condition of my mental health had been over the past few months.
Despite the ‘best intentions’ of researchers who align themselves with collaborative and egalitarian relationships with interviewees, the subject positions established by assuming the roles of researcher and researched must be acknowledged: undoubtedly the researcher exerts power throughout the research process, for example, by instigating and directing even unstructured interviews, right through to writing up the paper or thesis. In postmodern or critical terms, the categories of researched and researcher would be further analysed to reveal a potential range of identities bound up in each of those roles, which may make a person feel more or less (dis)empowered. A white, male professional may feel less of a ‘power differential’ with a researcher than a homeless female with a psychiatric diagnosis (although this construction is also open to problematisation).

Wolf describes how feminist challenges to traditional research methodologies and relationships attempted to create a situation of friendship, collaboration and reciprocity between the researcher and the researched. However, she cautions, referring to the words of Shulamit Reinharz, “purported solidarity” may sometimes be “a fraud perpetuated by feminists with good intentions…under the ‘guise of solidarity’ you can,” she says, “actually wind up betraying your participants even more” (1996, p.20). This is somewhat akin to Josselson’s sense of guilt in talking about participants “behind their backs” in language that is alienating, jargon-filled, and aimed at attaining academic status. In an article intriguingly titled ‘The Ethics of Rapport,’ Wong (1998, p.181) discusses the potential for exploitation he observed in his own research project, when he wondered if people were being “seduced” by a “friendship rapport,” whereby the interviewer makes a more or less conscious attempt to “defuse, displace and distort the power dynamics that exist…[creating] a “delusion of alliance in which betrayals can easily occur” (1998, p.192). He does not suggest what form these betrayals might take, but comments that something as basic as the informed consent form is a very real reminder of the power differential inherent in the research relationship.

At one point in my research process, a manager within the program’s parent organisation reflected back to me that I seemed worried that I might be ‘disarming’ participants by leading them into exposing themselves and then feeling burdened by the responsibility of having done so. In a sense he was right: I often asked myself how I could do justice to participants’ experience and the stories they shared with me, and, in particular how I could interpret their material in ways that did not exploit or distort
their experience. Berg (1988) discusses a range of anxieties that may develop in the research relationship, one of which is the sense of multiple responsibilities a researcher may feel, and the importance of attending to these anxieties as useful messages with their own potential for greater understanding of the research process. Indeed, the anxieties and concerns I experienced in relation to honouring the participants and their stories, despite their sometimes-excruciating discomfort, could and did hold great value as they sensitised me to potentialities for trespass and sharpened my commitment to do no harm.

At times, I shared my concern (or ‘guilt’) with participants; the following conversation occurred with a participant/former resident who had left the program several years previously and whom I had known quite well when I was a worker:

*Interviewer/me (I):* “I feel like... I hope I’m not just being selfish by taking people’s reflections... I’ve felt like that sometimes.”

*R:* “Like Margaret Mead with the Papua New Guinea highlanders?!”

*I:* “Not quite!”

*R:* “I mean... like, I don’t talk about this stuff very much at all...now and then I’ll have a chat with [close friend], but not that often. It’s not something that I’d really feel comfortable about chatting with people at uni, who don’t know my history...”

*I:* “Yeah, I respect that. And I hope that talking about it with me is okay?”

*R:* “Talking to you is always a pleasure.”

*I:* “Well, talking to you is too.”

Such an exchange left me feeling better about what I was doing and is an example of the gracious good will extended to me by individuals who could just as easily be my colleagues or my friends rather than be in the roles of worker/client, and now researcher/interviewee we occupied.

Power in the interview situation may be ever present and will, to greater or lesser degree, circumscribe relationships (Tierney& Lincoln, 1998; Kvale 1995), however the way in which researchers understand and use that power can vary dramatically. Interviewers are always directing in some way, and are, of necessity, using *themselves* as a tool (Jones, 1985; Wong, 1998). This use of self can, as Chase puts it, proactively “invite stories that encourage a shift of responsibility for the import of talk:” the task of an interviewer, she suggests, is “to provide the interactional and discursive conditions that will arouse [the interviewee’s] desire to
embrace that responsibility” (1995, p.12). The creation of a more egalitarian relationship might include, according to Wolf (1996), researcher self-disclosure, openness to being asked questions, and engaging in more of a dialogue than a question-answer format. All these practices seemed quite organic to me; they did not feel like ‘techniques’ but more like ‘natural’ and respectful ways of being.

Jones (1985) suggests that, like everything in life, people attribute meaning and significance to the research situations they are in, and the stories they share depend on how they define and experience the interaction. Participants, she suggests, may be less likely to feel exploited by the researcher if they see the relevance of the study and may appreciate follow up interviews as a means of extending and clarifying the meanings of their stories. Responses from interviewees, such as the one presented at the beginning of the chapter, suggested that participants in my project were keen to share their insights and experiences, believing they could be important to others and that they came from a view that was not always elicited or validated.

In following up an initial interview it was useful, as Hollway and Jefferson (1997) suggest, to use the words and phrasing of interviewees, echoing (what were to me) significant points from the previous meeting, and asking for further clarification or expansion. Sometimes this meant returning for a second interview, beginning with the interviewee’s own themes from the first interview as focal points. To ask people if they would be interested in doing a second interview, I sent them a letter thanking them for sharing their insights, experiences and observations, and asking if they would be interested in furthering our dialogue; I listed in the letter some of the issues they had touched on the previous interview, which I thought we might pursue. I hoped this would provide a choice of how much participation they wanted, whether they wished to converse more about these or other issues, and/or as an opportunity to raise anything new. It would also, if desired, give participants some time to think ahead – so that I would not be the only one with an opportunity to prepare; although I was still ‘setting the agenda’ this might, to some extent, be a way of sharing the agenda-setting power. Were the things I thought were significant of enough mutual interest to discuss further? Had the last interview been interesting or worthwhile enough for participants to participate in another one? The response was positive: everyone I contacted agreed to be interviewed again, some participants I had not contacted for a second interview rang to request one, and almost without exception all those I interviewed offered, unasked, to be available for another interview.
Having said this, there was one respect in particular, where my espoused aim to share power and collaborate with participants, became somewhat hollow in actual practice. This was in relation to sending interview transcripts to participants for checking. Indeed this is often suggested by qualitative researchers as an important aspect of true researcher-‘researched’ collaboration. Had I engaged consistently in skilful critical reflection throughout the research process I might have identified this gap between my espoused theoretical framework and my actions, leading to the possibility of reconstructing my practice more in line with my purported framework. My reasons, at the time, for not inviting participants to review their transcripts were primarily around the time and expense involved in reproducing transcripts which were often over twenty pages long, my fear about people withdrawing material if they felt they hadn’t really said it ‘right,’ and the extended process that it would entail as I felt time was running out. Unfortunately, my process potentially reflects that of others whom I might label as uncollaborative.

**Group membership**

Fook (1996), who has written extensively on the use of critical reflection as a key component of accountable social work practice, proposes that the researcher must be open to reflexive and courageous analysis of their own position, for example, how they influence the process and product of their research. Following on from this, it becomes important to acknowledge the contexts, identities and group memberships of the various participants in any interaction, including the interview process. Kram (1988) provides an interesting discussion of the salience of group membership (specifically age, gender and professional group identification) and its impact on interactions between researcher and participants. She comments on how her own stage of personal development, as well as her professional affiliation, shaped not only her choice of research questions but the relationships which evolved between herself and participants; she concluded that group membership (as well as personal characteristics) impacted on one’s capacity for rapport and empathy, creating blocks or limitations in communication or capacities for dialogue. Because group membership of some sort is unavoidable, the key is in one’s critical awareness of how the various group memberships of all parties may impact on the research process and ‘findings.’

Perhaps the most salient of my own group memberships in relation to this project was my former connection with the program as a support worker. While I
acknowledge the potential for this affiliation to impact negatively on what participants were willing to discuss, after considerable reflection (and exploring with participants how they felt about this) I believe that on the whole – and perhaps significantly – my connection and ‘known-ness’ in the program actually increased the potential for honest and open communication in my interviews. Some participants knew me from when I had worked in the program (for some, as their keyworker); others knew me from my relief work there; others did not know me, but knew that I was known by their friends/peers. As Kvale (1995) points out, familiarity with the content of a study is not obtained only through literature and theoretical studies – familiarity with the environment gained through immersion and experience can also be very useful in generating curiosity and talking points. It seems that in this project, familiarity with some of the processes participants may have experienced, familiarity with the language used within the service or program, and inklings of some of the issues that staff and residents grappled with, was useful. At the same time, it was important to not let my familiarity obscure opportunities to be genuinely curious about participants’ experiences.

I strongly believe that some former residents would not have agreed to be interviewed by a stranger, and given that they were required to contact me (as a result of the letter of invitation I sent out) probably would not have pursued the matter further, had they not known me and felt comfortable with me. The fact that a number of residents actually requested a second interview, and that none refused an interview, also seemed indicative of an openness to me and the project. Indeed, at one point in my field log notes I had written, after a very rich and insightful interview with a former resident: “I feel quite blown away by the realisation that I actually learned more about (name) in this interview – her struggles, views, needs, goals, obstacles – than I had in the months of working with her in the program. How can this be?”. I answered myself that perhaps she felt freer to speak when both she and I had left the program, or when the purpose of the dialogue was reflective and open to co-construction. There is also something about the benefit of hindsight that cannot be denied in looking back on a previous state or experience. I also questioned whether as a worker I had actually closed off communication that I felt was too difficult or confronting; perhaps as a worker I had been too bogged down by misguided feelings of responsibility to achieve change, which, coupled with anxieties of incompetence, precluded me from being more attentive. Perhaps I was now asking different
questions for different reasons. Perhaps we were now somehow more equal – engaged in a mutual inquiry. “What did we both bring to the research interview situation,” I wrote in my field notes, “that perhaps neither of us were able, at the time, to bring to the client-staff relationship?” This experience was to happen a number of times in my research process, where the stories told by participants in the research setting provided ‘light-bulb’ experiences to me as a former worker with that person.

Clandinin and Connelly (1994) contend that it is largely the relationship between the researcher and participants that shapes the material that is told and ‘collected’. The way the interviewer acts, asks questions and responds, they say, shapes the relationship between the two, and thus the way individuals narrate their experiences. The relationship between the interviewer and interviewee (or researcher and participant) should, according to Berg and Smith (1988, p. 23), receive the same intense scrutiny as other methodological issues; it is, they suggest, “an extremely powerful determinant of the quality of the data” and must be described in such a way as to provide the necessary context in which interview material is interpreted. Critical to this, they suggest, are the circumstances under which the research was begun, and the emotional context in which the study was conducted.

As previously mentioned, I entered the field of the program as, at least to some extent, a known person. Some current residents in the program I had known as a full-time worker, or as a relief worker. All the former residents were known to me, and I to them. Of the staff, I had worked with three in a full-time capacity; others I had come to know somewhat through relief work in the program. For residents who were newer to the program and did not know me at all, there was probably something about the fact that others knew me, that inspired some confidence or trust, or at least made my presence when I came to introduce the project and when I came to do interviews, not too intrusive.

**Making initial contact**

My initial physical entry as a researcher into the program, after negotiating the opportunity to present the project to the community with the parent organisation and program staff, was via a community meeting where I introduced the project and invited comments and feedback. Community meetings were held weekly to discuss issues of relevance that affected the whole group; all community members attended. At the time I was conducting my interviews, which spanned almost twelve months in total, there were approximately fourteen individuals in residence, and four staff
members, including the program manager. Several weeks after my initial introduction of the project, I returned to another community meeting to discuss the project further after people had had a chance to think about what I had said, and to read the material I had left. Staff at the time were very supportive. As previously mentioned, my own sense of comfort and familiarity with the program was that of someone who had worked there intensively over a period of several years as a support worker. In a sense, I was both an insider and an outsider, but the balance felt ‘right’ in that I belonged enough to have a certain level of understanding and empathy for program participants (including staff), but was enough of an outsider to, potentially, be freely spoken to. Residents who were interested in being interviewed simply told me, or their key worker, that they would like to participate and I followed up with them to arrange a time. Former residents were contacted by letter through the post, with a cover letter from the head of the organisation authorising the project. Of the former residents who were contacted, nearly all of whom had known me, all responded in the affirmative, by phoning me to say they would like to participate. It seemed that being known (and presumably trusted) was significant in getting such a good response rate to my letter. Former residents seemed keen to meet with me and discuss their experiences. All but two former residents asked to be interviewed in their homes; the others chose to be interviewed at the program setting. Descriptions of the interview process as one of mutual learning, conversation, and dialogue, from which the researcher writes an account resonate with my experience and engender a potentially empowering relationship for all parties, as well as a process that is likely to yield more detailed experience and insight (Burman, 1994).

All in all, I interviewed three former staff members and the four current staff members (including the program manager); twelve persons who were residents in the program at the time of the project; and fifteen persons who had formerly been residents in the program. All then-current staff members were interviewed twice, and there was one group interview. Approximately half the current residents were interviewed twice (either because they requested a second interview or because the first interview had been cut short due to time) and five of the former residents were interviewed twice, for the same reasons.
Chapter 2   Developing an approach

The interviews

Kvale provides a useful description of the qualitative research interview as “a construction site of knowledge...literally an interview, an interchange of views between two persons conversing about a theme of mutual interest” (1996, p.2). He suggests that a researcher-as-traveller (rather than researcher-as-miner) metaphor aligns well with a critical or postmodern approach to inquiry, in which the interviewer “wanders through the landscape and enters into conversations with the people encountered” (p.4), leading them towards certain themes the researcher is interested in, but maintaining a respectful and flexible openness to what the interviewee finds meaningful. While this may sound rather haphazard, he goes on to observe that technically, the qualitative research interview is neither an “open conversation” nor is it a highly structured one, but is conducted according to an interview guide focussing on certain themes and including some possible questions. Although I came across Kvale’s writing when I was nearly finished with my interview process, I realised that the method I was intuitively drawn to was very much like the one he proposed.

Maintaining flexibility

While I brought an interview guide (see Appendix C) to every interview, I rarely referred to it during the interview – it generally lay on the table between me and the other participant, for either of us to look at if we wanted. In the interviews I tried to go with the concepts and ideas that were being raised by the respondent, while keeping a general skeleton of topics or concepts in my mind. At times, depending on what I had been reading, I asked what they thought about a particular concept or idea. Turner (1989) affirms that useful questions can be formed by continually (re)adjusting one’s thinking and exploring the “inter relationships” that develop “between the new cognitions that are developing” (p.109). For example, in one interview with a former resident, we were discussing how difficult it was, at times, to separate ‘normal’ conflicts and issues (separating from one’s family of origin, or issues of sexuality) from those that were ‘symptomatic’ of an illness experience. I asked if the interviewee thought it could be helpful in a program or service, “to look at some of these things... I mean, a word that’s used sometimes is ‘normalise’.” After a pause, the interviewee responded, “Yeah... I think it is. I’m just not sure, off the top of my head... I can’t really think of an effective way of doing that. It’s hard to do it in an experiential way. I think its hard to do it in that kind of setting, simply because of
who the peer group is. I think it’s hard to normalise things in that kind of setting” (IR2 3).

Another example was in an interview with a different person who had formerly been a resident, which we engaged in at the time I was reading a book called Precarious Haven, by Juniper Wiley. We had been discussing the input of service users into program content and process, as well as notions of professionalism, which reminded me of material from the aforementioned book. I said, “I’ve been reading this book called Precarious Haven, about this therapeutic community in California that was really quite unusual. But they had the situation there where people were employed as staff but they sort of talked about their issues, and were open to therapeutic interventions, and the office was totally open for everyone to be in and out of, and reading everything in. And I was wondering what that would be like…” The interviewee responded, “Well, I did a thing [report in relation to studies) on [name of drug/alcohol program] and I was just reading up very briefly on therapeutic communities, and it says that the idea is that you’re all members of the community, and that you all share, whether you’re a staff member of a member of the community. And when you put really strict things on professionalism I don’t see how that fits in. I like the idea of that better. Although there’s different degrees to how far you can take that, I guess” (NA2 4). These seemed to be ways of sharing ideas and creating mutually informative and reflective dialogue around them.

The fact that the tape-recorder was recording the conversation left me free to listen and engage more attentively than in the few situations where participants asked that the conversation not be recorded. Most interviews with staff and then-current residents took place in the piano room – a smallish room with some comfortable chairs, a piano and a low table, looking out through a garden onto a quiet tree-lined street.

I saw the interview guide and questions more as a point of departure than arrival. I liked the image captured by Curt (1994, p.120) to describe their “Q methodology”: that of “establishing a concourse” not unlike that of an airport, the not-insignificant strip from which an impossibly large and heavy machine takes off, with the majority of the journey ahead. I gradually saw my interview questions that way - as a point from which to take off, to initially get this bulky thing - my thesis, which included ‘the literature,’ the participants’ narratives and my own synthesis - to fly, while maintaining an openness to possible changes of direction or destination. In my
experience, the concourse was gradually built from a whole series of more or less conscious choices, various degrees of ignorance and awareness, and a constant flux of theoretical influences. The erratic influence of serendipity, or the less erratic nature of karma also must be acknowledged in relation to exposure to new directions and ideas and the development of interests in particular areas, as well as who I am as a person and what – however subliminal – my quest was or became.

Patton (1990) describes the use of what he calls “sensitising concepts” as a way of opening up discussion around the researcher’s area of interest (for example, in my interviews, the role of support, or the notion of community), without determining the outcome of the exploration. The enquiries of a qualitative researcher, according to Patton, are in a sense “goal-free” (p.56) in order to avoid narrow conceptualisations and openness to unanticipated material. Speaking specifically about qualitative research in program settings, Patton suggests that in this goal-free model, the interviewer aims to suspend any judgement about what it is that the program is trying to do, and to “focus instead on finding out what it is that actually happens in the program and as a result of the program” (1990, p.57). This fits well with the type of research questions posed in the previous chapter, and was an approach that seemed quite organic to me as a researcher and to the program itself. Patton suggests that programs may be usefully explored from a process-oriented perspective that aims to illuminate and better understand the internal dynamics of the program – what makes it what it is, how do service users experience it, and what is the nature of the interactions within it.

My interviewing style may, in some ways, have reflected the style of the program itself, or my interpretation of it, which was formed during the time I was a worker in this and various other programs of the parent organisation. One former resident, who I interviewed several times, when asked to comment on how she had felt about participating in the interviews, said that the exploratory, collaborative and listening style of the interviews seemed much like the way I and others had worked in the program, resonating with the program ethos around respectful engagement, support and openness. Along the same line, feedback from staff whom were interviewed also indicated that an open, dialogical process had seemed appropriate to the spirit and focus of the research project. The following excerpt is from a staff meeting I attended, where I provided some general feedback from the research at that point.
Me: “Are you interested in hearing a bit about some of the stuff that’s come out of the interviews...and this is all very tentative, this is all still my grappling with the material...In a way, today, I’m trying to give something back to you...”

Participant (staff member): “This process, today, for me, mirrors the process all along, which has been collaborative and information-sharing throughout...”

Ely suggests that not only the ‘answers’, but also the questions need to be “discovered in the social situation being studied” (1991, p.55); ideally, she says, the interview is an “interwoven dance of questions and answers in which the researcher follows as well as leads” (p.59). By starting with questions that are easy to answer, she goes on, (and having five to ten questions up your sleeve to get things started and refer to if talk slows), the interviewer can facilitate the beginning of a discussion in which they must be prepared to listen and respond to the cues that are being generated by the interviewee. Like the Kvale material, I discovered Ely’s book when I was well underway with my interviews, and found her writing to be a source of validation as her suggestions resonated with what, on the whole, I was already doing.

It is also important for the interviewer to listen attentively to the cues that suggest an interviewee may be painfully vulnerable in some areas of inquiry, and to consciously choose, in what the interviewer perceives the best interests of the participant at that moment, to not go further down a particular track. At times in my interviews it seemed more ethical to let things go, rather than risk compromising the person’s sense of control and safety (and possibly my own capacity to respond) around aspects of experience that were still particularly raw. At the end of each interview I checked with the participant as to how the interview had been for them; for individuals who were currently residing in the program, I suggested that if there were any issues that had arisen as a result of our conversation, they might want to pursue them with their keyworker. Interviews that were conducted within the program setting were known to staff, who were then attentive in following up in response to individual need. Because of my previous experience in the field, I trusted my judgment about not leaving an interview in a way that appeared unresolved or disturbing for the participant.

As I left each interview, went home and listened to and transcribed the interviews, my thinking expanded and became richer – sometimes a whole new area of exploration (for example, the “staff-resident dichotomy” raised by a former resident) would open up, which I could then pursue further via a second interview or
with new interviewees - what Kvale (1996, p.100) refers to as a process of “getting wiser” whereby conversations with participants extend and alter the researcher’s understanding and focus. Kvale makes the interesting suggestion that the quality of an interview can be assessed by the extent of spontaneous and relevant answers from the interviewee, the length of the participant’s answers, the degree to which the interviewer follows up and clarifies the meanings of interviewee’s comments and the “self communicating” nature of the interview – in other words, that it is a self-contained story that does not require much authorial voiceover. In relation to this last point, I felt strongly at times that the best use of my transcripts would be to simply ‘turn them over’ to anyone who was interested in learning, as they really did not require anything else from me.

**Interviews as mutually growthful dialogues**

My interviews were approached from an “empathic stance” aimed at connection and collaboration with participants and attentiveness to narrative as a “form of knowing…which privileges the particulars of lived experiences” (Josselson, 1995, p.33). Manning (1997, p. 93), like others (for example, Burman, 1994; Chase, 1995; Hertz, 1995), suggests framing interviews as dialogical conversations where meaning unfolds within a caring and trusting relationship, and where obtaining the participant’s story and perspective is privileged over the confirmation of any existing theory. In this sense, what she calls “fairness” is represented as an “issue of voice” – with the responsibility of the researcher that of attending to the whole variety of voices expressing different perspectives. “Ontological authenticity,” she suggests, is indicated when respondents make statements attributing growth to the research process. Although ‘findings’ are not traditionally embedded in chapters on ‘methodology’ it seems pertinent to include the following paragraphs now, as they provide some contextual validation.

Staff, residents and former residents commented on how the interview had led, in a small sense, to new ideas or growth. One fairly new resident made this comment: “...having just discussed with you all the roles of staff... I have never clearly thought through all the roles staff play before... thank you... it’s good to sit and talk about it, and realise actually how important they are” (AK). This comment also highlights what should never be forgotten: that is, that social work research, like casework, community development or group work, *is itself an intervention*. For one former resident, who had left the program under what seemed to be less than desirable
circumstances, the interview seemed to provide some sense of closure, as well as an opportunity for sharing insights. She commented that the interview had been really good and had helped her “understand things”. She said that she had thought a lot about the program and her departure; her support person, who had been quietly present throughout the interview, said to me as I was leaving, “thank you, she really needed this.” Perhaps, for some residents and/or former residents, sharing their insights was also an opportunity to put their reflections to positive use. The same former resident reflected, “Well, I did have a long time to think about it…[my thoughts] otherwise will go into dust… I think it’s important to have some kind of a record, of how things are, in peoples’ minds… so it’s good to have these kind of things.” Other comments, as simple as “thank you for asking me to participate” were important to me in validating the study, for its process alone, and affirming that the interview experience was a positive one.

Staff also commented on the usefulness of being interviewed, and being asked questions which assisted them to reflect upon and articulate their experiences, concerns and their framework for practice. “It’s actually been really good. Because a lot of this stuff I haven’t really been able to articulate, and I think I’m really quite raw in speaking about it. I haven’t really configured in my mind the responses… You’ve really got me thinking about the outcomes…” And from another staff member: “…you ask questions in a really… sort of explain where you’re coming from with it, and then in a really open way… so… I’ve found it really easy to access my thoughts… I’ve really enjoyed the interviews… I’m feeling a lot less stressed than when I started [today’s interview]… this has been therapeutic!” (mutual laughter).

Several staff members also seemed to find it useful in their second interview to “hear [their] story played back” as I re-capped some of their comments from the previous interview, which may have been several months ago, and I asked them to tease out ideas they had shared in the first interview. “I suppose I’m interested to hear where I was back then, in the first interview. I’m interested to see how much I’ve probably radically changed!” (AC). This is also illustrative of the ongoing learning that occurs for workers who are open to critical reflection on their practice.

Another staff person commented on the potential usefulness of what I, in the privileged position of interviewer, had shared with participants. She put it this way, when I spoke to her towards the end of the project: “…I had a sense the other day of how much information, or peoples’ insights that you would hold – [and] that I wanted
to KNOW! Like I wanted to be a fly on the wall in your interviews, because you ask the kind of questions that we haven’t actually asked in the same way. They’re really important questions...So I just have a sense of...kind of envy, that you have all this information. ...I think, ‘well, I’ll get to read the thesis,’ but I won’t get to have had the personal contact. ...I just have this image of [you] being really full, and you’ve spoken to so many different people – staff, residents, ex residents – just the full picture, the overview. And I know it’s something I’ll never be able to have, because I wasn’t part of the whole process like you are. ... It feels quite special” (EC).

On occasion, participants seemed surprised that I would value their ideas and insights and consider them to be legitimate sources of knowledge, such as reflected in the following quote from a second interview with a former resident.

Interviewer/me (I): “I really appreciate your wisdom.”

Participant: “My wisdom?!?”

I: “Really, your wisdom. Because I learn a lot from what you say, and the other people that I interview... because you have actually had the experience, it is really valuable to hear what you have to say.”

While openness to participant direction in the interview is highly desirable to enable a sharing of power within the interview relationship, to elicit meaningful narrative and even personal growth, it is also problematic to make claims as a researcher of having no agenda. Burman pulls no punches in suggesting that semi-structured interviews are “at best disingenuous and sometimes a dangerous misnomer for refusing to acknowledge prior expectations or agendas” (1994, p.50). Assumptions, she contends, structure all research, and hence must be acknowledged and reflected upon, in order to gauge their potential impact on the material, which ‘emerges’. Given this, she does not entirely disparage the semi-structured or unstructured interview, and goes on to identify four main reasons for conducting such interviews, all of which fit with my project: a) concern with subjective meanings, b) capacity for responsiveness in the moment, and exploration of complex issues, c) forcing researchers to confront their own participation in the process, and d) rendering visible the power relations in research (including structural issues of class, gender, age and ‘dis’-ability).

In one of the few articles reviewed that challenged the authenticity of the research interview, Atkinson and Silverman (1997) provide a thought-provoking postmodern deconstruction of the interview. They suggest that it is romantic idealism
to think that someone’s true self is revealed in an interview; in fact, they suggest, a self is constructed or performed by an interviewee (and an interviewer). Interviewers may feel a sense of authenticity and security, believing that lived experience revealed in the interview setting is somehow above question, however Atkinson and Silverman suggest that lived experience is “always narrated,” thus the interview is a site where biographical material is “performed” as a narrative which “invents the self” as it goes along (1997, p.318). The collection of narratives, they caution, is not so much about revealing selves, but creating them through narrative work.

However, it can also be argued, and certainly I would suggest, that we are always in the process of creating and inventing our self: both within the confines of our own heads and in our relationships with others and with the world. Qualitative interviews can, if approached ethically, sensitively and reflectively, provide, as Miller puts it, a stimulus for self reflection in interviewees, affording the opportunity “to explore themselves, to increase their awareness, to find meaning” and, importantly perhaps, “to be understood in the context of a relationship” (1996, p.133). Miller goes on to suggest that both researcher and participant “are on a search – engaged in a project of exploration and inquiry…” together forming “a unit of inquiry” (p.138).

This was, for me, what made my interviews energised and rich, offering constant opportunities for critical reflection and growth. Ideally, according to Reason, we would be calling into question “the whole process of our knowledge creation…but in a way that continues to honour the experience of those for whom we speak” (1996, p.23).

An intrinsic part of this search, for the researcher/interviewer, is an openness to and willingness to embrace self-change as a result of the ideas of and interactions with participants. Research as intervention, applies to the researcher as well as the researched, although social work intervention generally may not adequately acknowledge this. Miller (1996) uses the metaphor of adding fertiliser to “the seeds of thought or feeling that had been lying dormant” in him (p.145), “in short…constantly being affected and influenced by the other,” and in turn affecting and influencing them; for Miller this was an experience to stand in awe of. Ponticelli acknowledges that this openness to self-change as part of the research process can be an unsettling feeling for researchers. However, she says, we “must be willing to place ourselves at risk of change,” especially when researching the experiences of those the researcher considers very ‘different’ to themselves (1996, p.217). Indeed, she goes on to state
that she would never ask individuals to reveal anything about themselves that she
wouldn’t reveal about herself.

In my experience, openness to being changed has felt, at times, like a ‘risk’ of
sorts: I discovered in my field log my own apprehension around learning things about
myself from my research participants(and here, shamefully, I am speaking particularly
of those who had been designated ‘service users;’ somehow it seemed more
‘acceptable’ to learn things about myself from staff). I had written: “...is it okay to be
learning things about myself?...some of the interviews...were dialogs where I really
did take on board ideas that were helpful to me personally, in my journey, in my own
inner struggles... I think of the articles I’ve read which are about workers and clients
being on a mutual journey of personal growth.” Not only can we be open to learning
and change in the focus of our research, but in the process of our own continual
becoming as humans.

Certainly, the focus of my research, my questions, my perspective, and my
idea of the nature of ‘research interactions’ changed throughout the project, and was
reflected in my approach to interviews – both the way I interacted and the directions,
which opened up. I was very keenly aware, after the interview with a former resident
which I referred to in the first page of this chapter – where we were sitting in her
living room – that I was going to make some changes in the way I ‘conducted’ or,
perhaps ‘was,’ in my interviews: that I would be more open to communicating my
learning in the immediate context of interview conversations, to sharing more of my
insights or observations about the issues being discussed and the process and purpose
of the program as I saw it, and the evolution of my research experience and project. In
other words, I made a decision to be more open to sharing my own process of
becoming. I then began to feel much less as though I was guiltily carrying parts of
people away in my briefcase, and felt noticeably lighter and cleaner after interviews.
Many interviews, from my perspective, were characterised by moments of mutual
learning and illumination, laughter and enjoyment in the co-creation of ‘knowledge’.
Perhaps this was enhanced by a sense of relief that I was, at the very least, not (to my
knowledge) harming people by asking them to speak about what experiences of
potentially extreme vulnerability, trauma or even ‘shame’ as reflected in the following
statements from former residents.

“As I said last time, it’s nice being asked how I feel (pause)... It’s a bit...
digging things up again... [name of partner] and I discuss [the program], but not that
often. And I wouldn’t with anybody else. Although I still think about it, it’s not something that I really talk about with people…” (NA)

“You can never gauge it [what people thought of the program]… and nobody wants to write back [to agree to participate in a research project], because they’ve sort of worked through their problems and it’s not as if they really want to remember the place… Some might, but some people might want to leave it behind” (YK).

Before going on to the next section about interpretation/analysis of interview material, I would like to comment very briefly on the use of metaphor that I observed by others and myself during the interview process. These metaphors were often particularly striking in terms of their capacity to illuminate something as complex as one’s emotional state in a few words. One such metaphor that comes to mind immediately is one resident’s comment that she felt like a “half rushed rug” in terms of her own process of recovery. Another was offered by the former resident who spoke of the therapeutic massage (from the thumbs of the staff and the community as a whole) needed to ease his psychological knots as a precursor to developing his own capacity for self-massage; another spoke of himself as a fragile butterfly coming out of a chrysalis; and another of being encapsulated in an eggshell which was beginning to crack and from which he could tentatively emerge.

My own metaphors were strongly experienced: my research material as wet clay; at times, my ‘thesis’ as a Loch Ness monster, stirring in the depths, and my wondering if it really existed at all; and often a feeling of being a circus plate-spinner, trying to keep all those whirling plates aloft– index cards of referenced material, transcripts, ideas, photocopied articles – as I ran around trying to keep them from crashing to the ground and breaking into irretrievable chaos. I often felt like I had no idea how I could possibly get them to fall neatly into my arms after they finished spinning. Somehow, once these images ‘emerged’ or perhaps once they were articulated, I felt able to move on. In relation to analysing, organising, interpreting, and ‘sifting through’ my interview material, the metaphor that most consistently reflected my experience was that of diving into the material, somehow feeling that if I could only immerse myself enough in it, order would somehow come about, from the inside out: some people say you can learn to swim this way, but there is also the possibility of drowning. Rather than the perhaps paternalistic, positivist or modernist imposition of order, I (however consciously) tended toward a more maternal, naturalistic or postmodern acceptance (or even nurturing) of ambiguities and
uncertainty, in hopes of engendering a more organic understanding of something (Caltagirone & Smargiassi, 1997). This approach, I believe, is in keeping with the nature of the program itself, in which it is hoped that people’s own desire to know something and growing capacity to do, is embraced in all its messiness and complexity.

**Interpretation/analysis**

“Research ... needs to begin with a mindset to look for sensemaking, a willingness to use one’s own life as data, and a search for those outcroppings and ideas that fascinate...” (Weick, 1995, p.191)

“It almost seems as if your interview material is a burden to you...”(comment made to me by a colleague, when discussing my interview process/progress)

The above comments encapsulate something of my relation to interpretation and analysis of ‘the data,’ the data being the seven hundred odd pages of interview transcripts created by fifty-five unstructured interviews. The first quotation from Weick sums up my approach to selecting which parts of the material to focus on. The second quotation from a colleague speaks of the experience, previously mentioned, of not wanting to impose an authorial overlay on raw material that seemed to speak for itself. Returning to the swimming pool metaphor, I also felt at times that I was drowning amongst so many experiences and words that I hardly knew where to start. It took me approximately one year to organise the interview material thematically.

**Choosing and categorising material**

Faced with hundreds of pages of interview transcripts, qualitative researchers seem to have no choice but to select certain themes to concentrate on, and produce some categories by which to organise the material in order to present it. The key is to be able to winnow (Wolcott, 1990b) – to keep what seems to be the most essential or illuminating, without trying to keep everything; this is a painful process, as material is sacrificed and excluded. This process of winnowing is also an undeniably subjective one. The interview quotes I have chosen to present are sometimes indicative of the interview as a whole, but at other times are chosen because they contain “particularly
poignant” (Kvale, 1996, p.224) or, to me, interesting descriptions, observations or stories of experience. It is also necessary to acknowledge that some interview material was difficult to categorise, and I have taken the liberty of choosing a categorisation or interpretive label that I hope will not detract from the intent or meaning-base of the participant. For example, while a participant may not have used the word ‘empowerment’ or ‘sensemaking,’ I may have categorised their material as such.

In addition to my typed word-for-word transcripts of each interview, I also compiled an additional set of interview quotes, which were organised thematically. This was useful, in terms of not having to go back through an entire interview transcript to find a comment about a particular theme, but also caused some confusion, in that a quote was recorded in two places, with different page numbers. I attempted, when writing the thesis, to cite the quote in relation to the original transcript. Each interviewee was given a code, such as EG, and direct quotes were presented with the interviewee code, followed by the number of the interview (1 or 2), or no number if they were only interviewed once, followed by the page number of the transcript upon which that quote was found.

Richardson’s description of research material as “wet clay” to be shaped by the researcher (1994, p.524) resonated with my experience, as I tried various ways of shaping the clay before it hardened. Fortunately it stayed reasonably wet for quite a long time. Similarly, Alberty (in Patton, 1980) describes the a new and discrete body gradually forming out of the morass of interview material, a body that in and of itself takes on a completeness and reality of its own. She describes a growing sense of herself “rendering” an account, in much the same way a musician renders a piece of music, making it accessible to others via a unique (re)presentation.

Using a different metaphor, Buchanan et al. (1988, p.65) and Kvale (1996, p.166) speak of interview texts as material that is “frozen in time” and abstracted from the relational context in which the words were spoken, thus becoming not only static and solid but open to frequent perusal. What was spoken relatively spontaneously in an interactional moment becomes something that can be read, reviewed and studied over and over. Kvale observes how the “lived face-to-face conversation becomes fixated into transcripts” which are “transgressions” in themselves: thus even the act of transcribing is transformative (1996, p.166). To some extent, such transformation, as Fine puts it, will always be about “hiding, about magic, about change…” (1993, p.290). On several occasions, several years after having done an interview, I might be
chatting with the former interviewee, whose words spoken during their interview were still fresh in my mind, having perhaps re-read them many times: the same words for the other would undoubtedly have long ago passed out of memory.

I agonised over how I could do justice to the material: how could I render it in a way that preserved its integrity, and that of the participants; and who was I writing for - fellow academics, practitioners, myself, participants - anyway? How could I meet academic standards of contextualising the interview material in relation to ‘the literature’: to, as Clandinin & Connelly (1994) put it, turn my inspirational field text into a credible research text? Mirroring my experience, they observe that the stories may be so good that we want to just let them be; however, they state, “the researcher’s task is to discover and construct meaning in those texts.” Researchers, they go on, need to ask “what is the meaning of the text, or a sequence in the text, and why does it make a difference to figure it out?” (pp.423-424). The way we answer such questions shapes the research text which is produced, as the researcher-interpreter searches for themes, patterns or narrative threads – a search which is based largely on the researcher’s standpoint and subjectivity. They summarise the dilemma well, as a “struggle for voice… to express one’s own voice in the midst of an inquiry designed to capture the participants’ experience and represent their voices, all the while attempting to create a research text that will speak to, and reflect upon, the audience’s voices” (p.423).

**Coming to grips with accountability and authorship**

At times as I wrote I visualised the faces and presence of various participants or potential readers and tried to imagine how they might respond to what was being presented, written, or interpreted. What would they think of my voice-over, or the material from the literature juxtaposed next to their words? While some participants might look favourably on certain theorising, others might find it invasive or domineering. The degree of hesitation I experienced in struggling to find a voice of authorship, where others may not have hesitated at all, makes me wonder, again, if personal qualities such as assertiveness or conflict-avoidance, timidity or self-confidence, also influence our authorial voice and capacity to engage in academic writing.

As previously mentioned, in some ways I also resented having to interpret the data at all: Lemert (1995) writes evocatively about the apparent unpalatability of “raw data” – as if in its original form it is “unfit for scientific consumption” – and how
making “the subject’s secrets known against a rule of truth” cooks it enough to be digested (p.176). Indeed, I did not want to be the cook at all: although I gradually accepted that I must ‘prepare’ the meal somehow. I knew I wanted to do it in a way that felt like an authentic ‘I’ – the same ‘I’ that was known and trusted by my research participants and my academic colleagues. Lincoln, writing about the role and voice of the author – choosing who and how “to be in the text” – suggests that as authors we will ideally be the same ‘self “that showed up to begin the fieldwork, the self that accomplished the fieldwork, and the self who left changed” (1997, p.48). Qualitative researchers such as Tierney and Lincoln, express a deep and admirable commitment to finding “an ethical way to be” in their lives and in their texts (1997, p.x), which is compatible with and inspiring for non-oppressive social work practice and research, which is not really separate from who we are as people.

Josselson (1996) continuously raises the issue of the researcher’s accountability to project participants. She does not worry that her interviews themselves will be harmful, as she trusts her interviewing ability/sensitivity, nor does she worry about betraying confidentiality, but she does worry about how people will feel about what she writes – “the intrusiveness of being ‘writ down’…summed up, encapsulated in language…which can never contain a whole person…[and] is inevitably a violation” (1996, p.62). Upon reflection, she concludes that what she writes – her participants’ “tenure as characters in my books” – is just one of many life experiences in which a person may learn something, and that in the end, she is not so powerful as to harm anyone by committing a part of their story to textual time and space. At the same time, feeling some discomfort in the role of interpreter/analyst, she suggests, is a good thing that keeps us humble and respectful of participants’ experiences and stories.

To say that I experienced discomfort in the role of interpreter/analyst is not an over-statement – I wrestled actively with it. I knew I did not want to engage in psycho-pathologising participants (whether staff or residents!) and I took the words of participants at ‘face value;’ while I tried to clarify their meaning with the speaker, I did not and have not attached psychological interpretations to their narratives. For example, when a former resident described what they liked or had not liked about staff, I did not overlay a psychodynamic framework suggesting they were ‘splitting’ in relation to the staff team, or that they had ‘issues’ with authority. Or as another example, I have not, when staff told me one thing or another, interpreted them as
having issues with ‘helping people.’ I told participants, and meant it, that I was interested in what they had to say, for its own intrinsic value, and that I did not plan to impose any ‘alien’ or ‘expert’ interpretive framework over it. The choice of interpretive framework is a powerful and consequential act: I am just as willing to believe that people, including myself, interpret reality and act as they do as a result of karmic baggage from past lives, their star sign and planetary influences, their genes, structural disadvantage, social context, temporary delusion, unconscious impulses due to unresolved childhood relationships, or because of past trauma - or all of the above.

Ochberg (1996, p.112) refers to interpretation as a form of “conversion” – the conversion of what we’ve been told “from one kind of account into another.” Like feminist researchers, I wanted to analyse/interpret in a way that was accountable to both participants and “broader emancipatory…goals” (Burman 1995, p.124). At the same time I knew that however strongly I wanted to be oriented to participants’ standpoints, in the end my analysis would, as Chase suggests, reflect my own “interests, choices and concerns” (1996, p.52), thus I had to claim authority over the interpretive process, no matter how difficult it was for me to do. Behar, in her book The Vulnerable Observer: Anthropology that Breaks your Heart (1996), speaks of how she too distrusted – or shrank from - her own authority, always worried that it was questionable, and “on the point of breaking down” (p.21). She suggests, however, that when one writes vulnerably, others will respond vulnerably. Perhaps part of my writing vulnerably, is to include my doubts, difficulties, confusions, and myself in my writing. The role of a ‘vulnerable observer’ is one of learning and growth, rather than closure and certainty. Indeed, I would not want anyone to think that I am – or consider myself to be – anything near an expert on mental health, and would feel extremely fraudulent if that expectation was placed upon me. This could well be a personal trait that carries over to my professional life: on the ‘down-side’ a fear of certainty, responsibility or commitment, on the ‘up-side’ a capacity to entertain many possibilities.

While a strong voice of authorship can greatly enhance a writer’s credibility, Ellis (1997) suggests that the validity of a story may also rest on whether it evokes in readers “a feeling that the experience described is authentic and lifelike, believable and possible…whether it speaks to the reader about their experience…[perhaps even encouraging] others to speak their silences as well” (p.134). This sort of determination of validity sits well with me: perhaps I am afraid to wield the power that I suspect lies
in the transformation of narrative into an “exposition of theoretical findings” (Childress, 1998, p.249). Still, somehow, to write a thesis, I needed to find a way of balancing the voices of participants with my own and others’: the challenge indeed being “one of preserving participants’ definitions of reality…in the process of creating a theoretical meaning system” (Daly, 1997, p.350).

**Struggling with analysis**

Burman (1995, p. 127, referring to Bewley, 1993) describes analysis as a “multilayered cycle of reflection and digestion” from which a picture develops; the cycle involved reading and thinking about the interview material many times until she knew it well, considering the material from different perspectives to discover any patterns, going through the information with a list of key ideas after an initial picture had formed and reflecting on her own experience within the particular organisation. The process she describes is akin to mine, whereby I became so familiar with the interview material that I could see a particular quote and know who had said it and in what context. Burman also reiterates the importance of acknowledging the *partiality and situatedness* of any analysis, acknowledging that interpretation is *always* both incomplete and motivated. For her, the key dilemma facing critical academics is how to “communicate in terms that engage with and intervene in academic genres without fragmenting, objectifying, or disempowering” the experiences of participants (1995, p. 131). Lather (1995) describes her aim in interpreting or analysing interview material she gathered from women living with HIV/AIDS, as an attempt to “frame meaning possibilities rather than close them” (Lather, in Kvale, 1992, p.96). Both these aims resonate with mine: to use material in a way that opens out meanings rather than suggest causal certainties. In Lather’s later writings, she has assumed a position which, she says, “defies a reader’s narrative urge to make sense of, to impose order on the discontinuity and otherness” of the material; she describes how she has mixed the women’s stories and the researcher’s “interpretive moves,” with moments of sociology, history, poetry, popular culture and “policy talk” into a “network of levels and orders in constructing an audience with ears to hear” (1997, p.255) (my italics). In this sense she has followed Foucault’s lead in stylistic mixing.

K. Manning (1997) echoes this view, by suggesting that a research document should continue to have *life* – the pulse referred to previously – that allows readers to add their own experiences and observations to the stories presented in ways that may be unanticipated by the researcher or the respondents (p.110). Having what Kvale
calls a “continued dialogue with the text” – whether it is through having a second interview with a participant in order to expand on meaning from the first interview, or by the researcher or reader having an “imagined dialogue” with the text “unfolding its horizon of possible meanings” (1996, p.184) - prevents premature closure or resolution. Meaning is thus approached as a reading, resulting “from the reaction to a formulation, not as an inherent feature residing in the formulation itself…” (Nijhof, 1997, p.179). Indeed, the purpose of interview material or data gathering in a case study, according to Stake, is “to develop vicarious experiences for the reader.” The interview is considered to be the “main road to multiple realities” (1995, p.64) in which contradictions are not seen as something in need of resolution, but as broadening and deepening understandings of experience. As researchers we can subscribe to a position of “both/and,” even though, as mentioned previously, it may be uncomfortable to sit with contradiction or ambivalence (Berg & Smith, 1988, p.284). Rather than seeing multiple interpretations of a text as problematic or a sign of weakness, such lack of closure or certainty can be seen and, importantly, I would argue – experienced – as a source of richness and strength (Kvale, 1996, p.212).

Ely describes the analytical process as a process of reduction, reorganisation and synthesis, so that the reader can “share the researcher’s findings in the most economical, interesting fashion” – a creation that “speaks to the heart of what was learned” (1991, p.140). Analysis, she suggests, as does Kvale, should have been ongoing during the interview process, as the researcher honed in on new ideas or hunches, phrasing and rephrasing research prompts and checking out ideas and insights. As I went along, certain “thinking units” (a phrase coined by Lofland and Lofland, 1984, cited in Ely, 1991, p.143) began to develop – as both a result of my own interests and reading, and themes which were brought up by participants - around concepts such as “community,” “the creation and transfer of culture,” “the meaning of support,” “power in the staff-client relationship,” “learning and outcomes” etc. They were, as Ely describes it, “broadly framed sorting files” (p.143) to give some shape or structure to the ‘chaos’ of my unstructured material. Following on from this, I established categories based on these thinking units, into which I gradually sorted selections of quotes from the transcripts. The categories were meant to help me organise the essential aspects of the material, as I saw them. As well as helping me organise the material, the categories also helped me tease out some meaning frameworks or themes, and present theoretical/literature-based material in relation to
the ‘raw data.’ Major themes, such as “community,” “staff-resident relationships” (and the other categories I have presented chapter by chapter) were those which were spoken about or touched upon by a number of participants, either by my directly posing them as discussion points or by their spontaneous presentation by the interviewee. My research is generally presented in a form which is “number-free” (Ely, 1991, p.155), as I hold, as does Ely, that a theme may be established either because it appeared many times or for the majority or respondents, or that it appeared only once or a few times, but that I thought it carried important information, that it was, as Weick (1995) says, an idea which fascinates. With so many pages of fascinating ideas, I am keenly aware that I have constantly made decisions (more or less consciously) about which thesis I was actually writing, as my role in constructing the ‘result’ was strongly felt.

**Methodological and theoretical underpinnings**

Curt (1994) describes an approach to qualitative inquiry that is both evocative and succinct, and resonates with my own attempts in this project: “The term disenchantment is an expressive one, for if there is any common theme it is an attempt to escape from ‘enchantment’ – enchantment, that is, with having ‘solutions’ to ‘problems’; having a scheme for what can be known; having a ‘hotline’ to the truth; there being something ‘real’ out there to address; there being authorised methods for finding out” (Curt, 1994, p.5). They go on to propose that “one of the most important questions to be asked about a text is what conduct it warrants…” (ibid, p.192). Indeed, the conduct warranting potential of any discourse or text, from a critical social work perspective, is a paramount concern.

Curt adopts an admirably evasive approach to describe their theoretical framework: by using the term “climate of problematisation” to label their endeavour, they avoid popular “buzz-words” such as postmodernism and social constructionism, making “only the most minimal of claims about what [they] are up to” (1994, p.218). This appears a sensible approach, as once one has aligned themself with an ‘ism’ they are open to attack by others of that persuasion who may have a more sophisticated grasp on the nuances that distinguish one ‘ism’ from another. As previously mentioned, what one author currently calls critical social work may be referred to as postmodern critical by another, or critical postmodern, or may not be overtly
identified as embracing postmodern thinking at all. Having said that, I will briefly identify, in this section, the methodological approaches that seem to be most aligned with mine, as well as other theoretical underpinnings that developed during the course of my research, which eventually informed my understanding of and relationship to texts (concepts from both the literature and interview material). My approach to research has been to go out and do it – then, learning through experience, interaction, critical reflection, reading and struggle, adapt my approach, and gradually locate what I’m doing within the literature.

The personal is (in some ways) the professional

Patton (1980) said that the nature of some things (such as programs and processes) may necessitate particular types of inquiry; thus, an experiential program may require an experiential inquiry; a holistic program, a holistic inquiry. As all inquiry is political in the sense that it can be used in an attempt to achieve certain outcomes, the choice of methodology, method and interpretation will variously reflect quite deep ethos or standpoints, such as ideology, philosophy, moral frameworks, and social justice ideals (Greene, 1994). One’s approach will also be embedded in the person’s professional education and affiliation and what is considered not only ethical, but also academically acceptable.

In asking why someone chooses a particular research method (or topic) it may be useful, as I have suggested previously, to look not only at the nature of the material being studied, but also the person’s general approach to life, whether it be as a result of karma, particular fears and desires, ignorance, interests, needs, safety zones, or unresolved childhood experiences. For me, it is hardly surprising that I would resist labels in my approach to research, in the same way I have consistently avoided being labelled in other aspects of my life, whether it be, at various times, Quaker, wife, Buddhist, social worker, researcher, lecturer, etc. Such labels define: they restrict; they make claims to knowing or being certain things; they carry responsibilities and duties, which I seem to prefer to avoid. While it is often uncomfortable being a fringe-dweller, it feels safer, for me, than ‘belonging.’ At the same time, despite the discomfort these labels may generate, I am part of the social world and in my public life as a lecturer I need to take on these labels to describe who I am and what I do,
although I am often aware that I use a self-deprecating form of humour as a way of expressing my lack of confidence in living up to other’s expectations of these roles.

In much the same way I have never created a ‘career’ or ‘life plan,’ I baulked at having a clear road-map for my research, preferring instead to set off on the journey, with a knapsack full of potentially useful items that I hoped would evolve into more lucid ideas. I liked what Greenberg said in relation to his writing approach: “It might be helpful at the outset,” he proposed, “to think of this book as a leisurely (and I hope interesting) drive through the countryside…[Rather than] hurtling on the empirical super-highway to some destination of certain and quantifiable conclusions…we will be stopping at various points by the roadside to consider the contours of the land, and to wonder how it got to be that way” (1994, p.5). As Curt puts it, in describing their approach of “critical polytextual scrutiny,” inquiry is a process of critical engagement: “not journey as quest, but journey as episodic transformations” (1994, p.230) involving the researcher, participants and eventually readers. So, now having described some of my difficulties in attaching labels or descriptors to myself or what I’m doing, I’ll take a more serious look at where my methodology fits and what approaches it is aligned with.

Naturalistic inquiry

To begin at the simplest or most general level, the term ‘qualitative’ is certainly appropriate: put succinctly by Lincoln & Denzin (1994), at its centre, qualitative research is based on “the humanistic commitment of the …researcher to study the world always from the perspective of the interacting individual…[allowing] new, previously oppressed or silenced voices [to] enter the discourse” (p.575). Janesick describes qualitative design as something that is “adapted, changed and redesigned as the study proceeds, because of the social realities of doing research among and with the living” (1994, p.218). Such complexities are certainly a feature of research around mental, spiritual and emotional wellness. Our inner life is multifaceted and subject to the ongoing constructions of such diverse meanings; this suggests that objectifying and ‘generalisable’ methods may not adequately encompass the richness of mental, emotional or spiritual life that makes up an individual’s sense of well being.

Indeed what is needed is a holistic approach that “expands rather than constricts the realm of relevant data”(Lieberman, 1989, p.274). Mohr (1997, p.285) suggests in relation to psychiatric settings, that interventions and outcomes are
“excruciatingly difficult to describe and capture,” and that qualitative research is needed to move beyond narrow concerns and indicators that “tell us nothing about the human beings for whom we care.” Qualitative researcher Timothy McGettigan suggests “imperfect scientists can best serve truth by caring about people more than they care about knowledge” (1997, p.380). This statement is deceptively simple, but its import is potentially profound. Under the broad umbrella of qualitative research, there are any number of sub-groupings, which, while each having their own subtleties and emphases, overlap significantly. At times it can be confusing as to which is which, and how they actually differ. Tesch (1990, p.71) proposes a very useful metaphor to describe the array of qualitative research types as a “painters palette,” rather than a map, where you choose daubs of the different colours to make your own shade. My shade was probably a mixture of some of the following approaches.

Phenomenological method (sometimes referred to as ‘clinical method’ – see Lowman, 1988) is basically experience-based, aimed at clarifying what cannot be illuminated by more quantitative methods, and demanding the full engagement of the researcher in ‘data’ gathering. Curt defines phenomenology as an approach which tries to understand human action and being, not as they ‘really are’ (as such ‘truth’ does not exist), but in terms of how the individual interprets experience (1994, p.240). Phenomenology uses research questions which are designed to elicit the “essence of experiences” resulting in in-depth descriptions; similarly, hermeneutics aims to elicit and interpret the meaning of lived experience (Morse, 1994, p.224). Phenomenology is not concerned with statistics and measures, but patterns and characteristics that can be illuminated by the study of individuals (Rotov, 1991).

Ethnography is also concerned with “experience as it is lived, felt or undergone” which involves, according to Taylor (1995, p.35) a concern with “phenomenological consciousness.” Ethnographic research succeeds, she says, to the degree that it “enables the reader to understand what goes on in a society or a social circumstance as well as the participants” (p.35), and requires an ethical and personal relationship between the researcher and the researched. Ethnographers are concerned with local (‘cultural’) interpretations, and, according to Wolcott (1990), proceed without a strict framework of analysis, but with something in mind to guide their work, whether it be a conceptual orientation or a “trustworthy sense of intuition” (p.69). According to Laragy (1996), ethnography is a way of learning whereby the researcher goes into a situation with an open mind and attempts to describe it from the
other person’s viewpoint. This view, according to postmodern thinking, will always be historical and contextual, with understanding always being contextual and a result of “concerned engagement with a thing or issue at a particular time and in a particular place” (Curt, 1994, p.164). While words might be frozen in time, understanding is always open to change.

Overall, the methodological approach that resonates most closely with my project comes under the heading of ‘constructivism,’ or what was earlier known as ‘naturalistic inquiry’ (Guba & Lincoln, 1994). Lincoln and Guba (1985), describing naturalistic inquiry in the mid 1980s, observe that this approach has travelled under a range of names such as postpositivism, ethnography, phenomenology, case study, hermeneutic or humanistic research. Like different denominations of Christianity, they suggest, different aliases reflected different nuances that researchers felt separated their approach from others. The basic features of naturalistic inquiry, however, suggest that research is done in the natural setting or context, with a human as the primary data gathering instrument. Tacit knowledge (knowledge gained by the researcher’s experience and ruminations) is valued and multiple realities are acknowledged. Data does not lead to law-like generalisations, but, because realities are diverse and knowledge is contextual, naturalistic researchers are tentative about making broad applications of findings. ‘Conclusions’ are locally grounded and indeed, a case study is often the preferred form of inquiry.

Naturalistic case studies – a phrase that could be used to describe my research – are, according to Robert (1986), “impelled” by a commitment to generate a vicarious experience for readers, providing material or ideas that may add to their own generalisations or sensemaking. This type of vicarious experience, Stake (1995) suggests, may actually contribute more to improved practice, than other forms of knowledge production which do not lead to or engender knowledge utilisation. Case studies, Stoeker (1991) suggests, (as well as providing a boundaried site for information gathering) help define abstract concepts, produce empathy for those studied, and expand the experience of the readers. He observes that they are effective in exploring and describing process, and presenting information or ideas in a more familiar and interesting mode than other forms of research can.

In my research, the common denominator of engagement with the program, provided an entree – a vehicle – to explore diverse experiences in a specific setting, from a range of standpoints. As one of my supervisors put it: I was using a real live
program to explore views of what works and what happens. The use of narrative (the
telling of stories and the sharing of experiences) is engaged with and presented as a
form of knowing, which expands possibilities through privileging the particulars of
lived experience, “of a self in conversation with itself and its world over time…not
records of facts… but of a meaning-making system that makes sense out of the
chaotic mass of perceptions and experiences of a life” (Josselson, 1995, p.33).
Openness and dialogue, rather than manipulation and control, are construed as
pathways to greater understanding (Greene, 1994).

Another methodological approach that resonates strongly with mine, is
Denzin’s “interpretive interactionism” (1989). Acknowledging the awkwardness of
the phrase, Denzin describes this approach as one which attempts “to make the world
of problematic lived experience of ordinary people directly available to the reader”
(p.7). The methods utilised by this approach, which are particularly relevant to my
study, are open ended, creative interviewing, personal experience and self-story
construction, and thick description. He likens the approach to postmodern
ethnography, naturalistic studies, hermeneutic, phenomenological and feminist
approaches. The assumptions which underpin the interpretive interactionist approach
are that a) “in the world of human experience, there is only interpretation”, b) “it is a
worthy goal to attempt to make these interpretations available to others” in order to
create better understanding and hence better programs, and c) “all interpretations are
unfinished and inconclusive” thus it is up to the reader to form their own
interpretations (p.8). Denzin suggests that the approach is particularly appropriate
when the researcher wants to look at the relationship between personal troubles and
the public responses which have been developed to address the problems (programs,
policies, etc), as well as the different perspectives of workers and clients; it’s
particular focus is on life experiences that Denzin refers to as “epiphanies” –
experiences that dramatically change and shape the meanings individuals give to
themselves, their “life projects” and to the world (p.15). This seems particularly
appropriate to my area of study. By attending to the individual’s story of both the
problems and potential ‘solutions’ they experienced (residents and former residents)
and the stories of those involved in responding (staff, workers), deeper understandings
of programs which are offered are made possible. As Denzin puts it: “The
perspectives and experiences of those persons who are served by applied programs
must be grasped, interpreted, and understood if solid, effective, applied programs are
to be created” (p.12). Interpretive studies collect and analyse “existentially experienced, interactional texts” (p.9).

According to Denzin, the role of the interpretive interactionist researcher is to be an “informed reader” who knows the language used in the stories, has some sense of the storyteller (which is always acknowledged as partial at best), has some experience with the crucial issues, is willing to take full responsibility for her interpretations, is conversant with a range of interpretive theories that can be brought to bear on the stories, and assumes that “there is no one true, or real, meaning of a story” and that readers will create their own meanings from the material presented (1989, p.45). Mohr (1997) suggests that Denzin’s interpretive interactionism is a method that is particularly congruous with the caring profession’s commitment to keeping the client at the centre of attention. She also suggests that it can contribute significantly to outcome research as it looks at various ways that problems are defined, how care/therapy/‘help’/support is experienced and what ‘recipients’ find helpful or unhelpful and in which circumstances.

Thus, this research project can be described as naturalistic, phenomenological, ethnographic, constructivist and/or interpretive interactionist in its methodological approach. My intent was to be involved in a respectful, anti-oppressive, empathic and shared experience of learning with research participants, and to present their stories, or parts thereof, likewise. As the thesis unfolds, a wide and diverse range of theoretical concepts will be presented, chosen because of their potential for illuminating or enriching theory-stories provided by participants and which sit alongside referenced material. (These theories cover, for example, diverse concepts such as the nature and consequences of psychiatric upheaval; therapeutic community principles and processes; meaning ascription and the creation of culture; grief and loss; and theories of outcome measurement, etc.) This is a deliberate decision, aimed at reducing the gap between theory and practice, concepts and experience, referenced truths and stories of experiences.

**Wider theoretical affiliations**

At a more macro level, it could be said that my overall approach draws on a number of broadly-based theories, primarily: a) some aspects of postmodern thinking (although neither Curt nor Orlie, whose work I refer to quite consistently, label their approach as such), b) critical social work theory, and c) sensemaking theory as presented by Weick (1995). These approaches are discussed in detail as they become
relevant throughout the thesis. I had not initially intended on using any of these theoretical frameworks to discuss the material, however they ‘presented themselves’ as I worked with the interview material and extended my own reading and learning in connection with my teaching role. As I began to understand more about postmodern theories, critical reflective social work practice and meaning-ascription, I became aware of their capacity to illuminate my thesis discussion and to try to make some links between social work practice and what are often considered to be esoteric theoretical concepts (see Saleebey, 1994; Polkinghorne, 1997; Healy, 2000 Fook, 2002, etc.). In particular, these three theoretical frameworks draw attention to the production of knowledge, the construction of identity and social relations, the instability of meaning frames, the fluidity of identity and the power of dominant discourse.

Most importantly, they provide a common thread by which to explore taken for granted assumptions around the meaning of everyday social work concepts and practices such as ‘support,’ ‘power,’ ‘outcomes,’ ‘professionalism,’ etc. In this thesis they are used to trouble, problematise and critically reflect on dominant narratives that underpin social work practice and work in the mental health field via the stories presented in the research interviews. The purpose of the inquiry then operates on a number of levels: the extension of therapeutic possibilities in mental health and other areas of social work practice, the creation of theory from practice and experience, and the practical development of critical social work extended by some aspects of postmodern thinking. My approach resonates with that of critical social work practice as an “open-minded, reflective appraisal that takes account of different perspectives, experiences and assumptions” resting on several key pillars: respect for others as equals, a “not-knowing” perspective that accepts and works with uncertainty and ambivalence, and critical action based on an empowerment perspective aimed at making a difference to people we work with (Brechin, 2000, cited in Payne, Adams & Dominelli, 2002, p.2).

In the following three chapters I will critically explore a number of key social work concepts: the professional gaze and its construction of subjects; worker power and professionalism; and authority, boundaries and vulnerability. These themes arose as I read and re-read the interview transcripts and extended and re-extended my reading around mental health, critical social work, recovery and therapeutic or empowerment-based environments. Often it seemed a matter of ‘chance’ or karma
that I would pick up some reading on a particular theory or concept and then, almost miraculously, see its relevance to my interview material. The other possibility, of course, is that what I was reading was projected onto the interview material as I more or less consciously sought particular cues or meanings based on the theoretical lenses I had donned. The reader can decide if anything that is said, or any parallels that are drawn, is of use to their own construction and experience of reality.
Chapter 3

The professional gaze and the construction of subjects

In this chapter I explore various constructions of what it might mean for service users to be the focus of a professional gaze – that is, to be ‘gazed upon.’ This is discussed via participants’ stories of their experiences within the program setting, as then-current resident, former resident or staff member. My stance might appear somewhat slippery, as I vacillate between a view of the professional gaze as disempowering and/or objectifying on the one hand, and, on the other, potentially useful and empowering for service users. This slipperiness may, in some ways, mirror the tensions that exist in practice and in experience, and, rather than being a problem, can, from a critical or postmodern perspective, be considered a useful reminder of the ongoing need for critical reflection on the consequences of our gaze in specific instances of social work practice.

Like much of my engagement with this research project, the theme of the professional gaze was not pre-conceived, but seemed to suggest itself to me as I read and re-read the interview transcripts. By reviewing the stories of participants, this often-dichotomised aspect of experience, practice and professionalism opened up for exploration and reconstruction from a number of vantage points. It seemed that certain forms of the professional gaze were indeed experienced as disempowering, as critical literature suggests, but at other times, other forms of the gaze of the professional seemed to be experienced as useful and emancipatory. As my reading, analysis and thoughts unfolded and melded with new ideas I came across through my teaching, links with critical postmodern and reflective social work practice also ‘suggested’ themselves and I began to incorporate them into my discussion. It goes without saying that what seems to ‘suggest itself’ is a product of many things, including the selective (and always limited) gaze of the researcher.

This chapter begins with an examination of the ‘traditional’ professional gaze aligned with a discourse of professional power that constructs others not as active subjects on a life journey but as passive objects to be remediated. Service users’ comments reinforce the suggestion that such a gaze is not a helpful one; workers’
comments frame such a disempowering and objectifying gaze as one they felt they actively resisted in the program. Participants then comment on what seems to be a professional gaze that is experienced as beneficial and empowering: a gaze that, on the individual level, notices both strengths and struggles, and, on a community level, is attuned to the dynamic needs and fluctuations of the program entity as a whole. This chapter will reflect on interview material and relevant literature to explore the following questions: How is the professional gaze experienced? What might an empowering gaze look like in practice? How might it be experienced? These questions are linked to notions of professionalism, dialogical social work practice and the status accorded to holders of legitimated knowledge.

**The modernist gaze**

Critical and postmodern thinkers have challenged the notion that an objective, value-free knower/gazer can be positioned outside and above objects of knowledge. Mullaly (1997, p.143) draws attention to Foucault’s (1977) assertion that such a gaze creates “observations [that] are not mere passing looks but normalising gazes that assess their object according to some hierarchical standard [whereby] some of the particulars or attributes of the object are then defined as deviant or are devalued in comparison to the norm….” Such a modernist gaze, as exemplified in the medical model and often enacted within mental health systems, has been used historically to construct an object to be acted upon – to diagnose, categorise, control, coerce and segregate – to create an objectified other. This gaze has the potential to create rigid and limited identities based on perceived deficits in the gazed-upon and to legitimise certain forms of knowledge whilst marginalising others, thus creating particular possibilities for action or intervention. Like any discourse, it masks as it reveals, drawing attention to some things and not to others, constructing identities in powerful terms. Thus, the “activity of seeing,” according to Curt (1994, p.236) needs to problematised as an act in which “both the seeing-subject and the seen-object are treated as constructed rather than pre-given or taken for granted.”

Canadian political theorist Melissa Orlie (1997) refers to the ‘trespass’ that is inevitable in all forms of interpretation and knowledge, and which is enacted relationally
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in the world. She suggests that “every way of being trespasses against others, albeit to varying degrees… Every way of making the world conflicts with some other ways of living in it, each of which precludes or circumscribes others” (p.21). She goes on to say that trespasses are “the harm brought to others by our participation in governing ways of envisioning and making the world…”; for some, she says, their “makings rarely prevail on their own terms. They are made more than they make… They are profoundly wounded; they are even defined by their wounds” (p.27). This is an evocative and powerful description of the potential for harm and oppression that can be engendered by those who gaze upon others from the perspective of dominant discourses, which construct objects and subjects in particular ways. One project participant described how her sense of self was shaped upon entering the psychiatric system: “I had such a horrible experience in hospital... it’s just awful, the way you’re treated by the nurses – it’s like you’ve done something wrong because you’re unwell. There’s no respect there at all… I really don’t understand, apart from having medication stabilised... what you actually gain from going to hospital, because you don’t get any insight into your illness, and you definitely don’t feel cared for…” (AG)

Indeed, both psychiatry and social work have been described as agents of social control, subsuming the stories and lives of complex, many-faceted individuals into an ‘objective’ and problem-laden ‘case,’ with the power to define and label the reality of those who come under their professional gaze (White, 1995). This can be linked to non-critical modernist thinking, and the quest for unitary and generalisable truth, formulated, possessed and dispensed by experts, constructing reality and fixing identities of both the gazer and the gazed upon, with little attention to the trespass created. This binary-oppositional thinking restricts the range of legitimate gazes and truth-tellers to those who are structurally and discursively dominant. The knowledge of those at the top of the hierarchy is considered superior to those ‘below’ (sometimes clients, sometimes social workers) thus devaluing other subjectivities and precluding the development of a sense of agency in the object of their gaze: the (re)emergence and encouragement of a thinking, speaking subject is restricted. Contributors to the Victorian Women and Mental Health Network’s book (edited by Zierke, et al., 1998) described how, upon entering the psychiatric system, their stories were dismissed and their words were appropriated into
the construction of an objectifying medical history. This view was echoed by a program resident, who put it this way:

“The hospitals don’t make you think; the clinics don’t make you think – they give you drugs and send you out to various activities. The mental health system doesn’t really encourage you to have power of mind – they don’t really teach you how to think... there needs to be a structure of encouragement of your own mental realisation and your own power over your own mind. Self-empowerment. That’s something I never got at the (name) clinic...” (DA)

And, remarkably similar, from a staff member, in a separate interview:

“...a lot of the issues for people with mental illness is that they’ve become isolated and disconnected, and DONE TO... they’re given medication by their doctor, they are given counselling by somebody, and they are put into a rec program that is provided for them. Their sense of agency is diminished, of being able to DO on the world, rather than being done to... I have somebody in the hospital at the moment, and I’ve just been watching them go backwards... ‘you are the patient, you are the sick one’... So I’m just thinking about environments, and the expectations of the environment...” (CA)

Rosemary Smart, a New Zealand psychiatrist and mother of a daughter who eventually committed suicide after many experiences in the psychiatric system, coined the term “expertosis” to describe the malady she observed in many professionals: “the deadly gap between professional expertise and lived reality,” that develops when professionals believe their knowledge is the only knowledge. She suggests that the flourishing of this malady in the mental health system discounted her daughter’s reality at every level “in the face of expert knowledge,” where the theories themselves were experienced as overwhelmingly disenabling (1994, p.7).

Prior (1989) identified the power of the professional gaze to strip down the complexity of a person’s life until they become “nothing but the behaviour which they exhibit... [which is then] sorted into constructive and unconstructive, useful and useless, dependent and productive categories” (p.144). Again, such binary oppositional thinking constructs polarised extremes, putting in place a fixed identity and value hierarchy that creates particular and limited possibilities for understanding and action (Berlin, 1990). Consumer-practitioner Jerry Dincin (1994, p.9) highlights the dangers of such a gaze,
suggesting that when a person is seen only as “sets of behaviour to be altered” the most potent question is actually being ignored: the question he suggests does not necessarily have easy or tidy answers—the question is: what is trying to emerge from this person? Such a question allows for the co-existence of ‘contradictory’ behaviours and creates fluid possibilities for ways of being or actions to be useful in one setting at one time, but not in another at another time. (For example it may sometimes be productive and strengthening to depend on others, however modernist discourse constructs independence as always the preferable option for adults in western society.)

In her keynote address to the 1996 Recovery Conference hosted by the Prahran Mission in Melbourne, Cheryl Gagne described the power of the professional to frame experience and construct identity through a powerful gaze that attaches particular and often unquestioned meanings to certain behaviours: “Almost everything you do [once diagnosed] gets understood in reference to your illness… You used to disagree sometimes but now you get told you lack insight. You used to act independently but now you get told that your independence means you are uncooperative… you used to take risks… but now the dignity of risk and the right to failure have been taken from you… it is very important that you resist the efforts, however unintentional they might be, to transform you into an illness” (Deegan, n.d., cited in Gagne, 1996, p.17).

Podvoll (1990) cautions against a state of mind he calls “asylum mentality…a mind of exerting power over others” manifested in non-reciprocal observation, where one’s state of mind – their mistakes, awkwardness and transgressions are “catalogued, diagnosed, and studied…[whereby] the mind of insanity must learn to bow before the superior power of reason and logic,” and where spirituality is seen as dangerous (p.65). Indeed the subtlest form of asylum mind, he suggests, is “the silence that humiliates – a studied interpersonal rift between doctor and patient,” where the powerful gaze of the doctor allows them to “assume the privilege of deciding who is insane” (p.66).

A psychological experiment conducted some time ago, that has always stayed with me, comes to mind now, as it exemplifies the power of an objectifying gaze to frame and attach meaning to experience. The story goes that a number of ‘sane’ university students got themselves admitted to psychiatric units, in order to experience being a patient first hand. One of the students, who was keeping a journal to record his
experiences, was described in the psychiatric unit case notes as ‘engaging in writing behaviour.’ Sadly, engulfment in the patient role (Lally, 1989) or transformation into an illness (Gagne, 1996) may be difficult to resist if one’s own one’s sense of identity and competence has been shaken and destabilised. As the above example suggests, professional responses to particular behaviours may over-therapeutise something that is ‘normal’ for non-patients, for example the labeling of a simple bushwalk as ‘recreational therapy,’ or enjoyment of reading as ‘bibliotherapy.’ These are terms workers would be unlikely to attach to their own lives, needs or experiences, yet they come to seem appropriate within practice settings, when applied to others.

One staff member commented, “...the experience lots of residents have is of psychiatrists... telling them they’ve got this and this, and that’s devastating to the person... one of our goals is to try to help people reframe their experiences and broaden that label... It feels like once residents have a particular set of labels...that they really start to fit everything into it. And I guess part of our role is to try to help them to decipher what are normal struggles in life...” (EC). This approach to practice seems to consciously resist the universalising and problem-saturated discourses so prevalent in the mental health field that carry such power to construct identity and experience.

Several decades ago, Illich (1975) postulated that medical professionals had been granted “inquisitorial powers to discover wrongs to be righted” (p.9). He suggested that these powers of diagnosis and therapy had the power to transform “the sick man (sic) into a limp and mystified voyeur of his own treatment” (p.14). Over two decades later, consumer-practitioner Dale Walsh (1996) described his experience of being “put on a shelf” and occasionally taken down for medication changes. “No one really talked to me,” he said; treatment was “administered by an expert – always at a professional distance.” Recovery, for him, began when he realised he could be, and in fact had to be, an active agent in his own healing process.

Indeed, the act of diagnosis itself, although serving at times a beneficial purpose, is an extremely powerful product of the expert gaze that defines not only an individual’s problem but their entire identity thereby legitimising a whole course of actions. This is the “conduct warranting potential of discourse” that Curt (1996) observes, which has been described as dangerous (Smith, 1990; Farber, 1993) due to its capacity to create
Chapter 3  The professional gaze and the construction of subjects

situations where it comes to be accepted as ‘natural’ that one act upon another in particular unquestioned ways. Indeed it is striking to read of diagnosis having the power to “turn the fright of chaos into the comfort of the known; the burden of doubt into the pleasure of certainty; the shame of hurting others into the price of helping them; and the dilemma of moral judgment into the clarity of medical truth” (Reich, 1999, p.205). This, according to Reich (1999, p.205) is “the beauty of diagnosis,” which, as he suggests, is indeed attractive, not only to psychiatrists who are enabled to act in particular ways which might be distasteful otherwise, but also to families whose lives have been turned upside down by a psychotic family member, the community at large who wish to remain safe from unpredictable behaviour and even the troubled individual themselves who may be relieved to have a scientific certainty to explain their experience. Giddens (1991, p.149) suggests that the orientation of modernity itself is to control and “sequester” any experience that is outside the norm in order to retain “ontological security.”

Similarly, Smith (1990) proposes that a key task of any (modernist) professional is to produce order out of the chaos and complexity of individual experience, in accordance with their own professional meaning system and discourse. Whilst acknowledging the relief this may provide to both worker and client, she cautions that this transformation also serves to “subordinate the individual within the relations of ruling… [whereby] the patient becomes a resource, but not an agent in the making of accounts of her behaviour…” (p.91): the powerful gaze and knowledge of the professional thereby claims authority and legitimacy. Potter uses the phrase “constructing out-there-ness” to identify the “powerful device that is used to construct descriptions as factual,” while simultaneously erasing the identity of the knowledge producer (p.150). Not only does the agent of production become invisible, but “any concerns about their stake in a particular description – what they might gain or lose – and their accountability” for such a construction are nullified. The practice of professional assessment – a construction of identity which is often quite consequential in nature – often directs practitioners, according to Potter, to “limit variables, reduce uncertainty and provide…tidy explanations for problems” (236).

Coles (1989) reflects on his training as a young psychiatrist, and how “the story of some of us, who become owners of a professional power and a professional vocabulary,
is the familiar one of moral thoughtlessness… [where we are] taught the comforts and rewards that come with the embrace of certain magical verbal constructs” (pp.18-19). Psychiatrists in training were taught, he observes, to develop “free-floating attention” or “hovering distance,” the attainment of which would mean the achievement of “professional maturity and competence” (p.9). A later mentor taught him a different approach in which the professional gaze focused on the “unfolding of a lived life, rather than the confirmation such a chronicle provides for some theory” (p.22). “Hardly considered any more,” says Podvoll (1980, p. 2) is the simple notion that psychosis might be one of the … conditions of being human… rather than the comforting notion that psychosis is only a rare disease, psychosis may be the natural consequence of the way anyone has lived…”; this, he goes on, “nullifies” the experience as a “human tragedy… [and] has created for all of us a false sense of security.” Human tragedy is indeed a difficult thing to order or control, or to locate entirely as the experience of the ‘other;’ human tragedy or trauma, like recovery, is something that creeps unexpectedly into the security of every individual’s ontological cocoon, and while it leaves its mark, is more an experience than an identity.

One former resident commented, “... ‘mental illness’ is a term I don’t feel comfortable with... I prefer the word ‘loony’ actually!” To this I replied, “To me, the word ‘loony’ has an element of humour... it’s different to referring to something as an illness... it’s more like referring to a period in your life... a time of a particular experience...” He replied, “That’s very much how I look on it... I see the whole illness paradigm as something which is not useful... it’s very disempowering” (IR 75). Kate Millett (1990), in her book, The Loony-Bin Trip, uses the word ‘loony’ quite differently, describing the deeply wounding, shaming and madness-inducing nature of her involuntary commitment to psychiatric hospital. “The bin itself,” she says, “is insane, abnormal, a terrifying captivity, an irrational deprivation of every human need,” in which “maintaining reason…is an overwhelming struggle” (p.218). However, not unlike the former resident quoted above, she concludes that “going mad,” insofar as it exists, is a place visited – a pure, chemical or circumstantial consciousness – “mental activity at the margin” – but that it is mainly manufactured or constructed out of “social controls, family disagreements, lovers’ quarrels, professional interests and advantages,” for which the
punishment of incarceration and drugs is both “cruel and stupid” (p.314). Leonard (1997, p.xxiii) refers to the “power of the file” in which the client is created as an object of scrutiny to be disciplined or remediated in some way. Once this act of labeling takes place, “handling” the patient/client “becomes the special province of experts in [the particular] sort of deviance.” This process, according to White (1995) puts the client on the other side of knowledge (the outside): a position that might be internalised to a significant degree by someone who is recovering from or grappling with the experience of ‘having lost their mind’.

At this point, I have used, or referred to authors who have used, a range of terms to describe or label individuals positioned in a particular way in discussions around mental well being. The term ‘client’ or ‘consumer’ is often used in literature around mental health and/or illness, and I have used (and continue to use) these terms interchangeably with ‘service user,’ ‘resident’ and ‘former resident.’ I acknowledge that all of these terms are potentially disempowering and objectifying, and are certainly contextual, historical and partial. Within the program itself, the term ‘resident’ was used frequently, as was the term ‘worker.’ ‘Community member,’ ‘program participant’ or ‘person I’m working with’ are potentially less stigmatising words; however, my use of the words ‘resident’ and ‘former resident’ is a shorthand method of describing literally where the person was, in relation to the program, at the time of interview, and in no way a descriptor of the person’s whole identity. Similarly, it must be acknowledged that the term ‘worker’ or ‘staff member’ is also, as a descriptor of an individual, partial, contextual and historically located.

Returning to White’s observations in the preceding paragraph, residents commented on the experience of losing trust in their own capacity to see things clearly, as well as losing their sense of trust in those they had previously been close to, and others around them who were invested with a professional gaze. After you’ve been in hospital, “you just don’t know who to trust... and when something affects your mind, I sort of doubt myself and my ability to know who the person is to talk to... I really haven’t had anyone to talk to about what happened to me in hospital” (AG 70). Another resident commented that the most significant thing she had needed to recover from, after her hospital experience was the depression brought about by the labels she had received, and
to regenerate a sense of “trust in people” which had deteriorated in relation to both medical staff and her own family whilst in hospital (LC 35). In this healing process, the program/community itself became pivotal in redeveloping both a capacity to trust others and to critically examine the ‘truths’ presented and constructed through the gaze of an other.

One former resident commented on her distrust on her own perceptions, particularly when it conflicted with the professional’s view. Sometimes she had noticed a “workers’ own agenda” coming into their work which was, she said, “almost exploitive of people... you can see it in hindsight, but as a resident, when I was noticing it, I really doubted that I was seeing what I thought I was seeing... like I must be the one who’s wrong here” (RD 2). So, at times it seemed, the expert gaze of the professional may be trusted more than one’s own gaze, whether that gaze is one which disempowers or something more consciously chosen by a critical practitioner. Potter (1996) describes how certain “categories of actors are treated as entitled to know particular sorts of things” by virtue of their professional standing or position (p.114), making certain views more credible than others and “obliviating the need to ask how the person knows” (p.133). At the same time, other groups of persons are worked up as “having a specific and distinctive character suitable for some action” (p.176). Curt transforms the noun ‘knowledge’ into a verb, to encapsulate this process, suggesting that truth is “knowledged into being …by the language games used” that allow producers to not only lay claim to privileged access to truth, but also to be its sole architects. Thus, language does a sort of “reality work” where the “narrative qualities of the story [are]… rendered invisible” (1994, p.73).

Psychotherapist Windy Dryden (1997, p.95) suggests it is possible to state one’s therapeutic stance in a fairly transparent way, for example, “look, this is the kind of person I am, these are the kind of beliefs and values that I have.” Lomas (interviewed in Dryden, 1997) suggests that the therapist, by pretending that he doesn’t have a stance from which his gaze emanates actually may confuse clients; there is a fine balance between not wanting to indoctrinate clients with one’s own view and also not wishing to hide or conceal them. Indeed, the vast diversity of individual clients might suggest that no one universalised approach to sharing one’s theoretical orientation will suit all clients,
some of who may not want to know such details. One former resident, reflecting on her experience in the program, suggested that education for service users about various approaches to therapy and theories of psychosocial rehabilitation would be a way of sharing both power and knowledge. She commented in no uncertain terms:

“I always got the feeling that the wool was being pulled over your eyes… because things weren’t put openly in front of you. For some people this wouldn’t have been an issue, they wouldn’t have cared less or known what you were talking about. But for me, I would have appreciated [being told by staff], ‘this is a psychodynamic approach, these are the values behind it, which are not the values that everybody believes in. This is such and such’s view and he thinks you get this from this. We practice this because this…’ Not ‘this is life, this is just as it is.’ And when you questioned it, [staff] just closed ranks, I felt. I don’t think it was intentional, but often that was the impression I got… it was important for staff to have professional development and learn about interaction with people and psychology, but it wasn’t important for us! Then three years later I’ll be reading a psych book and discover that when something a certain way every day, there was a theory about it…” (NA)

Like Curt (1994), Potter (1996) concludes that the tension between varying views and positions is preferable to a more peaceful coexistence, as attentiveness to the constructed, motivated and consequential nature of various descriptions and theorising may be helpful in unraveling taken for granted assumptions. This may be an important area for staff teams also, in which there are invariably divergent views, some of which – more or less consciously – may become more privileged than others.

In a fascinating article entitled ‘Clinical Writing and Schizophrenia,’ based on an Australian study comparing tapes of patient-doctor interviews with case notes written about the interview, Barrett (1988, p.268) identified how the “performance” of writing case notes defines and transforms clients. The form of writing required demands that clinicians “capture patient’s private and personal mental experiences in codified idioms… easily reduced to a publicly available numerical discourse.” Barrett also highlights how the ideal case record legitimises and further entrenches a patient-professional divide, by portraying the clinician as rational, capable, empathic, and controlled – in fact, the exact opposite of their patient. What is recorded is highly selective, with no trace of the
questions that were asked to elicit responses: the category entitlement of the doctor or professional allows them to become both central and invisible. The more the person is inscribed as a case, over time, the more entrenched the description becomes. According to Weick (1995):

“…problems are constructed…from the materials of problematic situations which are puzzling, troubling and uncertain…we select what we will treat as the ‘things’ of the situation…and we impose upon it a coherence which allows us to say what is wrong and in what directions the situation needs to be changed” (p.8).

He goes on to suggest that:

“.control over which cues will serve as a point of reference is an important source of power…to establish a point of reference – for example to direct people’s attention to the dye in a cloth rather than to the density of its weave to infer value – a consequential act” (p.50).

While the professional gaze is influenced by individual theoretical orientations, experience, biography and values, it is also firmly embedded in dominant cultural values and discourse which engender a macro social gaze of what it means to be a productive, normal or successful human being. White (1995) refers to the “dominant story of what it means to be a person of moral worth in our culture…a story that emphasises self-possession, self containment, self actualization and so on…” (p.16). Psychotic expression, White suggests, is the exact opposite of this. Even with all its emphasis on diversity and multiple truths, he suggests, postmodernism has not made much of a dent in destabilising the dominant cultural story of what it means to be a deserving citizen in Western society. He makes the interesting observation that stepping into “a site of illness” may actually be one way to step out of the stress of trying to live up to such a narrow ideal (p.118). The individualistic nature of contemporary western society certainly may make it difficult for workers to expand their gaze to include structural aspects of individual problems. To challenge restrictive interpretations of success or worth prescribed by dominant social discourses, workers must first be able to see that a dominant discourse is in operation, and then, together with the client “reduce the possibility that people might read failure into their responses to the world” (White, 1995,
Workers and service users then, can engage collaboratively in directing their gaze outward as well as inward, what is traditionally referred to in critical social work practice as consciousness raising.

Noticing behaviours – the extraction of certain cues from amongst the myriad of possible observations – is unavoidable, like the unavoidable trespass of all knowledge: the view always emanates from somewhere, and focuses on something rather than everything. Indeed, as I will argue in the second half of this chapter, the extraction of cues itself is neither inherently good nor bad, and is indeed necessary if we’re not to be overwhelmed. As critically reflective practitioners, however, we need to ask, how does my extraction of certain cues, amongst various possibilities, construct the individual, and my subsequent interactions? In other words, how does the selectivity of my gaze enable or oppress the other? As mentioned, the local culture and ethos of a service or organisation will also significantly influence the type of gaze that is employed by workers to frame individual experience. The agency/organisational culture will undoubtedly have its own norms and blind spots, it’s “sacred cows” which are not to be tampered with, blinders and elements of “world closure” that understandably make the messiness of experience manageable at some level (Alvesson, 1993).

**Function of the gaze**

In the area of mental health and illness, Davidson & Strauss (1995) acknowledge that most psychiatric practice and research focuses more on pathology than health or recovery. McGorry (1992, p.13) observes that clinicians, “particularly psychiatrists, may selectively overlook the strengths and resources of the recovering patient,” including relationships and networks that are outside the mental health system and past experiences of accomplishments and wellness, the noting of which would reflect a different sort of gaze. While a professional gaze can be a disempowering one, there are also possibilities for critical workers to consciously use their gaze in ways that are experienced as empowering by service users. Podvoll (1983, p.183), for example, suggests that the helping role is, or could be, one of uncovering a person’s “history of sanity” – to use one’s professional gaze as a form of alertness to “islands of clarity” – those fragile moments when a person’s intrinsic health emerges. Thus, a gaze that is attentive to these
islands of clarity and history of sanity suggests extraction of a different sort of cue than those that focus only on pathology or deficit. In some respects, this is similar to a strengths perspective. Barham and Hayward (1991) refer to the notion of “personhood” whereby support persons attempt to bring “into the light aspects that are obscured in a framework that focuses more narrowly on the disorder” (p.3). Similarly, in what is still a very evocative phrase, Estroff (1989) refers to the “persistence of person” that calls to be recognised under the ‘crazy’ identity.

Law (1994) acknowledges the inevitability of involvement in some sort of ordering – a dynamic process of sensemaking, categorising and monitoring that generates stories and ‘truths’ about the social world. However, he observes that every act of ordering – or as Weick puts, it, extraction of cues - is incomplete and is necessarily an act of inclusion and exclusion. Orderings, Law suggests, “can generate power and pain… they can translate, conceal and profit from the story they create” (1994, pp.105-106). What is needed, then, is to recognise the selectivity of our ordering and the partial, incomplete and situated nature of our gaze, being mindful, as Law points out, of the questionable assumption that “what is to be selected exists before it is selected, like tins of soup sitting on a supermarket shelf…” (p.155). Like Orlie, who encourages us to recognise the trespass inherent in interpretation and action, Law encourages a critical analysis of any type of ordering. At the same time, he says, we still “have grounds for telling stories – local grounds… that carry and embody values that we hold dear” (p.153).

Organisational theorist Debra Meyerson (1991) describes the desire for order as deeply rooted in the dominant values of modernist Western society. She urges us to question why we tend to notice and value that which is “clear, stable and orderly (that which is readily understood, measured and controlled) and ignore that which is unclear, unstable and ‘disorderly’ (that which is more fragmented, intractable and difficult to control)” (p.255). The way we answer this question, she suggests, says something about our professional identity, values and interests. While the quest for control and certainty has been dominant in modernist thinking, Meyerson suggests that a “formulation of [organisational] culture that acknowledges ambiguities will more likely recognise and potentially legitimate a diverse chorus of voices and perspectives” (p.260) – something which is highly desirable from a critical approach to social work practice.
Meyerson goes on to suggest that the way in which an organisation views and responds to ambiguities can have a significant impact on the way individuals within that organisational culture experience ambiguities themselves – as threatening, destabilising and devalued, or as legitimate, potentially productive and normal. This has important implications for work in human services, including psychiatric disability support services, as the lives of all individuals are full of ambiguities and non-linear development, which can be constructed (and hence rejected) as indicative of deficiency, or acknowledged and worked with as part of a process of personal growth. Indeed, as Weick (cited in Manning, 1997) suggests, it is when people are confronted with ambiguities that active sensemaking takes place and a greater sense of clarity can emerge. One staff person commented that the program and its mother organisation should be able to handle ambiguities productively, just as it expects its workers to do and as workers support clients to do. This would be manifest, for example, in viewing and responding to conflict and diversity, and different forms of knowledge – amongst the staff or residents - in healthy, respectful and mutually empowering and enriching ways.

Alexander Murray, a consultant psychiatrist in New South Wales, in a 1998 article in *Australian Psychiatry*, suggests that if professional helpers “discard information that is not easily processed, the object of our inquiry [sic] may slip through our fingers” (p.60). He also raises questions around the meaning that is attached by professionals to an other’s behaviour or experience: “With a ruler you might measure wrist scars quite precisely, but what do they mean? The patient is crying: were they sad when they arrived, or have I been rude?” Tibetan Buddhist scholar Sogyal Rinpoche (1995) simply says, “If you are too clever, you could miss the point entirely” (no page number, November 14 meditation). Indeed, gazing upon and theorising the experience of an other holds the potential for empowerment or oppression, which can only be recognised through honest, ongoing and conscious engagement in critical reflection on practice.

Curt cautions that we need to be conscious of the power of discourse and taken for granted assumptions in any theorising. However, like Law, Curt suggests that such deconstruction of ‘truths’ need not lead to the total rejection of a theory or story; indeed, Curt (1994) comments that we “can and do take from stories the knowledge they have brought into being and to our attention – we learn from them” (p.73). Saleebey suggests
that a critical practitioner needs to realise that “the theories we arm ourselves with are
really just stories, not facts…” (1994, p.355), a view shared by Rossiter who, citing
Baker (1993) refers to theories as “empowering fictions” – historically constructed stories
about people that guide our actions and decisions rather than universal truths (1996,
p.33). Rossiter suggests that this view encourages workers to be mindful of the limits of
any story they are investing in, and the inclusions and exclusions of the gaze that
emanates from any story. Curt concludes that the most important question we can ask
about any text – including those we (re) create and enact - is “what conduct it warrants”
(1996, p.190). Indeed, this resonates well with a critical and reflective approach to
practice in which workers are encouraged to problematise their practice in
(re)constructive ways, and to turn an inquisitive and honest gaze upon their practice.

One of the most intriguing theory-stories about psychiatric upheaval that I came
across in my reading was put forward by Gara, Rosenberg & Cohen in an article
appearing in the journal Psychiatry in 1987. They proposed that in psychosis, one’s
“prominent identities” are severely compromised or negated, forcing the person into an
“unidentified identity contrast” incapable of organising behaviour or experience. These
unelaborated identities are likely to appear totally chaotic and inappropriate to others. For
the sufferer, the negation of important identities seriously threatens their very reality.
When the psychosis gradually settles down, a “new me” emerges to replace the now
negated former identities with something less frightening or out of control than the
unelaborated contrast which was manifested during psychosis. The new me, according to
this theory, is a shallow, stereotyped identity replacement that is only a remnant of
previously established identities. This new me is often gradually replaced by a patient
identity which becomes, over time, fully adopted and may well be an attractive
alternative as “any identity, however negative serves to organise experience more
effectively than does no identity” (1987, p.276). The post-psychosis person, they suggest,
is in desperate need of some sort of elaborated identity, and the heart of treatment,
“should be to foster the elaboration of new non-patient identities” (p.277). As with other
theory-stories, the question a critical postmodern social worker might ask about the
relevance of Gara et al.’s interpretation is how does this theory-story illuminate or
resonate with the lived experiences of individuals, and how might a gaze emanating from this conceptual framework empower or disempower an individual?

One experienced staff person also commented on the importance of turning one’s own reflective gaze, as a worker, onto their own motivation for working in the mental health field, as this may also, despite one’s professionalism, impact on practice: ‘It’s important for workers to able to talk about and acknowledge... ‘what is my desire to work in this field?’ Otherwise the desire remains un-thought of, un-looked at, and eventually is thrust down the client’s throat... If I do not allow myself the possibility of seeing that my want to work in mental health is not just about helping others, if I cannot...see what is mine in the work, the inevitably it will be transferred – it passes down the line” (EG 89). Orlie (1997) contends that while we often cannot change what we are at a given time (for example, white, female, occupying social worker role) we can become responsible for how we “carry and pass on the social effects configuring what we appear to be...who we are,” she says, “is revealed through our words and deeds” (p.87). She constructs power in relationships as neither good nor bad; she does, however, encourage us to become mindful of, rather than remain thoughtless about, the effects of our power – “If we reflect on the effects of our power [the inevitable trespass created by our gaze and our knowledge] we may be able to consciously create better ways to exercise power” (p.169). Rather than imagining ourselves to be outside the problem or the relationship, we place ourselves within it. Goldfried (interviewed in Dryden, 1997, p.68) observes that it is often more difficult to see things outside of ourselves “than it is to see ourselves in the context of an interaction...in much the same way that clients find it difficult to see their own contribution to some of their life dilemmas.”

Leonard (1997) suggests that relationships and subject positions in human services are created through struggle and confrontation, although this may feel uncomfortable to workers. He suggests we pay attention to what this sort of discomfort might mean in a given context. A very experienced staff member made the following comment, which highlights the potentially productive nature of confrontation and struggle within the program setting: “When you’re in your 20s or 30s and are in a program like this, which is so structured, and you’re told what to do a lot of the time, you OUGHT to be challenging that... it’s a pretty healthy state to be challenging that a lot of
the time... No client, when I was in the program, the way the program was, could stay there without struggle. It was a very challenging environment, particularly to someone at that age of their life, where you’re meant to be determining your future! We mustn’t protect our clients from this ambivalence, because it’s a healthy thing to be having” (RT 45).

This is a way of gazing upon and making sense of conflict that embraces – or at least does not try to shut down - confrontation rather than minimise and tidy it away. This requires a great deal of skill and grounding, as well as a particular type of ordering, in which conflict is not necessarily positioned as the inferior binary opposite to harmony. At the same time, it must also be acknowledged that a desire for order, based on logic and universalisable truth, is understandably appealing: we all seek some sort of order in our lives and in our work. A fixed, clear and constant order (the sort of ‘world closure’ proposed by Alvesson) may indeed be easier to deal with than the messiness and unpredictability that diverse, interactive and speaking subjects might create. Our gaze, perhaps ‘naturally’, seeks to impose psychological and material order, to varying degrees, in order to feel secure and function in our various roles. However, it is also possible that the existence of “fault-lines full of tension” (Giddens, 1991 p.168) can provide places for new understandings and relationships to be generated, where we can critically reflect on ways in which we may unwittingly be colluding with oppressive or disempowering practices (Leonard’s “sites of struggle” (1997, p. 54)). The program, in some ways represented such a space, allowing for uncertainty, challenge and ambiguity, wherein loose ends were not only accepted but expected, and in which workers, at times, actively resisted collusion with objectifying discourses.

One program staff member expressed his reservations about the increasing expectation for psychiatric disability support services to frame their work as that of experts who have all the answers. Referring to Foucault, he commented: “What that makes us... is that 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 – that we can actually help someone be happy. My hope is that someone can get into contact with what they want.” As a worker, he tries to “encourage a much more radical subjectivity... to help [residents] re-engage with themselves more fully, as subjects. Not
as objects of study, or objects of my knowledge, or objects of the state saying ‘these are the outcomes for rehabilitation programs… We try to encourage greater empowerment, for the people who live here to be able to know their experiences as their own, rather than one that’s given to them… To be able to speak more about their lives, to be able to be a speaking subject, not one that just has a number of terms about their malady from others…” (EG 4-5)

Patients in the psychiatric system, as well as others seeking help or support at vulnerable times, may willingly grant “omnipotence” to professionals, particularly doctors, as they may be frightened and dependent on professional expertise, and, as previously discussed, distrustful of their own gaze or perception. Giddens (1991) also speaks of worker/professional omnipotence, however, he suggests it is actually a “fantasy state of dominance… a brittle defence that can dissolve into its opposite – engulfment” (p.194). In a worst case scenario, it may be that the gaze of one who is positioned as omnipotent could further entrench an unhelpful power continuum in which the professional operates from a fantasy state at one end, and the patient remains disempowered at the other.

One experienced staff member has this to say: “this omnipotent fantasy… I can’t think of any staff who I’ve worked with… who didn’t have a struggle with this fantasy, including myself… that balancing act of this issue of omnipotence… with the intensive engagement needed in order to come up with the goodies” (RT 86). When the needs of those you are working with are great and immediately present, the wish to achieve change quickly and to be powerful in doing so, may be difficult to resist; conscious effort is required to critically examine the empowering or oppressive aspects of this belief. The staff member quoted above went on to say… “everyone who works in an organisation like this is impacted by [that desire to help]… the clients are so desperately wanting improvement in their life… consequently [staff] can become quite unrealistic in interpreting their role… There is a great danger, as a support worker in these services, to feel quite omnipotent – to actually feel that you can impact on people’s lives in a substantial way. That is very dangerous… you have to look at all of your assumptions in doing that. It’s a needy client group… many have had very traumatic experiences… that
adds up to a pretty needy client who has every reason to expect a great deal of their keyworker, and that is very hard to resist” (RT 85-86).

Writing in the 1970s about the therapist as a mediator of healing, Sanford observed that “the contemporary healer of the soul… will find himself the object of all kinds of unrealistic expectations, magical projections and demands which put him at risk of believing himself omnipotent” (1977, p.84). He went on to say that the “humbling admission” that the real healing power comes from individuals themselves “saves the humanity of the therapist… and also rescues the integrity and dignity of the client” (p.84). While a social worker may baulk at the possibility of being considered a healer of the soul, the observation does have some relevance in that social workers are often constructed as fixers of problems. In this sense, a conscious and empowering gaze would be one that sensitively seeks to use their professional gaze in the service of the other’s own change process.

White proposes the notion of “returning the [professional] gaze” as a way of challenging who is allowed to speak and to contribute to theory/truth-making: a way of “challenging the hegemony of psychiatric knowledge… [and] the extent to which their own lives are knowledged” (1995, p.121). However, he does not just leave this idea in the realm of the abstract, he goes on to propose ways in which disempowering speech acts can be embodied, i.e. “situated within the context of the speaker’s… motives and purposes…[and] personal experiences…bringing forth the history of controversy that surrounds the speaker’s objective knowledge claims” (p.129). This idea may well send shivers down the spines of workers! Can we imagine for a moment, as a worker, being asked questions like these (or, as a client actually being empowered to ask them): “If you were to succeed in influencing what I do on this occasion, how would this fit with your overall goals for my life?” or “Could you tell me about some of your personal experiences of life that have played a central role in the formation of this opinion…then I could know more how to take your opinion?” Or “In what circles are these sorts of opinions most strongly held? Do all of the people in these circles agree with this opinion?” (White, 1995, p.129).

It is interesting and illuminating to ask how we might, as workers, feel about and respond to such questions, and if we were service users, what purpose would asking the
questions serve and how might the asking contribute to or reflect our sense of self. As a worker, would responding to these questions undermine our sense of professionalism or the power of our gaze? After posing these questions, White goes on to say that the questions do not actually require an answer to be effective. Simply by asking such questions, he suggests, “those who are subject to disembodied speech acts become less captive and are confronted with new possibilities for action” (White, 1995, p.130). Again, we might refer back to the powerful comments of the former resident whose words appear earlier in this chapter, in which she indicates her desire or need for theorists to be located and their situated subjectivity acknowledged.

Several residents spoke about experiences that could be connected to this idea of ‘returning the gaze:’ one commented that sometimes staff attitudes and staff energy made her “feel like a sick and dependent person”: however, after being in the program for a period of time and coming to a place of greater well being within herself, she felt she was able to “challenge staff” – in a way that was dialogic rather than antagonistic. A former resident recalled how generally, in her view, service-users’ criticisms of staff came out in ways that were difficult for staff to hear and that they would then “take on the worker’s role” as a form of deflection or minimisation that allows the criticism to be ignored. Having an inquiring gaze ‘returned to us’ as workers may initially feel uncomfortable, and may, from psychodynamic perspectives, be interpreted as having certain unconscious motivations, which may allow us to neglect the actual content of what is being expressed. It is important as critical and reflective social workers, no matter what our theoretical orientation, to not shrink from such an experience but engage with it with respect and interest, and be willing to examine our responses and their affect.

In my interviews, the word ‘gaze’ or ‘professional gaze’ was never used directly, by either participants or myself. However, I have taken the liberty of grouping together a number of quotes that seem to suggest a particular type of gaze that was found to be useful within the program setting. It was in my reading and re-reading of interview transcripts that this way of theorising experience suggested itself; or perhaps more accurately, the readings combined with my thinking around the usefulness of postmodern deconstruction/reconstruction to social work. As mentioned previously, and in keeping
with the spirit of this thesis, the value of this theorising lies in its usefulness to any reader.

**An empowering gaze?**

Our gaze as social workers and the discourses we enact and perpetuate help us define both our own and our clients’ positions, the nature of ‘help’ or support that is offered by our selves and our services, what cues we attend to and how we construct their meaning, and the location and boundaries of knowledge to be valued. Not unlike psychiatric discourse, social work has been criticised for complicity in oppression and subjugation of clients’ stories and experiences. Margolin (1997) presents a scathing indictment of how social work (and social workers) masks its power to pathologise and oppress clients, all the while generating a beneficient and self-justifying discourse that hides the real nature of its social control function. This power, according to Margolins, is consistently reinforced through the mechanism of record-keeping and record-sharing amongst other professions; their rapport, friendship and sincerity a form of manipulation and coercion. Even critical examination of practice, in the form of self criticism, Margolis argues, “exists only to the degree it supports social work’s legitimacy as a profession” (1997, p.170).

Rossiter (1996, p.33) also problematises the way that much of social work theory “positions social workers as the knowers and their clients as, at best, repositories of ‘strengths’.” She suggests that an illusion is created whereby the worker is seen to have a complete, objective view of the client that will lead categorically to the right intervention. Arguably, this is expected and perpetuated by funding bodies, who, reasonably in some respects, want results. Insightfully, Rossiter highlights that by making clients into “the problem” the potential for creating knowledge together is destroyed. The co-creation of knowledge is at the heart of critical, rights-based social work practice – whereby the worker does not actually lose power (through sharing it) but becomes empowered together with the client. It cannot be denied, however, that having the capacity and the position to *be able to share*, or to *decide* how or if to share, is a position of power in itself, and one which consumers and clients can justifiably feel and identify no matter how collaborative the worker attempts to be.
Saleebey (1994, p.355) refers to the “helper myth” that underlies typical worker-client interactions, as the worker “clumsily or deftly imposes his or her version of the situation” while clients “surrender” or “repress” their own story. He argues that an approach more aligned with critical practice is one that attempts to act as a catalyst in bringing suppressed stories into the open, not only to facilitate empowerment but as a political act of resistance to universalised discourses of deficit and objectification. White and Epston (1989) also refer to the political nature of the helping activity, suggesting that critical workers need to assume a conscious and critically reflective stance in which they must challenge “the techniques that subjugate persons to a dominant ideology” (p.33). Thus, the gaze is again turned back onto ourselves as workers and onto the relationships we are part of. Moren (1994) suggests that every encounter is one in which our self is revealed, “[challenging] my own confined and stunted view of the world, the person-I-am-not” in which a worker willingly runs the “risk of discovering my own narrowness of outlook, that I myself live in a destructive normality” (p.282). Like the client, the worker’s gaze is inevitably situated and stems from a particular and limiting range of assumptions. Brandon (1983), writing about ‘now-ness’ in the helping relationship, asks soul-searchingly, “How often have I compelled some poor client to come back from some pathway of exploration simply because I was holding firmly to my view of what he ought to be doing? I use my power to make what I believe to be true, probably to the detriment of the client” (p.143). Rossiter (1996, p. 33) contends that social workers can only make room for the client’s perspective when they acknowledge the partiality of their own. Professional expertise, she suggests, referring to Gadamer (1992), can then shift from something “acquired by an ‘expert’ to something held by an ‘experienced person’” who exercises responsibility by remaining open to new experiences and new understanding. This, to me, is a far more liberating and realistic position than that of expert, and no less accountable.

As workers we may choose, more or less consciously, to be aligned more with an ‘expert’ or ‘co-author’ position, and may slide along this continuum in different contexts, for various reasons. At times a gaze that is more aligned with traditional notions of professional expertise may not only be encouraged by the setting in which we work, but may also feel like the ‘right’ intervention, for example, the directiveness that is
sometimes needed in crisis intervention. Ideally, this tension and ambiguity need not be destructive or threatening; it may provide a healthy opportunity, if engaged with in a critical and reflective way, to unravel the assumptions upon which any professional gaze is based and honestly assess the impact of such a gaze on emancipatory practice. We are then potentially able to (re)construct a gaze and a practice that is more in line with our critical intent. Often our choices are not as conscious as they might be: our own subjectivity is situated within wider discourses and social practices that may have become invisible; thus it becomes even more important to engage in critical reflection that problematises ‘common sense’ approaches to practice that (re)create social control models.

To conclude this chapter, I now look in more detail at the sort of gaze that was described by research participants as an empowering, facilitative one: a gaze used to support and enable – a gaze that seemed to allow for and be attentive to the fluidity and complexity of identity and personhood, and able to embrace many forms of valued knowledge. Such a professional gaze aims to facilitate the developing awareness of a person’s own capacity to both know and act: to “make visible new possibilities” for both client and worker (Moren, 1994, p.280). Through the stories of various people involved with the program it is possible to link somewhat abstract concepts (such as an empowering gaze) with narrative and experience within a particular site of interaction.

Most staff interviewed commented on the benefits of a residential setting, which enabled them to gain a more holistic view of the people they were meant to be supporting. One staff member observed that seeing how residents interacted with others in a wide range of situations provided a huge “observable clue” to what might be important issues for the person, especially in relation to “what it means to be noticed [by other community members] and to take responsibility for things, and what it means not to” (EC). This extra insight into people’s relational patterns provided program staff with a greater capacity to provide support in various situations that they thought might be particularly challenging for individuals, or which individuals had identified themselves as difficult. Seeing someone across a range of activities, as another staff member commented, could be “very liberating for the person”: for example, someone might be very quiet and nervous in a therapy group setting but quite confident and relaxed on a
bush walk or cooking a bar-b-q. The residential program “allows you to be continuously aware of the complexity of the person (EG 27, and to subsequently “have a holistic sense of working with people…to really get to know people on different levels, to laugh with them… and do sporty things” (EC 27).

While this aspect of a holistic gaze is potentially very useful to all concerned, there are also some issues here for staff to be aware of. One worker commented that, for some residents in the program, being noticed by staff – and the rest of the community - felt very daunting and even threatening at times; it was as if there was nowhere to hide, and the sense of being known could be a frightening thing in itself. For one former resident, the constant presence and ongoing contact with staff across a whole range of activities, served to highlight what he referred to as the “staff-resident dichotomy” – a disempowering experience of feeling ‘othered’ and ‘less than.’ “One of my biggest problems,” he said, “was the staff resident dichotomy. It’s very hard to set up structures like that [the program] where there aren’t power differentials. While he felt that ongoing contact with staff was generally helpful, it also “fuelled my dis-ease with the power differential…the line between the professional and you, because of the situation – you are actually spending a lot of time [being exposed to]…You can say that whole process of delineating and dealing with boundaries is useful, but... I found it more frustrating” (IR 91). Thus the constancy of staff presence, who were in a sense always observing (from a particular role and position) was sometimes experienced as disempowering and reinforcing of difference.

Despite some of these frustrations with the gaze of staff, in other comments made by participants, it seemed that a particular type of gaze was felt to be supportive and empowering. These comments can be theorised as capturing certain elements of what a non-oppressive gaze might encompass or look like in practice. For example, one individual, who had just moved out of the program after several years, described a positive nurturing role of staff as one of “…being all eyes and ears… noticing the person, what they’re going through…when to approach them and when not to…” (IT 26). This seems to suggest a gaze which is used for the client, in their service, not to ‘other’ or label or act upon, but to make the worker sensitive to their experience. This resonates with some of the literature discussed earlier in this chapter that suggests that workers
need to be aware of and attuned to windows of opportunity or islands of clarity (Podvoll, 1990), the persistence of person (Estroff, 1989; Barham & Hayward, 1999) and the capacity for collaboration to make visible new possibilities (Moren, 1994; White, 1995).

The gaze of the worker must, from a critical perspective, always be a gaze that maintains a sense of wondering or uncertainty, as a complex individual continues to grow and reveal their self in interaction with their environment. Moren suggests that the most important competency of a social worker is to be aware of, and to control, the act of balance between two risks: “the risk to obtrude and to infringe upon when you should leave alone, or the risk to abandon when you should stay firm…to maintain the offer of human assistance, but without intrusion and offence – that is the most essential aspect of social work” (1994, p.282). Thus the task is to gaze consciously and conscientiously, and to engage in critical reflection on the intended or unintended constructions our gaze creates. As the previous quote from Moren suggests, a crucial part of our expertise is in our attentiveness to what is needed for a particular person at a particular time.

Postmodern thinking highlights the fluid and changing nature of identity and the contextuality of experience and understanding: in relation to the development of an empowering professional gaze, the dynamic nature of human experience suggests that there is no fixed truth around what will always and even constitute an enabling gaze. Only through critical reflection on and in practice, and listening to the voices of those we work with, can we negotiate and be empowered by this uncertainty.

While the nature of a therapeutic community will be discussed in greater detail in Chapter 6, at this point it is suffice to suggest that the gaze of workers in a therapeutic residential setting is absolutely vital in attending to the pulse of the community and facilitating a safe and therapeutic environment. Workers are continually making choices about when and how to intervene: when to act and when not to act – with significant repercussions. As Savalle and Wagenborg (1980) observe, unproductive periods in a community can be prolonged by staff inaction, during which time the community becomes increasingly polarized and people leave. On the other hand, staff may decide to intervene in community process, but do it too quickly, resulting in the suppression of important individual material or prematurely closing off a productive, although potentially difficult, exploration of conflicting views. By having an overview of what is
happening, both for residents and staff, and bringing such observations to the community in an open, respectful and engaging way, staff may use their gaze – their power to extract cues – in a way that is empowering rather than oppressive. In terms of keeping the whole program together, almost all residents and former residents who were interviewed agreed that the staff were basically, as one resident put it, “the backbone [of the program], so it works”; monitoring what is going on, mediating group discussions, etc. Several residents and former residents commented on the need for more staff observation and intervention in the goings-on of the program, and particularly in resolving conflict between residents.

Another potentially empowering form that a worker’s gaze might take is one that notices more rather than less. One former resident, looking back on their experience of the program several years previously, recalled an experience of pleading silently to staff, “...don’t be fooled...please don’t be as ignorant as everyone else in the world, that just because you can do it on the outside [speaking about herself; in relation to daily living skills], means that somehow you’re fixed. The realisation that nobody had a clue what was going on [internally, for her], even though I thought it was so obvious [was] not a great realisation” (NA 26). Here the message seems to be for staff to notice more, to have a gaze that is skilled enough to see what others may not. Indeed the skilful and attentive gaze of program staff at times seemed to have a ripple effect in the individual’s social system. One resident commented on how her involvement with the program had assisted others who worked with her to see her more holistically. Since being in the program, she observed, her doctor had been able to see more “what was... wrong with me...she didn’t really see the full picture till I came here – [the program] helped her to see what was going on for me” (BM 28).

Sometimes the gaze of staff, as described by service users, could be a source of real relief when one’s own capacity for self-awareness was at a low ebb. One resident talked about how, at a particular point during her stay in the program, her keyworker noticed that she was feeling quite unwell and set aside special time for her every day. The keyworker rang her doctor, saying that she was concerned: for the resident, “this was good... [it] was a weight off my shoulders... If I’d sat around and made a decision, I wouldn’t have made a right one... and I would have ended up in a very bad way” (BM 27). Another resident had this to say: “One thing I’ve discovered about this illness is that
you can’t see yourself going down… I’ve been helping a few people out, with their illness, and it’s like they don’t see it. I didn’t see it... 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” (AG 28). This sort of gaze, then is a sensitive and holistic one that is attuned to both strengths and vulnerabilities and can be offered as an expression of collaboration and support.

Critical postmodern thinking and critical reflection on practice can assist social workers to deconstruct potentially oppressive professional gazes and reconstruct possibilities for a more empowering gaze; this “destabilising” of (modernist) certainties can lead, as Healy describes it, to “a recognition of the importance of context in defining processes or power, identity and change” (2000, p.145). This requires a critical eye to be turned on oneself as a worker, to identify the forms of trespass generated by our professional gaze, the conduct it warrants and how our gaze fits with critical practice. As illustrated by the interview material presented in this chapter, this is not as straightforward as it might seem on the surface; the professional gaze has the capacity to facilitate empowerment as well as entrench objectification and more or less subtle forms of oppression. New constructions of practice and relationships, as a result of this process, may, as Healy suggests, be both modest and contextual; however, they can be consistently “oriented towards extending social citizenship within local contexts of practice and service users’ lives” (2000, p.145). The next chapter will engage in a similar deconstruction and reconstruction of issues of worker power and professionalism.
Chapter 4
Problematising worker power and professionalism

“Our act of helping is (and should be) troubled...”
(Rossiter, 1998, no page number)

“Problematising what we appear to be... in turn reveals who we might become...”
(Orlie, 1998, p.172)

In a similar fashion to the previous chapter, in which I explored and problematised the professional gaze via theory-stories from the literature and participants’ narratives, this chapter aims to explore worker power and professionalism and open these concepts and experiences out to consideration within the context of the program. Just as the professional gaze has been called into question by critical approaches to social work practice, worker power and professionalism have also been critiqued as more egalitarian forms of practice have emerged. Critical postmodern thinking, however, invites us, again, to challenge generalised meanings and grand narratives even in critical theory, and engage in contextual analysis of diverse and situated experiences. Through deconstructing and reconstructing notions and experiences of worker power in relation to the specific practice site – the program – alternative understandings are made possible that, at times, seem to challenge universalised constructions and critiques. Indeed, as I analysed my interview transcripts it seemed that worker authority and power, which certainly can be used oppressively, could also be used and experienced in ways that were enabling and empowering. As occurred with the theme of the professional gaze, the theme of this current chapter also ‘arose’ during my readings of the interview transcripts, in which some participants used the words ‘power’ and ‘authority’ whilst others spoke of experiences and made observations that I subsequently grouped under this theme.

It is suggested in this chapter that it is fruitful to question or critically reflect upon how power and professionalism operate (are exercised and experienced) at local sites, and ways in which they control or enable. A critical and postmodern approach is useful in deconstructing these concepts and reflecting upon how they may be consciously used and experienced in a particular setting. The critical element of the
analysis is important, as it calls attention to issues of empowerment or oppression. The postmodern element of the analysis is important because it draws attention to the production of truths, the fluidity of identity and the local, partial and contextual nature of any view of reality, including grand narratives around worker power and authority. As I read and re-read the interview transcripts, alongside continuous engagement with a range of relevant literature and the evolution of my own thinking, it seemed that traditional notions of worker power and professionalism could be revisited in light of specific contexts and experiences, resulting in a more fluid construction of these core aspects of social work practice.

As mentioned, the experience/conceptualisation of a ‘power differential’ between staff and residents was not something I had consciously considered when I began this research project, nor had I thought deeply or reflectively about the use of professional power as a worker, beyond some awareness of my own discomfort at times when pressed to assume a directive stance, despite my theoretical orientation towards a more egalitarian worker-client relationship. (At that time, while often in touch with feelings of inadequacy as a worker, my capacity for productive critical reflection was quite limited and my social work understanding often constructed in quite dichotomous either/or terms.) The power vested in social workers as agents of social control seemed remote to me as a support worker, where I genuinely felt I was on the client’s side; rather than perpetuating disempowered subject positions, it seemed that that the program was more about support and facilitating a process of reflection, engagement, and empowerment. However, as Rossiter (1996, p.29) observes, social workers are inevitably involved in power relationships: as a result, the crucial question for social workers is, “How can we best handle our position at sites where power and help are interwoven?” Indeed, the interweaving of power and help is potentially much more complex, contextually fluid and dynamic than we often realise. Conscious and critical reflection on the effects of our power in creating both social work itself and the individuals we interact with is a core component of critical practice, easily overlooked as we carry on with ‘business as normal’ and the in-one’s-face demands of practice.

Establishing collaborative and power-sharing alliances with clients is a central theme in critical social work theory and practice; in the mental health field, the consumer movement has argued passionately and convincingly for partnership-type relations between ‘professionals’ and ‘consumers.’ In the psychiatric system, clients
have often been positioned as recipients of treatment ‘for their own good’, and indeed
there are, at times, issues of duty of care when individuals may, temporarily at least,
be out of touch with ‘reality’ and at risk of harm. In general day to day practice,
workers often have power to define the needs and goals of service users and develop
‘expert’ strategies on how to meet them, to define what is appropriate behaviour and
right thinking, and to write a particular version of the truth in official records. Ife
suggests that one of the greatest potential mis-uses of professional power is when the
professional “becomes the expert in need definition,” effectively denying the
consumer the “right to define her/his needs in her/his own way” (1995, p.262).
Certainly this must be a disempowering experience, yet I know I have done this many
times, perhaps to relieve my own anxiety around being helpful and being seen to be
helpful, as much as anything. If, as Szasz suggests, what we are dealing with, as
support persons in mental health, are not scientific or medical questions, but “riddles
about life” (1993, p.xiii), then perhaps our assessments are indeed, as Fook (1996)
puts it, more realistically described as professional narratives than truth: having said
that, it must be acknowledged that they carry undeniable power to become ‘truth.’

Despite my initial blindness to the interweaving of power and help in the
program, on reflection, and as a result of immersion in interview material, I began to
see that the program could indeed be described as a site where this interweaving was
enacted and experienced on a daily basis. In this chapter I again present views of
participants alongside references to various theory-stories from the literature, to
explore and interrogate various constructions of worker power generally, and then,
more specifically in relation to the program itself.

**Inherent inequalities of the worker-client relationship**

As a privileged category, the ‘professional’ label confers a certain degree of
legitimacy and power to the one so named. Social work has had an ambivalent
relationship with professional power, resulting from different and varied constructions
of social work itself; feminist, anti-oppressive and community development
frameworks have aimed at equalising worker-client relationships by promoting a
collaborative approach in which all parties contribute their wisdom whilst power
differentials are consciously minimised. White observes, however, that the ‘non-
egalitarian’ nature of the worker-client relationship is unavoidable; he sees this in
terms of accountability, referring to the “special moral and ethical responsibilities associated with [the worker’s] position” (1995, p.70). Given this inherent inequality, he suggests that workers/therapists must do whatever they can “to make it very difficult for that power differential to have a toxic or negative effect” (p.70). This view resonates with Orlie’s (1997) concept of the unavoidable nature of trespass whenever we act on the world from positions of situated subjectivity; thus what is important is mindfulness of the nature of the trespass being enacted and a willingness to reconstruct less oppressive (inter)actions.

Along this line, whilst acknowledging that the worker-client power differential is a reality, one staff member suggested that ‘...it’s how we work with it 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’ (EC 10). She then went on to re-frame the exercise of worker power as a way of providing safety, reflecting that she had heard lots of residents say they feel held and supported by staff… ‘support, by its very nature is in some ways tied with the fact that we’re in a certain role. The positives they’re [residents] probably not going to see in terms of power – they would use different words, perhaps ‘safety’” (EC 11).

Winnicott (1986) proposes that it is the particular qualities of the client, rather than any desire to control or dominate on the part of the worker, that leads to a necessary and therapeutic power imbalance. Winnicott suggests that illness of “psychotic quality” demands a complex response from practitioners, one element of which is referred to as ‘holding’. ‘Holding’ in itself requires a certain power imbalance, as the client relies on the practitioner (and the trusting relationship that has been developed) for a certain level of “protection from the unpredictable” and the creation of “conditions that foster individual growth” (1986, p.119). The worker must have the strength or power to ‘hold’ and the client must accept, on some level (consciously or unconsciously) what might be described as the less ‘powerful’ position of being held, as part of a process leading ultimately to greater well being and empowerment.

Williams and Swartz (1998) also refer to an inherent inequality of power in the worker-client relationship, and the necessity of the worker occupying a position of power in order to define boundaries needed by the client in order to feel safe, contained and effective in the world. The power of the professional is again
constructed as serving a protective function in relation to the client. Williams and Swartz, like Winnicott, come from a psychodynamic framework, in which developing an awareness of unconscious forces present in the worker-client relationship (such as transference and counter-transference) is crucial to the therapeutic process. The psychodynamically oriented worker-client relationship does not attempt to create an egalitarian relationship, but a deliberately one-sided and strongly boundaried one, even at the risk of engendering a certain degree of alienation. “Obscure treatment boundaries” they caution, can lead to confusion. By maintaining professional distance the therapist/worker, they say, makes a compromise – decreasing the possibility for role confusion, even though potentially losing an additional source of information via connecting to the client on a more egalitarian level as a fellow human being (1998, p.306).

Obholzer and Roberts (1994) further caution that to deny difference can lead workers to identify so strongly with clients that they (workers) become overwhelmed. One staff member commented that as boundaries between staff and residents can get quite blurry in a community setting, “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. The team meetings help to make that distinction, to create that boundary. A lot 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 own experience” (OR 92). For this worker, and undoubtedly for others, an overly-strong identification with service users was conceived and experienced as a drawback in relation to effective helping.

At the same time, for some residents and former residents, the separateness of the office, and the debriefing done by staff behind closed doors was an unpleasant reminder of their different status. “I always thought it wasn’t fair that you [staff] got the de-briefing sessions and we didn’t! Because we were the ones that had to live there! ... at five o’clock our day didn’t end... 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 5:00 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’” (NNA 91) Another resident, who had been in the program for some time, expressed that a lot of the “rationale behind the program” was kept behind the closed doors of the office (LC 93). She went on to suggest that
there was something about the house “being split in two,” with staff having their section downstairs, residents upstairs that “creates a hollow in the house.” She said that it reminded her of a turn-of-the-century mansion, comprised of separate quarters for servants and gentry, and asked, “When people look back at [this place] in one hundred years, are they going to be looking at staff or residents?” (LC 93). For some residents, on the other hand, the separateness of staff did not seem to be a problem; indeed, for at least one resident, it seemed to be a relief; she liked having staff downstairs because “upstairs is my home... I don’t like it when staff troop through... no matter how benign it is” (AK 91). She commented that she would like to see program and living areas completely separated. While she noted “the staff are very much behind closed doors a lot of the time” she was ambivalent about it.

In his intriguing book, Madness and Cure, Langs (1985, p.4) makes the controversial assertion that practitioners’ deviation from strongly boundaried “therapeutic norms” can lead to them being justifiably considered ‘mad’ themselves. He argues that by deviating from the traditional psychotherapeutic framework – i.e. succumbing to over-gratification of self, and applying inconsistent rules - practitioners actually create situations which are anti-therapeutic –the patient/client ultimately feels unsafe as the therapist/practitioner runs rampant in expressing their own “pathological needs, fears, and desires.” Clearly, this is something to be avoided. Langs defines madness, as “the inner and often unconscious turmoil and contradictions that exist in all human beings...[which] become manifest in a wide range of ...symptoms” (p.9). One source of madness, he suggests, is “unquestionably the madness of others whom we trust to contain us...” (p.21). Patients and therapists, according to Langs, can collude in a mad therapy, which provides surface gratification to both parties, but is actually non-therapeutic (or even damaging) at a deeper level. He observed that therapists who allowed their own “emptiness and hunger” to contaminate their practice, created situations in which clients felt like “children who were being gluttoned with candy, ice cream, and cakes offered by parents whose own dread of deprivation, hostility, and depression is so inordinate that they must keep their children incessantly stuffed with junk, while unable to provide them with genuine nourishment” (p.189).

While this may seem far from what the typical social or support worker offers clients, there are some valid grounds for honest reflection. Why might workers feel compelled to provide something which gratifies/satiates their clients? Does the
desire/drive to help (and be seen to be helpful) lead workers to provide the wrong type (the easy type?) of support - providing direct ‘satisfaction’ to clients, rather than the more difficult and painful exploration of meaning that might lead to a deeper and more authentic resolution? I know I have been guilty of the former, responding to the need I perceived in the client’s eyes, and being unwilling or unable to resist giving them something, even if it was the wrong thing – the thing to satisfy my hunger to be helpful. The workers I observed to be the most effective in supporting client growth and empowerment were those who could balance challenge and containment: perhaps the genuine nourishment referred to by Langs. ‘Sane’ psychotherapy, Langs concludes, is not easy for clinicians to carry out, nor is it easy for patients/clients themselves to tolerate.

Support /social work is clearly different to (psycho)therapy (although individual staff members had quite different views about the therapeutic nature of their work). However, it is useful for workers to reflect on whether their ‘collusion’ with clients is a result of well conceived or intuitive practice – or simply the line of least resistance based on the needs of the worker or perceived wishes or demands of clients. I know, as a worker, how difficult it was at times to grapple with the real, very painful issues of clients, for which I had no answers (but thought I should), and how much easier it was to work with their ‘well’ parts and hope the less well (more problematic) parts would just stay at bay. My own denial was operative in this, as was my lack of experience, and perhaps while it provided some relief or camaraderie to clients, it may not have been effective in facilitating a real process of growth.

How might workers know if their interventions are ‘mad’ or ‘sane’? Langs suggests that moments of sanity in therapy are noticeable by the healthy responses and observable growth they generate in both clients and practitioners, in contrast to the more superficial relief provided by avoidance of deep fears and pain that effective therapy/support can mobilise. As a worker in mental health, I know that at times I opted for superficial relief, rather than working with the pain. As helpers or social workers, we need to be willing to critically reflect upon how we might be expressing our own ‘madness’ and what this might be calling forth in our clients. This is part of positioning ourselves firmly in the picture, and consciously adopting a reflexive approach to practice. While the preceding discussion may seem off the track of this section’s focus on the power imbalance of the worker-client relationship, collusion in ‘mad therapy’ may be due to an uncritical resistance or fear on the part of a worker in
relation to assuming professional power in a way that would actually be experienced
by the other as containing. In these instances, an egalitarian relationship could stem
more from anxiety on the part of the worker than a mindfully conceived and
theoretically grounded approach to empowering practice.

Ellis (interviewed by Dryden, 1997) provides a provocative commentary on
what he calls the pretence of some practitioners who propose that they and the client
are co-collaborators - equally knowing the answers to the client’s problems. If you are
a competent practitioner, he suggests, you actually DO know more than the client
about how to alleviate their distress. “Why,” he asks, “should you waste therapeutic
time collaborating 50-50 with clients when you can effectively help them quickly zero
in on what their …problems are?” (p.12). He goes further to suggest that the reason
some practitioners prefer the pretence of a collaborative stance is that they are “scared
shitless of making mistakes” and that by ‘collaborating’ with clients they can “cop out
on taking risks and on doing a great deal of the therapeutic work themselves… They
are,” he says, “in a word, afraid of being directive” (p.15). While observing that the
worker’s role was primarily facilitative or dialogic, that “a person has within
themselves their own answers [and] my job is to help them discover their own
answers”, one staff member commented that, on the other hand, “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?’ …How do we know what’s of value till we’ve
tried it? Sometimes staff do know best, and we’ve certainly been given the
responsibility of making decisions” (ID 6). The same staff member went on to say,
“I’ve asked the question, not infrequently, who do you think is the most powerful
person in your life? … it’s easy to see the other as more powerful – there IS a power
differential [between workers and staff] but it’s in terms of power to do what… in my
life? …Sometimes it would be lovely to have a big mummy in the sky who’d give me
infallible answers to what I should do…” a lot of the work of staff is “refraining from
doing things for people” (ID 9). And, from another staff member, “I struggle with
that a bit, about wanting someone to take hold of their life and make something of it,
but not wanting to impose my lifestyle on someone else” (AC 6). At times, refraining
from defining need, or actively pushing one’s agenda onto clients, who may be
struggling for direction or answers from someone ‘knowledgeable’, may be an
important aspect of the role of staff.
At the same time it is unavoidable to ask, isn’t someone who ‘knows what others do not’ precisely what is needed, precisely what anyone might need, when stuck in an entrapping niche (Sullivan, 1997; Taylor, 1997) or when life has fallen apart due to psychological disturbance? Experiences of upheaval and distress may put us at such a loss that we need someone to bring their gaze, their knowledge or professional power to bear on our situation. Just as the diagnostic gaze can be comforting in its certainty, allowing someone knowledgeable – i.e. a professional – to make decisions on your behalf can also be appealing (although perhaps not conducive to the development of agency or empowerment). Caltagirone (1997, p.168) suggests that clients can become “compliant” in someone else having power over them and making decisions about their life, feeling “entitled to not collaborate” and relieved to have someone else in the driver’s seat. Indeed, we have all probably experienced any number of times when we were happy or relieved to have someone make difficult decisions for us. From a critical or postmodern perspective, does one’s right to choose (self-determine) also include the right to abdicate control?

Sass (1992, p.169) warns that postmodernism’s “inventive nature of what passes for truth,” carries the “potentially debilitating and anxiety-provoking tendencies” that lack of certainty can engender. Individuals, particularly when vulnerable or confused, he suggests, may find their distress heightened by the notion that everything is relative and open to multiple meaning constructions. Along similar lines, Ellis (interviewed in Dryden, 1997) states unapologetically that his aim is to fit the client into his theory because he considers it a good theory – one that, from his perspective, has proven itself to be effective, and if clients don’t like it, they can go elsewhere. Camilleri also suggests that the expertise and knowledge of helping professionals is what consumers of services both need and value (1999, p.34); however, expertise need not preclude an openness to diverse meaning constructions and an acknowledgment of uncertainty and fluidity.

As critical practitioners, we can attempt to unravel, in specific situations, how and for what reasons we exercise our professional power, and how this fits with our critical intentions, exploring the assumptions that underpin our practice, and whether our use of professional power at this time, in this place, with this person in their current space, is likely to be empowering or oppressive. This approach acknowledges the fluid, contextually-bound and individualised positions and experiences that workers and clients engage with – and, to some extent, create - more or less
consciously. In the next sections of this chapter I once again rely on the voices of participants, as well as material from the literature, to further explore some of the ambiguities of professionalism and professional power.

**The ambivalent nature of professionalism**

A critical approach to practice invites social workers to problematise constructions and expressions of professionalism that serve to mystify and fence-off bodies of expert knowledge. Social work professionalism has been associated with “elitism, exclusivity, monopoly on skills and domination of consumers;” at the same time, it is acknowledged that professionalism can also imply “commitment to high quality service…high ethical standards, …concern for accountability and the development of useful knowledge and skills” (Jones & May, 1992, pp.289-290). Professionalism, according to Jones and May, can also be used strategically in organisations, for the ultimate benefit of service users. In this sense, professionalism can mean the use of power in the service of consumers: using discretion to define needs in a consumer-centred way, and to contribute to policy development aimed at distributing resources equitably. They suggest that workers may need to “de-emphasise (or re-interpret) their professionalism in their relations with consumers, while using strategically whatever professional status they have…in relations with most other organisational participants” (p.291). In some senses this could be described as a critical postmodern approach to professionalism, enacted consciously and contextually, and underpinned by emancipatory and anti-oppressive principles.

One program staff member made the observation that when speaking to staff from government departments (clinicians, policy-makers) he utilised a particular professional discourse and language in keeping with bureaucratic medical-model constructions of service: “I talk much more about social skills development; I talk much more about the ability to live more independently; I talk much more about remissions from hospitalizations. I use more behavioural indicators in my speech when I’m talking about or to policy makers and funding bodies... A lot of my thoughts [about what is really therapeutic for people] have to remain quite private. Whenever I deal with funding bodies or talk about what we do, you have to speak a certain language... quality control... all these notions, where even we as staff members are seen as objects as well...” (EG 2/4-5). Meanwhile, his work on the ground was
conceptualised much more in terms of complex interactions, working with uncertainty and individual and group dynamics. In this sense, the skill of knowing which discourse is beneficial in a given context and the capacity to work from a range of discursive positions is an element of professionalism in critical practice.

According to Kenny, there are two main uses of the term ‘professional’ – one to describe and embody “a commitment to a profession or an occupational grouping,” the other referring to a particular set of skills, attitudes and knowledge that informs one’s work (1994, p.112. While these commitments, in relation to social workers as professionals, are potentially emancipatory in intention and action, like other taken for granted assumptions they can be deconstructed in relation to local contexts and experiences. The former – a sense of loyalty and commitment to the profession or to the organisation - can, it seems, sometimes be experienced as undermining to service users. One former resident recalled her experience this way: “... a lot of the time I got the feeling that you weren’t working for us at all, you were working for the [name of] organisation. And that included spending a bit of time with us... I wonder if it would be better if the staff didn’t belong to this organisation, which comes before us, on all grounds. It comes before us. ... [For example] if someone else could be [making phone calls in the office] and making appointments and you just rolled up, and that’s what you did for the day... and you didn’t go off into the office and shut the door and say ‘we’re having a meeting now, and you can’t come in’...” (NA 1/8). Perhaps the question that this raises is something like: How is our professional or organisational accountability communicated to and experienced by service users? Are the complexities of accountability we are involved in, and which guide our actions, clear to ourselves or discussed openly with others who may be affected by them?

Accountability within the profession is also characterised by the gatekeeping role that is part of professionalism. Kenny refers to the powerful position occupied by professionals in gaining category entitlements through their qualifications. This function can be critically analysed to reveal both oppressive and empowering potentialities: the task then becomes one of problematising the conduct warranted by this gatekeeping process, and the degree and type of trespass that results. Rather than assuming a grand narrative around the role of gatekeeping as inherently ‘good’ or ‘bad’, a critical postmodern approach acknowledges the contextual nature of this role in specific settings at specific historical moments. Gatekeeping the doors to the helping professions can be used to prevent those who have not achieved professional
status through respected academic processes from setting themselves up exploitatively as those ‘who know’ something, but it can also lead to the discrediting of knowledge or experience outside prescribed discursive boundaries. As Ross and Pam (1995, p.235) point out, professions are defined partly by their “ability to capture markets” and to limit the participation of others: as Smart puts it, to “put a fence” around knowledge (1994, p.2). Critical reflection would enable practitioners to unravel their assumptions around this fencing-off of knowledge in specific instances of practices, and analyse its consequences, thus allowing alternative constructions and practices. It may be, for example, that spiritual healers (with no formally recognised qualifications), cultural elders, teachers of meditation or a range of other ‘helpers’ have equal or greater potential to support recovery from emotional or psychiatric upheaval as those with formal qualifications.

If, in the Foucauldian sense, knowledge itself is power: being the holder of ‘legitimate’ knowledge is a powerful position. Monopolising knowledge and skills, and hence maintaining the position of powerful knower may actually be experienced as disempowering by service users, and, as Ife (1995) suggests, may serve to reproduce relationships in which structural inequality is reinforced. Knowledge sharing, on the other hand, can potentially be an antidote to the negative effects of expert status and power (Hugman, 1998; Leonard, 1997; Rossiter, 1996). Knowledge sharing can occur in a variety of ways, both subtle and overt. One former resident commented: “…the idea that we have to be protected from [what a theorist has suggested about therapeutic interventions] because it might not work – that this therapeutic approach might not work – like ‘I have to protect them [residents] from this information somehow... is quite ridiculous...” (NNA 2/6). The suggestion here seems to be that workers at times seemed to withhold theoretical knowledge that might actually have been useful to share more openly with clients. It is a strange dilemma, but one that I have experienced as a worker, when I have read an excellent article on, for example recovery, but then have been unsure whether to share it with service users/clients. What is the source of this uncertainty? Is it because I think somehow it might not be relevant to the clients I’m working with, or that it will potentially harm them in some way that I will then feel responsible for? A less benign motivation would be that I wanted to keep the ideas for myself, as the professional, thus maintaining a professional separateness between me and service users, rather than engaging with potentially useful ideas as two human beings exploring
possibilities together. I remember a consumer/client once saying to me, when she saw a flyer about an upcoming conference on my desk, ‘why do you guys get to go to all these things, when we’d really benefit from them?’

Another aspect of professionalism that has been critiqued by consumers and critical practitioners has been the potential for the professional mantle to create a situation whereby the professional label allows one, as Johnstone puts it, “to avoid honest discourse or hide behind emotionally” (1998, p.13). Podvoll also describes certain professional positions in Western cultures (he refers specifically to therapists) as occupied by someone who does not “have to reveal how he or she walks, eats, handles money, celebrates, does physical labor, relates to friends… and so on” (1990, p.265): thus the professional retains the power not to be known - a power that is perhaps vital at times, but nonetheless worthy of deconstruction, although it certainly raises important issues about what are ‘healthy’ and necessary boundaries.

One program participant described her experience this way: “…in some cases, with professionalism, the roles [of staff] were so defined, that it was just almost an excuse sometimes, I found, to not have to input personally into a situation…to say ‘well, it’s not me talking any more, it’s my role, it’s the definition of my role, and it’s really important you understand that.’ [pause] I think that 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.” This extreme, she went on to say felt quite condescending at times and tended to invalidate the content of service users’ views: “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.” She went on to talk about how, after leaving the program and studying at university, she 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… and yet all this time, through the mental health system, I’ve been able to believe that [her ideas and opinions were inferior to staff, as the professionals]. And I just thought, ‘thank you, whoever wrote this – thank you!’ Because that’s how I felt so often, and to actually find someone else that said it, was good… Consumers need to feel that they’re a part … of a movement out there… people gain a lot of power from that… What use are the articles in the library, if as a consumer none of it filters down to you?” (NNA 4).
As mentioned in the previous chapter, the emphasis of professionalism on closure and expert knowledge, Rossiter (1996) suggests, can actually make clients into the “problem” and in so doing, destroy the potential for creating knowledge together while workers retain the power to be the knowers (see also Ife, 2000.) Truly being professional, she proposes, may mean becoming more aware of our ignorance: doubt and uncertainty, she suggests, can be resources rather than signs of a lack of professionalism or competence (see also Moffatt 1996). This re-framing of professionalism seems emancipatory for all concerned and allows a range of potentialities to exist.

One experienced staff person in the program described this blend of professional expertise and uncertainty very articulately: “I’m not sure if that is what the work really is with clients...then we [staff] become experts who have knowledge of a way to live...a way of being... whereas my hope is that someone can get into contact with what they want, to allow new possibilities...My approach is to try to encourage a much more radical subjectivity with the clients – to help them re-engage with themselves more fully. As subjects, not as objects of study or objects of my knowledge or objects of the state... We work hard against providing an expert model here...so, even though in some ways we act as if we’re the subjects who are supposed to know...for example, why something has happened – we are only the subjects who are supposed to know, we’re actually not the ones who know. I would like to think that the place we occupy is one which allows the possibility of some doubt around knowledge, and hopefully then, a space for someone to come into their own experience, and their history, and hopefully their own future... and I don’t know what that place is...” (EG)

Duncan et al. (1998) humbly describe how they (a group of therapists) stepped away from some of the restrictive aspects of their professional identity and learned an extremely valuable lesson: that of honouring their clients’ theories of change. “Our clients rubbed our noses in our blind obedience to theory, technique and our presumed one-up status as therapeutic experts” they said. “Dethroning” themselves, Duncan says, didn’t mean “abandoning what I had learned…but instead of intervening...listening for change...discovering and respecting their frames of reference” (p.13). They discovered that “what clients brought into the room” – their personal qualities, persistence, support, beliefs, life events – along with the creation of a supportive worker-client relationship, had as much to do with positive outcomes as anything else” (p.7). Ife (1997), Fook (1996) and others consistently emphasise that
theory, for social workers, emerges from practice, that the client has an equal role in formulating theory as the worker, and “any idea of theory being accessible to the social worker but inaccessible to the client is unacceptable” (Ife, 1997, p.41). This appears to be a way of sharing the power to create knowledge that acknowledges and values both the expertise of the practitioner and the wisdom of the client.

On a macro/structural level, Hugman (1998) draws attention to how dominant discourses of the day define what is legitimate knowledge (often because of its efficiency in meeting goals which have also been defined by dominant discourse, presented as common sense or truth). Professionalism, he says, is one of the “defining features of modern society…[resting] on the principle (Weberian) of closure…i.e. staking out a claim to an area of knowledge and skills” which excludes the “laity” as knowledge producers (p.113). He does not deny that the knowledge and skills of a professional may be valuable, even crucial, but suggests that the “boundaries set around forms of knowledge and skill are arbitrary” and can be used oppressively to control not only the profession “but the lives of those who require the services” (p.114). In order to be genuinely critical and professional, he concludes, we do not abandon our skills and theory stories, “but seek ways to make these more openly available to service users” (p.192). By doing so, he suggests, workers can reject modernist assumptions of professional closure and replace them with what might be described as a postmodern critical approach to human services which values the knowledge and experience of diverse speaking subjects.

As professionals, workers are invested with the power to enact environments (Curt, 1994) that make sense to them. In doing this, they must make sense of uncertain situations that initially make no sense: “when we set the problem, we select what we will treat as the ‘things’ of the situation, we set the boundaries of our attention to it, and we impose upon it a coherence which allows us to say what is wrong and in what directions the situation needs to be changed…” (Weick, 1995, p.9). Indeed, “control over which cues will serve as a point of reference is an important source of power” (Weick, 1999, p.50) that may serve to oppress or to enable. Deegan has written movingly and eloquently about what she refers to as “spirit breaking” – the disempowerment of service users at the other end of the misuse of professional power (1990, p.301). She suggests that professionals, in assuming the power which is granted to them, run the risk that their “minds can become severed from [their] hearts such that [their] human hearts no longer guide, inform and shape
[their] work with people” (p.302). Worker power, she says, can actually serve to erode values and ideals, and oppress and hurt those who come for help. Relationships between professionals and clients are empowering, she says when both are available to “be moved by the thoughts, perceptions and feelings of the other” – this, she says, is about having power-with, rather than power-over, where both can experience themselves “as being heard and responded to as well as being moved and moving the other” (p.309).

**A critical and postmodern approach to professional power?**

Given that there are many ways to conceptualise (and enact) power and professionalism, how might workers know what is emancipatory (or therapeutic) and what is oppressive (or non-therapeutic)? The capacity for critical reflection is something that social workers and all helpers are potentially able to bring to their practice, as a form of dynamic and ongoing interrogation or problematisation. Critical reflection on practice, as developed by Fook (1996) encourages workers to critically locate themselves in situations they are involved in, and to courageously analyse how their assumptions, values and theories contribute to the construction of worker, client and (inter)action. This deconstruction allows for reconstructed practices, potentially opening up new possibilities in specific sites and interactions. A willingness to locate oneself in practice requires humility and resiliency on the part of the practitioner – to identify and unravel biases, and to problematise power relations – a process which can be liberating and empowering for the worker as well as the service user. Resistance to critical analysis as workers can result from framing interrogation of practice as personally or professionally threatening or somehow leading to the diminution of status, sense of competence or professional power. Critical reflection can also be criticised as a way of ‘pretending’ to challenge one’s own practice, while remaining unwilling to do so; this, however, does not reflect the intention of critical reflection any more than ‘pretending’ to engage in dialogical practice reflects the intention of critical practice. Critical reflection can create an emancipatory experience in which workers are freed to be creative, think laterally and continue to develop and re-think their professional identity, role, knowledge base and skills. Modernist quests for universalisable certainties can be replaced by a more critical postmodern approach in which uncertainty can be experienced as productive, enlightening and empowering.
Along this line, Moffatt (1996) suggests that moments of confusion need not be debilitating for workers - signalling weakness or incompetence - but may, if consciously attended to, provide an opportunity to resist submersion in generic ‘master narratives’ or unarticulated eclecticism. Postmodernism, according to Rossiter (1996, pp.142-143), has forced social work to question “by whom, and for whom social work knowledge constructs the world.” She shares the words of Hans-Georg Gadamer (1992) which she finds a heartening reminder that an experienced person may be someone who is “radically undogmatic…who, because of the many experiences he [sic] has had and the knowledge he has drawn from them, is particularly well equipped to have new experiences and to learn from them” (1996, p.149). This approach to professionalism sits well with a critical and reflective approach to social work practice. Polkinghorne (1992, p.151) proposes that a “positive postmodern transformation of [a] modernist discipline” – in his case, psychology – is “its pragmatic usefulness in accomplishing a task.” The postmodern science described by Polkinghorne does not seek generalisable truths or a ‘true’ reflection of reality, but actually “wallows” in chaos and change, fragmentation and diversity (1992, p.148). Polkinghorne’s vision might be extended further by problematising who gets to decide what the task is, and indeed, what successful results actually are (and according to whom).

While openness to uncertainty and wallowing in chaos and change are appealing and potentially liberating in some senses, it must be acknowledged that professionals are also responsible for demonstrating that they have some expertise – they are accountable in terms of coming up with the goods: services don’t get funded if they are not seen to be delivering some form of worthwhile service. Taxpayers’ money is being spent and welfare resources are limited: needs are many and governments/funding bodies must be seen to be effective. As Robbins reminds us, and as indicated in the staff member’s quote on a previous page of this chapter, professionals are in a position where they are expected to take responsibility for the content of services, to make judgments about what constitutes good practice (1993, p.102). Professional helpers have taken this role on board, and are structurally positioned and expected to define what is needed, how best to achieve it and deliver the goods, thus social workers need to mindfully operate in and be responsive to situations and interactions in which certainty and uncertainty, ordering and chaos are engaged with contextually and critically.
Chapter 4  Problematising worker power and professionalism

The most important stakeholders – service users – have been increasingly involved (arguably at times in a tokenistic fashion) in defining what services should be like, although their power, in comparison to professionals, is still minimal. Recent research, educational and policy development is increasingly based on the conclusion that the lived experiences of service users must drive and inform service delivery. A good example of this is found in the report produced as part of the National Mental Health Strategy Evaluation, entitled Learning Together: Education Training and Partnerships in Mental Health (1999). The project was based on the findings of a conference combining input from five professional disciplines involved in mental health service delivery (psychiatrists, psychologists, social workers, occupational therapists and psychiatric nurses), and, importantly, consumers and carers. The aim was to review current approaches to professional training for mental health service delivery. In the foreword to the report, Dr Harvey Whiteford, Commonwealth Director of Mental Health, states that the new service delivery environment demands an acceptance that “people with these illnesses themselves have ‘expert knowledge’…[and that] fostering a culture which values the opinions of consumers and carers must be the overarching goal of continued reform” (1999, p.i). For the social workers involved in the conference, a timely reminder emerged that the most important task they might undertake as professionals is “assisting to interpret the social world” of consumers to other professions and to “value and assist consumers and carers to validate and strengthen their ‘lived’ reality outside the mental health service system” (p.60).

It is interesting that the two guiding principles for future education and training in mental health agreed upon by the Conference participants were: 1) for mental health practitioners to value and learn about the lived experience of consumers and carers, and 2) that professionals “should recognise and value the healing potential in the relationships between consumers and service providers…” (1999, p.1). It is remarkable to note that the ‘dated’ and ‘non-scientific’ words of the 1970s and 1980s – from writers like Sanford, Welwood, Podvoll, etc - are now being asserted in the public domain, under the auspices of the National Mental Health Strategy, as guiding principles for mental health policy. The vanguards of social movements, in this case the anti-psychiatry or recovery movement, while considered radical fringe dwellers at the time, are often in retrospect (re)discovered for their progressive insights. Social workers, radical or otherwise, need to consider whose knowledge they consider valid
and be willing to genuinely engage in unravelling both the impact of these assumptions and their source, as well as how they fit with critical practice.

Modernist notions of professionalism, within which social work has been embedded, have often implied a sense of ‘having the answers,’ which may be inimical to the basic social work tenet that clients have their own answers, the emergence of which can be facilitated by skillful and sensitive workers. Indeed, social work is full of contradictions, many of which are manifested around notions of professionalism: inherent contradictions that Hugman describes as creating a position “between autonomy and responsiveness, between exclusivity and openness, and between status and service” (1998, p.189). On one hand, workers are trained and expected to ‘know what’s best’, and on the other we are committed to ‘entering the client’s world and starting where the client is’ (Wood, 1997). Indeed, clients may have pressing and immediate unmet needs which need to be addressed, as quickly as possible. Here again it is through critical reflection on practice within specific settings, at specific moments, that a worker may able to determine when and how to use particular forms of power or authority (for example, a crisis situation may demand decisive intervention). Grand narratives around worker power and authority may be less useful than a more nuanced and reflective approach that, while consistently underpinned by a critical framework, is open to interrogation and dynamic (re)construction, particularly in light of the complex and dynamic nature of human experience that social work is involved in.

Social work, according to Moren, is always “carried out within the realm bridging man’s [sic] individual and societal existence, [in which] the task of the worker is to control the borderland spanning adjustment and transformation” (1994, p. 291). Helping activity, he suggests, needs to be conceptualised and organised in such a way that the worker is able to discriminate between “essentially different kinds of achievement: adjustment/compensation or transformation…these parallel and intertwined aspects of the task [need to be] recurrently recognised and made visible” (p.291). Having said this, a critical and contextual postmodern deconstruction could reveal that both hold the potential for empowerment or disempowerment, and various uses of worker power and constructions of professionalism. Worker-as-expert (or work carried out within rigid outcome/output related guidelines) might set the terms for both adjustment and at least superficial transformation in a way that is oppressive. Similarly, a worker may use a different form of professional expertise (such as that
described by Rossiter) in which their use of power and authority is designed to create conditions in which clients can define their own goals of adjustment and experience transformation at a deeper level.

It was very interesting that, unprompted, several program staff members commented on this dual function of their work which at times created a sense of conflict. One staff member described these roles as follows: “One, the managerial one – managing the boundaries, at the border of the program, the structure – making sure that the program functions and also managing the boundary between our authority and residents’ participation and decision making... The other function, and I think this is often where the role conflict occurs for the staff, and also with the residents, is the one of the therapeutic role... I don’t think that the two are divorced, because the managerial functioning... has its therapeutic effects. But when you’re actually using authority, as you do sometimes... when, for example someone’s not attending the group or is starting to withdraw from involvement in the program... What can happen though... is that it can prohibit the client speaking; it can actually prohibit a space to talk, because your action in the role of using authority [makes it difficult] to continue to offer a space where something of significance to the client’s subjective experience is able to be talked about...” (EG 2/2). Another staff member put the same concept somewhat differently, by referring to the role of staff in “...maintaining the program... maintaining the spaces in the program, running the program, keeping the program balanced... And its also... about keeping people on track to move through being here... and to work through issues with people” (AC 1).

Both these roles: management and support/therapy obviously position the worker as ‘different’ to the service user. However, here, as Healy proposes, it may be useful to ask, “Are differences between workers and service users necessarily experienced as disempowering?” (2000, p.6). She interrogates the critical/radical assumption that differences in knowledge and skills between professionals and service users need be conceptualised as inequities. A critical postmodern perspective would suggest that what we need to ask is: how do particular clients, at particular times in their lives, in specific settings, with specific workers, in specific program/agency cultures, experience worker power and the perceived and real difference between workers and themselves? Baistow (1995) has suggested that in order to find out whether our interactions are indeed empowering for people we need to ask them, and add this vital perspective to our sensemaking process.
As we de-stabilise taken for granted assumptions around worker power, it is interesting to consider who – worker or client - might actually feel – or ‘need’ to feel - a greater sense of ‘difference’ from each other, and what effects, intentional or otherwise, this has. Pinches and Robertson (1998, pp.19-20) conceptualise workers and service users as being on a shared journey, in which the worker’s self knowledge and life experience may be more important than theoretical knowledge. Workers, they say, need to be aware that consumer’s experiences, like their own, are about “common, normal and difficult passages in life” which have (perhaps temporarily) swamped the service user. This awareness, they say, leads to a “leveling” between workers and clients, rather than a rigid us/them regime that, from a consumer perspective, “withers our spirits and tends to gravitate against recovery.” From this standpoint, the power of professionals to be fixed absolutely as the ‘well ones’ may be experienced by a client as oppressive.

Parker, Fook and Pease, in reconceptualising empowerment from a postmodern perspective, discuss “the difference dilemma,” which rests on the question: “how is it possible to identify and provide services to a group without, at the same time, labeling and stigmatising that group?” (1999, p.151). This dilemma, they say, using a Foucauldian analysis, is linked to the normalising power in society, which is “about separating people from each other, labeling some as deviants” (p.152). Epstein (1997) also suggests that workers in mental health – indeed all humans – consciously or unconsciously sustain stigmatising behaviours to create and maintain a sense of order and social identity; in order to feel better about ourselves we stigmatise others. Moore (1996, p.164) refers to stigma as a “weapon” used to silence and segregate people. Indeed one staff member spoke about society’s need to ostracise some group, whether it be Aboriginal people, or people with a psychiatric diagnosis.

The antidote suggested by Parker, Fook and Pease, to this dilemma of difference (1999, referring to Minow. 1985), is, rather than avoid the dilemma, we need to “re-immersce ourselves in it,” to understand it better. The aim of this re-immersion, this conscious engagement, is not a solution, “but a more productive struggle” (p.152). This resonates with Coles’ words that the whole point of theorising experience is not solutions or resolutions but a “broadening and even heightening of our struggles…with a new source of concern, or apprehension, or hope…” (1989, p.129). Again, this embracing of uncertainty may, at times, appear or feel un-professional and intolerably uncomfortable. It is also worth noting, as thoughtfully
described in the quote earlier in this chapter from an experienced worker, that wider modernist (scientific, managerial, economic rationalist) discourses around objectivity, certainty and professionalism do not support workers to embrace or even accept uncertainty, ambiguity and contradiction.

Parker et al. (1999) go on to suggest that we need to relocate difference “in the relationship rather than in the person or group called different” (p.152). This is quite a profound, and conceptually difficult, notion. No wonder it is unpopular or evaded – who wants another struggle when what we really want, perhaps what our clients really want, are solutions. The uncertainty and messiness of non-hierarchical theory-stories from a range of situated subjectivities are not valued in a modernist world, where control, prediction and a particular form of efficiency are guiding beacons. A postmodern perspective calls upon us to rethink difference in a way that does not turn difference onto the other – but where difference is consciously explored for the mutual empowerment and education of both individuals. Somewhat paradoxically, Wadsworth and Epstein conclude, “ironically trust and good feelings will only develop if both parties to the encounter remain conscious of their real differences;’ thus staff retain an awareness of both their power and their humanness, and consumers retain an awareness of themselves as able and respect worthy (1996, p.188).

A group that is actively grappling with this relocation of difference is the Power to our Journeys group, based in Adelaide at the Dulwich Centre: this is a community mental health project aimed at consciously exploring relations of power, both in clients’ lives generally, and in the worker-client relationship. They openly acknowledge the potential for their own work to reproduce potentially destructive relationships, which clients may have experienced previously; they have been brave enough to locate themselves, as workers, within the field of client’s ‘problems’. Workers in the project try not to minimise or render invisible the power aspect in worker-client relationships, which may serve to “exempt workers from responsibility” (1997, p.15). Rather, they attempt to emphasise how relations of power have impacted on the construction of client’s self-stories. They try to enable clients (called “project team members”) to “separate themselves from negative ways of understanding themselves and their life” (p.14). By denying power relations, they say, workers risk perpetuating practices of domination and/or abuse, and reproducing relationships, which have not proven helpful in the past.
Writing from a considerably different position – as professor of psychology at the University of New York - Paul Wachtel echoes a similar observation. He refers to the task of helping patients/clients as “in some ways, a terrifying one…to work with people who have a history of thwarting themselves and to think that we can reverse this trend. Inevitably at least part of the work involves our getting caught up in that pattern. There is a kind of quicksand involved here and therapy is the art of *extricating oneself from quicksand; that’s not the easiest thing to do*” (in Dryden 1997, p.151). One worker put forward a similar view as well: “…*one of the complexities in the work is in trying to understand what is the core issue that this person is dealing with, and how can we make sure we don’t get trapped into repeating that pattern for the person… so that might allow them to see what’s theirs… rather than [the worker] reacting to this person, to give them space to see what’s theirs*” (EG 79). This may also be theorised as an example of relocating difference – and the essence of supportive or therapeutic work – in the relationship. Russell (1995) proposes that the primary question to ask as workers or clients is “which relations promote human flourishing?” (p.162). This question is far-reaching in its implications, and it may not be possible to construct a grand narrative to provide answers. While various disciplines may have different approaches to the ideal type of relationship established between worker and client, postmodern thinking suggests that consideration needs to be given to the contextual and dynamic nature of any relationship. The creation of, and engagement with, relations that promote human flourishing may have some ‘bottom-lines’ (such as honesty, transparency, putting the client’s needs first, respect, etc.), however, beyond that, there are many possibilities. White suggests a number of ways in which professional knowledge can be shared with clients, to consciously and deliberately undermine “the mystification of therapeutic knowledge… and to challenge the therapists’ privileged position …” (1995, p.51). He suggests this might take the form of sharing literature, collaborating on the taking of client notes, sharing insights and observations and coming to some consensus about what represents the ‘truth’ of the situation or interaction. The sharing and de-mystification of professional knowledge has been a key tenet of ‘radical’, community development, critical or anti-oppressive social work practice for some years. This is encapsulated very evocatively by a staff member who said, “*One [staff] can never assume that you know… the danger is to assume too quickly, to give answers too soon. And so here what we offer is a time to allow things to unfold… to*
This view echoes those of Leibrich and Smart: that ‘no one else is an expert on me.’ The term ‘professional knowledge’ is itself worthy of critical analysis: does it imply that certain knowledge or ideas is the property of professionals alone, that others may not understand enough of the knowledge base to make good (at the least, not harmful) use of it, or that the professional occupies a privileged role/space in which they have been able to glean this knowledge? Certainly in relation to the medical profession, reading a chapter or an article on the removal of gallstones, for example, wouldn’t qualify one to perform surgery. But, in relation to literature that is read by social workers, it might be useful to ask, in specific contexts, how, why or if we choose to share professional knowledge with service users and what assumptions underpin our choices.

The relative privileging of professional knowledge over theory-stories from lived experience or non-professional accounts has been critiqued from a postmodern perspective. At the same time, from a critical postmodern perspective, Healy (2000) cautions that simply shifting the hierarchy of truth claims from professional-on-top-of-the-ladder to lived-experience-on-top, may simply recreate an unhelpful dualism that negates one form of knowledge in favour of the other, without acknowledging the different but perhaps equally valuable nature of diverse forms of knowledge in achieving a particular goal (i.e. empowerment). Epstein and Rechter (consumer members of the Learning Together Project) propose a non-hierarchical view of knowledge and need definition. Their image is of service users at the centre or pivotal point within the mental health system, in which the voices of users are privileged yet balanced with others. “If this is a hierarchy,” they say, “it is less a ladder with users on the highest rung (an image which is the inverse of the standard picture), than concentric circles with users (and perhaps in a different way, carers) at the centre. Nor is it an exclusive privilege. The metaphor of a lens allows for dialogue in the determination of meaning via the overlay of different lenses” (1999, p.21).

Winship (1995, 1996) observes that a power gain by one group is often conceptualised as a corresponding power loss for another. In this sense, the empowerment of clients would potentially mean the disempowerment of professionals in some way. Post theories guide us to reject this formulation, opening up possibilities for all parties to participate in mutually educative and empowering relationships; indeed critical social workers could be instrumental in creating service cultures of
mutual inquiry and learning. As Rossiter puts it, social workers and clients can learn together “how social formation is vulnerable” (1996, p.32), thus achieving mutual empowerment as well as developing compassion and wisdom – themselves a form of expertise.

Healy suggests that just as professional knowledge may be oppressive, it may also be empowering; indeed, for the activist social worker, their particular professional knowledge is vital in guiding their practice. Dualistic representations of professional knowledge and lived experience, she suggests, can negatively impact on the crucial ability of workers and clients to enter into dialogue, and can suppress the valuable contributions of both parties. Critical postmodern theory, she suggests, can highlight the value of “an ongoing scrutiny of the knowledge that both bring to the practices of change” (2000, p.132). This ongoing scrutiny can take the form of the worker’s own critical reflexivity (practice-reflection-change) as well as a willingness to engage in authentic dialogue.

The idea of a shared journey between workers and clients – albeit potentially different journeys– is worth exploring for critical social workers; is it possible to acknowledge the power and knowledge one has as a worker and also be willing to share in mutual learning? One former resident commented on the difficulty she experienced in challenging staff members’ views or interpretations, saying that “…people did try to do it (challenge staff) …” but it was very antagonistic so the staff member would react by protecting their self from thinking they had done anything questionable… “by taking the workers’ stance – ‘well, you’re angry, ’that type of thing...” (AS). As a staff person, the capacity to ‘handle’ being challenged can be a difficult skill to achieve; however, if one’s work is based on a genuine acceptance of mutual learning, this may become easier. As helpers, it may be important to ask, whom do we allow ourselves to learn from? The same resident went on to comment that staff seemed, at times, ‘threatened’ by her capacity to provide support for fellow residents and her insights into shared experiences. Another resident, who had been in the program for an extended period of time, commented sympathetically that it was very “difficult for the staff to be helpful because they haven’t had the experience of mental illness themselves” (TI 4).

Given this, one staff member commented specifically on the mutual learning he observed taking place within the program: “...what happens is that the environment becomes one of learning, and the staff are included in that...
a set knowledge, but one that is continuously involved with changing circumstances, that the whole program can learn from the experience... From my perspective, because my philosophy is so much around unconscious life, you can never assume mastery over your work...” (EG 1/8).

In troubling this aspect of human service work, narrow or unquestioned views of ‘professionalism’ can be problematised as to how they might actually get in the way of the work we attempt to do. How can our human-ness combine with a type of professionalism that is non-oppressive and empowering? Perhaps to dichotomise human-ness and professionalism is another modernist hangover; by constructing the two as incompatible, rather than open to a range of dynamic constructions, we might be relegating practice to the worst of both ways of being. John Watkins, after many years of experience and reflection as a mental health practitioner, says that “…what we are as a person, and the quality of our human presence with our clients may be a more powerful healing influence than we know…simple human companionship may indeed be the most potent healing factor of all…” (1996, p.41). Along this line of the most poignant quotes from my interviews came from a former resident, who said, “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” (NNA FR13).

Epstein and Shaw (1997, cited in Johnstone, 1998, p.12) observe, “…staff behaviour which sometimes borders on the unprofessional is experienced as good care by many consumers.” (What this means is potentially quite complex given the potential disjuncture between what people ‘want’ and what they might actually ‘need’ or benefit from at a given time: this is a shared human experience, certainly not restricted to those in the client role.) Watkins (1996) suggests that sometimes the easiest road for workers to take is that of ‘expert’: “being with our clients…[can] easily be sacrificed to the expediency of ‘doing to’ them since the latter activity is usually easier to justify in terms of measurable short term change” (p.39). Insight into what it feels like to feel powerless, Epstein and Shaw (1997) suggest, is just as important for staff to possess as any psychiatric knowledge. Perhaps this insight can then direct workers, as Leibrich (1998) suggests from her experience, to adopt as the
central task of a helper, that of assisting the client to find the healer within themselves.

Moorhead (1994) also talks about how much easier and quicker it can be to “give care” rather than actually “inviting someone into participation in their own rehabilitation,” particularly when that person might be feeling hopeless, unmotivated or having difficulty engaging in relationships. She observes how easy it can be for a worker to question whether it’s worth it to “pick up the racquet” when the person at the other end of the court refuses to pick up theirs (p.305). Sometimes the expert-driven ‘doing-to’ model (which fits with some modernist notions of professionalism) is the easiest one for workers to embrace, and also one which allows us to distance ourselves from the pain and hopelessness which the client may be experiencing. Giving care, rather than the more difficult work of engaging people to become agents in their recovery, Moorhead says, may be like “waiting for the bread to bake while not turning on the oven…” (p.306).

I remember wondering sometimes, as a worker, if the moments when I was ‘my best’ as a worker where the moments when I was the most human, the most connected…Sometimes these experiences felt quite ‘unprofessional’, and I was unsure what to make of the feeling I had that these were some of the most truly ‘helpful’ moments I could offer to others. Nothing in my training suggested that they were. Had I been more reflective, and less worried, I might have benefited from reflecting on how exactly these feelings impacted on my work, and what I actually meant by ‘helpful’ and ‘unprofessional.’ Tooth’s finding (1997) that over half of the participants in her study referred to the negative impact of intervention by health professionals suggests that ‘simply being human’ might, at times, be worth a try.

As a result of personal and professional experience, Smart says that she tries to work with clients in a way that values their uniqueness; where she has become “less and less an expert and more and more a learner,” having “moved from owning knowledge to owning my own knowledge” (1994, p.9). This, I believe is an important, profound, and liberating distinction for critical workers to engage with.

What is problematic, according to Camilleri, is not so much the existence of professionals, but the “zero-sum game of professional power” (1996, p.174). Following are several quotes from, firstly, a staff member, secondly, a former resident, and lastly, a then-current resident, which attest to the complexities of teasing out concepts like equality, shared human-ness and professionalism:
“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” (ID).

Commenting that she feels “more sick around certain staff” which conflicts with her personal values around equality... “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” (AS).

Speaking about the frustration experienced when, after leaving the program after nearly two years, contact with staff felt cut off, and when a former resident tried to connect with their key worker of several years: the staff member was “seriously contemplating whether to ring someone back or not... but then natural relationships weren’t something [the program] was about...” (NA)

In her deconstruction of the representation of worker power as “anathema to the dialogic and egalitarian practice preferred by critical workers,” Healy (2000, p.71) suggests that worker power need not be oppressive. Critical postmodern thinking suggests that the effects of power need to be located and analysed contextually (Healy, 2000, p.75). Rather than attempting, always, to minimise worker power, it may be that increasing the transparency of decision-making power and collaboration, in full acknowledgment of worker responsibility and authority, is a more realistic and ultimately more helpful approach. Worker power is thus conceptualised as potentially productive and empowering. Advocating the total removal of worker power, Healy suggests, does not acknowledge that the use of power may actually be demanded in order to practice critically. She lists such practices as initiating projects and processes, encouraging participant involvement, facilitating meetings, promoting critical attitudes, imparting technical information and skills are all powerful actions which “dramatically shape what workers and service users do and even think in the practice context” (p.77). Thus worker power can be instrumental in revealing (as well as suppressing) voices of service users, in subtly working towards the “achievement of such things as group cohesion, collective focus and, even, the participants’ ownership of the …change process” (p.82).

Indeed, all these uses of power and authority, and more, can be seen at work in the program, and are often discussed by participants as beneficial. Healy (2000) concludes that “once egalitarian practice relations are recognised as an accomplishment of power rather than as arising from the absence of it, we are
compelled to address ourselves to the productive exercise of worker power within activist practices" (p.87). Worker knowledge, rather than inhibiting the expression/insight of lived experience can be a resource used by clients to assist them in finding and expressing their voice. As Healy proposes, workers can engage in critical reflection to “differentiate between those forms of power that are productive for extending empowerment to participants and those forms that are used to further domination” (p.111). By looking at what goes on at the local level of practice, useful insights into the nature of worker power at a particular time and in a given setting can be generated as humans – whether clients or workers in that particular site – engage in dynamic relationships and interactions that are always to some degree uncertain and evolving. In the next chapter I continue to look at the construction of worker-client relationships and interactions generally and in the context of the program.
In this chapter I explore further various constructions of worker practice and professionalism, in particular worker-client boundaries, worker vulnerability and worker authority, as theoretical concepts and, more specifically, as they are enacted and experienced in the specific practice setting. As with previous chapters, this is done via theory-stories from the literature as well as participants’ narratives and my own interweaving of the two. One of the values of postmodern thinking and critical reflection for social work is that taken for granted assumptions about what is professional, helpful or empowering are opened up to deconstruction and reconstruction in relation to context. Professional authority, worker vulnerability and the construction of worker-client boundaries, particularly in community-based services, is thus recognised as contextual, responsive and open to productive critical reflection that sometimes challenges grand narratives or regimes of truth. This does not mean rejection of any particular form of worker-client relationship, whether egalitarian or more tightly professionally boundaried, but rather an acknowledgment of the need to critically reflect upon the impact of powerful and consequential constructions, and openness to reconstructing critical practice in light of these problematisations.

**Distance, friendship and vulnerability**

Beginning with the Charity Organisation Society in the late 1800s, social workers have often positioned themselves as role models and diagnosticians, clearly delineated from service recipients who were positioned as needy and/or deficient others. Historically, the Settlement Movement moved into a different realm of worker-client relationship, based on an underlying principle of universal brotherhood, positioning young well-intentioned workers literally amongst the community of need (Martin, 2003, pp.17-18). With the advent of psychodynamic approaches that infiltrated the social work scene with the introduction of Freud’s ideas, a new slant on the worker-client relationship appeared – that of the therapeutic relationship - in which a certain amount of professional distance was required for effective treatment to take place. Social movements of the 1960s, in particular the women’s movement,
brought challenges to psychodynamic and casework approaches to practice, proposing a radical sharing of power. Community development workers suggested that workers place their expertise at the disposal of communities, valuing local knowledge, skill sharing, empowerment, and egalitarian relationships between worker and community members (Kenny, 1994; Ife, 1995). Today’s social work students may be uncertain as to whether the anti-oppressive practice they learn in more progressive social work schools is achievable in the real world of practice. At the same time, postmodern thinking has led to a destabilisation of certainty and grand narrative in social work, posing a challenge to critical practitioners to confront and examine their beliefs and practices and acknowledge the dynamic and contextual nature of their work and gaps that may exist between espoused anti-oppressive theory and practice. The following sections explore some of the challenges involved in conceptualising, enacting and experiencing a worker-client relationship.

Emotional protection: fear of sameness?

Holloway (1993) suggests that despite a worker’s desire to create and sustain a partnership-like relationship with clients, the emotional challenge of working with people in times of crisis, vulnerability or ongoing disadvantage may actually make it difficult not to distance oneself. Workers realistically require defenses as difficult and perhaps confusing emotions arise in the course of their work, and in response to clients who are experiencing psychological distress. The anxiety and even fear evoked by those who are “designated mad” – whose unpredictable behaviour may break social norms and remind us of our own potential for “impulsive, destructive, self-debasing actions, for passivity and dependence, or for paranoid mistrust of others” - has been thoroughly and evocatively discussed by Almond (1974, pp.xxiv). Indeed Western institutions and mental health systems have traditionally responded to these unsettling “primal themes” by exerting control over the ‘deviant’s’ behaviour and segregating him/her.

Gagne also acknowledges how frightening it can be for workers, or anyone, “to just spend time with people who are in great pain” (1996, p.7), which requires workers to confront (or shield themselves from) the uncomfortable “potential for disintegration” that is a shared human experience (Banton et al., 1985, cited in Collins, 1989, p.151). “Mental illness,” says Epstein (1997, no page number), “is outrageously different as well as alarmingly familiar.” She acknowledges the sense of
uncertainty and ineffectiveness that may be experienced by workers attempting to assist in situations that evoke both identification and distancing.

Almond (1974) suggested that traditional “asylum staff” attitudes about control and management of patients conveyed to clients a belief that mental illness is not only incurable, but that they are abnormal and not to be trusted. While this may seem an outdated reference, it is notable that Rickwood, writing in 2004 – three decades later - states that these attitudes are often held by service providers today, particularly those in clinical settings, who still believe that “a diagnosis or mental illness is a life sentence to an incurable condition,” thereby perpetuating stigma and creating ongoing obstacles to mental health reform (2004, pp.2-3). Staff/practitioner attitudes are extremely powerful - as Almond says, when staff expectations of a patient/client are that they will be/are “passive, needy and out of control,” they may very well meet those expectations. Rather than distancing themselves from the “personal impact of disturbing behaviour,” Almond says, a healing community is one in which the behaviour of others is confronted (1974, pp.59-60), difficult as this may be for all concerned, including workers.

The difficulty experienced by workers in productively confronting disturbing behaviours, may, paradoxically be directly connected to their reasons for becoming involved in this sort of work. The service setting itself, as Obholzer and Roberts point out (1994, p.116), may resemble or reconnect workers with “early-life situations they are still unconsciously dealing with,” that may have drawn them (more or less consciously) to the work. Obholzer and Roberts suggest that the similarity between the worker’s own painful, unresolved personal experiences and those they experience at work may lead them to produce defences that “accentuate differences: ‘they’ (the clients) are the sick, mad or needy ones; ‘we’ (the staff) are the well, sane, strong, helping ones” (p.118). Even in community-based support programs, where psychiatric labelling is minimised, Mosher and Burti (1994) suggest that diagnostic categories continue to serve an important function, allowing workers to be more “certain, and hence more distant and comfortable, about who the helper and the helped are” (p.171).

When I was working in the program, I remember reading a short article written by one of the management team of the organisation that I never forgot. He said that his first impression in visiting the organisation’s programs was that one of the “great fears” of workers was “that there might be very little which separates them
from the experiences of the client. The clients,” he went on, “fear being sane and the
staff fear being mad. We each fear the other. What possibility, or wish,” he asks,
“does each group hold that the other desires but fears…” (Morgan, 1998, p.4).
Shainberg (1983) also takes up the theme of workers’/therapists’ fear of sameness
with clients, suggesting that the anxiety produced by this fear may block one’s ability
to really listen to clients, making it easier to ‘do to’ rather than ‘be with.’ It is possible
that these anxieties or fears partially underpin the professional distance we generate,
rather than any carefully thought-out theoretical orientation. In problematising our
practice it is important, then, to be willing to interrogate the degree to which our
professional boundaries are constructed from fear, and indeed to ask what we are
afraid of. My own fears, in retrospect, were around not being able to really help
someone, and how much to ‘be myself’ in the support relationship, as well as fears
around being able to handle harmful behaviours. Looking back on my experience, I
am also aware of how difficult it was to admit these fears to others, which might have
been one way of working through them.

Professional distance

Professional distance is often discussed as an important aspect of practice.
Curtis and Hodge (1994) describe professional distance as “the degree to which the
personal life of the staff person intersects with the life of the consumer,” the purpose
being to keep the needs of the client uppermost, and to help the worker “retain some
objectivity in the helping relationship” (p.24). However, as they go on to suggest,
while negative consequences of over-involvement are a serious reality, “consumers
report that greater damage may be done by rigid enforcement of the traditional
connexion of professional distance”; the self-help movement, they remind us, “shows
that the line between ‘staff’ and ‘consumer’ is mighty fine and that our shared
humanity provides us with more similarities than differences” (p.24). The difficulty,
perhaps, is in knowing what to do with this conceptual understanding: how can
workers productively use both their similarities and differences for the well-being of
the client?

Indeed, staff distancing has been mentioned often by consumers of psychiatric
services as being particularly disempowering. The Melbourne Consumer Consultant
Group, discussing the disempowering affects of stigma and othering, put it this way:
staff present themselves as not having “anything to be stigmatised about…[their
attitude is] you carry all the illness, and I will carry none” (1997, p.5). Wadsworth and
Epstein (1996, p.153) tell a story highlighting what they call the “self editing” or “unspeak” of staff, when at a nurses’ meeting a young nurse suggested that staff and consumers “really had a lot in common” and was met with deafening silence from her colleagues. A useful question, then, is whether it is a ‘good’ or ‘bad’ experience for clients to feel the staff are the ‘well ones,’ and whether this too is contextual, dynamic and ripe for critical reflection. Deegan (1988) comments that it is particularly unhelpful for staff to assume an attitude of assisting people in the ‘abnormal world’ to fit into the ‘normal world,’ creating an us/them dichotomy, where clients are expected to “do all the changing and growing” (1988, p.18). A recovery paradigm, according to Deegan implies that we are all wounded and in need of healing. The question then becomes, how would this understanding translate into practice? How would acknowledging our mutual woundedness construct relationships differently, and how would this impact on workers and clients?

One resident made the following comment along these lines, suggesting that staff need to empower clients to believe “that you’re 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” (DA 73). This could be theorised in terms of workers being willing to share the power of being the ‘well ones.’ Feelings of discomfort with this sharing of power and wellness could be usefully problematised by human service professionals, to unravel the assumptions and beliefs around difference that we hold as workers.

Almond (1974, p.349) suggests that while it is appropriate for staff to “have their dependency needs gratified elsewhere [other than their workplace],” it must also be acknowledged that the reverse is expected from services users, as they are invited (or required) to expose and share expressions of their need on a regular basis. While this may be entirely appropriate and create conditions for effective service delivery, it is hardly surprising that residents experience themselves as the only ones with dependency (and other) needs. In this construction, identities, authority and power relationships are fixed, possibly, at times, to the detriment of all concerned. Almond suggests that a more realistic outlook might be to acknowledge that staff also have
dependency (and other) needs, but that they do go elsewhere (at least overtly) to have them met. Of course one of those needs may be to ‘be helpful’ which they are enacting on a daily basis as workers, although this need would generally be constructed as healthy or altruistic.

Almond (1974) states “without reservation that staff members always bring some dependent feelings into their work situation” and have their dependency met, to some extent, by their position within an organisation. The one-way flow of nurturance that results, Almond goes on, “fixes a difference in role definition of staff and patient… one is well and caring, the other is sick and needy.” Such a polarised division, while perhaps attractive to both staff and residents, Almond argues, restricts the healing possibilities for the client/patient by limiting the possibilities for them to “identify with staff and experiment with role behaviours…” (p.350). Workers can critically analyse and challenge modernist urges to create fixed identities of wellness and need – not only ‘theoretically’ but in specific sites and incidents of practice.

Redfield Jamieson, describing her struggle to “stay sane and stay alive” (1996, p. 124) suggests that all people build internal walls to keep overwhelming emotions at bay – a process and an accomplishment which creates both sanctuary and isolation, whether one is a worker or a client. These walls, in order to be healthy, she says, must be permeable – they must be able to keep out “crippling pain and turmoil” but also able to let in healing forces. She writes unashamedly about the power of love in shutting out terror, while allowing in “life and beauty and vitality” (p.215). Leibrich, writing about her personal recovery journey to find “the healer within,” asks “what do I want people who work in the area of mental health to know more than anything else?” (1998, p.277). Her answer, she says, is profoundly simple: to know themselves. “Find the space within your heart…and rest there. Look around from that perspective. Then listen to the people you want to help…Put aside the rush to find answers and listen…Do not force solutions. Let them emerge…Finally, return to the space within your heart. Discover your ability to love and your ability to suffer. Through this you will find compassion. And the healer within yourself” (p.277). This may be quite challenging to conventional notions of professionalism.

While workers are no doubt able and eager to incorporate ‘respect’ into their working ethos, discussions around the value of ‘love’ are (perhaps rightly) conspicuously absent in professional discussions. As a worker, when I felt ‘love’ (or was it compassion? …and what’s the difference?) for someone I was working with, it
felt embarrassingly unprofessional. Perhaps there is no place for love in our professional roles, even if we knew what it was or what it meant. Buddhist philosophy seems to equate real love with compassion, rather than with attachment (the latter seemingly the more usual way of understanding or experiencing what we call love). Compassion is a strong desire for an other to be relieved of suffering, and to be helpful in that process. Attachment, on the other hand, has more to do with getting our own needs met via another person. In that sense, might love/compassion be an acceptable motivation for social workers? (It is probably important to note that the other quality which is needed, from a Buddhist perspective, is wisdom – to be coupled with compassion – as one without the other may lead to more suffering.) If we are willing to consider love in social work practice, perhaps a consideration of friendship is also acceptable.

Troubling the notion of friendship

Being a friend to one’s client is generally constructed as undesirable, potentially confusing to all concerned, and unprofessional. Indeed, this may be true. However, it is useful to deconstruct where our view on friendship with service users comes from and what its effects might be. Podvoll (1990, p.278) explored the “therapist-friend dilemma” and observed, in his program, that there were “many levels of meaning and maturity to the experience of friendship,” and that there was “much to be learned from an open dialogue about it.” Staff in his program observed that at times they wondered: “am I really being a therapist or a friend? …as if you needed to choose one of two different roles to play or identities to assume…” . This can be a memorable moment, he goes on, for both patients/clients and therapists/workers, because it “suddenly becomes the opportunity to peer down into the nature of their friendship, of what is essential and what is not” (p.278). The argument here is not that workers should conceptualise their role as that of a ‘friend,’ but that it is useful to engage in critical reflection on the nature of friendship as each individual constructs it, based on their own assumptions, experiences, and beliefs, as well as their theoretical orientation.

As a result of quite extensive conversations, Sullivan suggests that what consumers of community-based programs valued most highly was not the techniques of workers or even the specific programs they offered, but the “strength of relationships and the caring atmosphere and protection these programs and persons offered” (1997, p.186). He reported that consumers valued the professional helpers in
their lives for their friendship, companionship and encouragement, and making them feel welcome in the program setting. Indeed, quite a common experience for individuals in the psychiatric service system, and certainly those in the program, was that the psychological upheaval or mental distress they had experienced had, in various ways, negatively impacted on their support networks of family and friends, provided these networks had ever existed. Given this, the relationships developed with staff, particularly in intensive program settings may be particularly significant; hence, critical reflection on the nature of that relationship is important for both worker and client.

One resident put it this way: “I found that all my relationships changed since I went into hospital, with family friends. With everyone really... there wasn’t much stability there. So, having one person who... your keyworker – is really important to you, because they give you a lot of support. And that’s one relationship that’s stable in your life, and that doesn’t change” (RA 97). Another resident commented on some of the difficulties she experienced in relationship with her family, that exacerbated her feeling of stigma, “I can’t stand their so-called sympathy. It’s not empathy, because they don’t understand it – but I don’t even think I want empathy! I just want to be me... the whole thing, and they can’t handle it. I have looked to them for support before, but they don’t know what it means to give emotional support... I’d rather be the problem child than the sick one” (AG 98).

Interestingly, staff made the following observations, that highlight some of the complexities around losing and forming friendships and supports; the first comment also picks up on the resident’s comment above, around the potentially toxic or problematic nature of some relationships:

“I think a lot of people who come to the program have lost a lot of friendships – I don’t necessarily see that as a bad thing always. People may realise that the friendships they had, and even in some families, they had before coming here, the relationships were toxic rather than supportive or nurturing” (OR 99).

The following comment by a staff member highlights the potential significance of re-bonding with supportive others who may form a new network of friendship: “…what I think is the therapeutic effect of the this program, is when the community surrounding somebody who’s had a rupture in their social bonds, their social ties, for example with family and friends when they experienced their first psychotic episode... meeting others who’ve experienced psychotic episodes allows new
binship to be established...a linking back into society...what [the program’s] continuing effect is, when someone leaves, that this place ends up being...a symbolic rejoining into a life with others…” (EG 99).

Still, the issue of friendship between workers and clients is a fraught one: the role of a worker may be more to support the person in (re)developing their friendship links, rather than replacing them with a worker-client friendship that is bound to terminate at some point. Unlike a worker-client relationship, friendship is generally more spontaneous, less accountable, and more subject to mutual self disclosure than the worker-client connection. The issue of friendship between staff and residents was something I did not directly raise in interviews. However, it did come up quite often, in more general discussions around the role of staff. For some residents, the ‘one-way relationship’ they experienced with staff members was frustrating, and sometimes felt further stigmatising. From a psychodynamic perspective, such perceptions would probably be seen as grist for the therapeutic mill and subject to various interpretations; however, it can also be conceptualised as a perfectly normal response to an unusual relationship.

One former resident reflected that “…it was awful...and I never got used to someone being your friend one minute and then clocking off work at five o’clock. That is problematic...” (NA2 9). And, from another former resident, “[professionals] have always helped me, but they won’t take my help back...so it’s hurtful to both” (TI 46). And, from a then-current 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...” (IV 48).

Indeed, the worker or therapist’s view of the relationship may be quite different to that of the client, although they both may struggle to make sense of a potentially confusing relationship, particularly if the relationship itself is never discussed (a tempting option for the worker, as such a discussion is often quite confronting). Almond (1974) cautions that because of the nurturance provided by the worker-client relationship, potentially unavailable elsewhere, it is easy for confusion or contrary understandings to arise. One former staff member made this reflection: “…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 the program], 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” (UR 46). This feeling of knowing each other quite well can indeed be intensified in a residential setting. “If you see someone for an hour a week and you’re having a really off day you can act your way through, but when you’re at [the program] five days a week, if I’m not feeling well, the residents know I’m not feeling well…in some ways it models normal life… that people who are psychologically healthy can be sad…can experience difficult emotions” (ME 49).

As mentioned, one of the elements of friendship usually missing from the client-worker relationship is that of mutual self disclosure or reciprocity, although as the previous quote suggests, people come to know each other on a number of levels and through various overt or subtle ways. Much traditional social work and certainly psychodynamic orientations posit that workers should reveal little about their values, fears, opinions or problems. However, Curtis and Hodge (1994), deconstruct this notion, suggesting that to censor such information, particularly in community mental health settings, not only creates unreasonable pressure on workers, but also “withholds one of the most powerful aspects of helping relationships” (p.25). They propose that worker self disclosure can help establish trust and understanding, “to validate the normalcy of consumer feelings and concerns, provide examples of how situations can be alternatively handled, and to demonstrate effective ways of expressing both positive and negative emotions” (p.26). In saying this, they also stress that the important thing for staff to keep in mind is that the purpose of self disclosure in helping relationships is not to meet the worker’s needs, but those of the client, which separates the sort of self disclosure consciously used in a professional sense, from the sort of self disclosure experienced in a friendship. Again, critical reflection is a vital resource for workers, to ask what motivates self disclosure, and importantly, how is it experienced by clients – inquiring into the local operation of self disclosure and the trespass involved. To take this interrogation further, a worker might ask if the ‘use of self disclosure’ has become another therapeutic technique, rather than being together as human beings.

Reciprocity may be one aspect of friendship; companionship may be another. Watkins, after many years of experience as a counsellor/support person, says that “…what we are as a person, and the quality of our human presence with our clients, may be a more powerful healing influence than we know…On the journey of recovery – for our clients as well as for ourselves – simple human companionship may indeed
be the most potent healing factor of all” (p.41). A number of residents and former residents commented, unprompted, when discussing what was helpful to them in the program that some of the most important aspects of their experience had been when workers simply spent time together with them. One former resident put it this way: “...when I often found the staff most useful is when you’d maybe be relaxed, and just in a relaxed setting, and you’d share some moments or just have a friendly conversation or something. And I think that for someone who is isolated, who’s lost their friends, who may have lost their family, who is lonely perhaps or having a hard time, that is powerful. You know, ‘I’m a professional and now we’re going to talk about how we all feel about this, that and the other thing’ can really be lost along the roadside” (NA2 9).

The following comments, from residents, resonate with this notion of the significance of authentic relationship, which may, arguably, be a form of friendship. When asked about what was the most crucial role of staff, one resident responded, “I’m not sure, but I really appreciate it when staff come upstairs and just sit in the smokers’ room and have a cigarette and just chat... like a friend... talking about things that are really real, like person to person” (AS 48). Another resident commented that it was important to “relate to staff more on a friend level, not like school teachers” (MA 7), and for another, “I see staff more as guides than authorities...power trips make me shut down” (AG 7). A former resident, who had left the program very recently, recalled, “I remember a few times I went shopping with a worker and it was really enjoyable... just that half hour – I felt like a totally different person. It’s important for your confidence... just going for coffee and maybe talking about something else, besides your problems... to just clear your head a bit” (IV 49, 95).

From a critical and reflective perspective, it might be useful for workers to problematise or critically engage with their own construction of friendship generally and the ways in which they relate to other human beings. Our stance towards friendship with service users may, as well being shaped by our professional theory and ethics, also have something to do with our own issues, our level of maturity, our needs (for protection or connection, both of which are potentially constructive or otherwise) and life experience, as well as the needs and personality of the client. Perhaps the bottom line, when engaging reflectively with this issue, is to ask the question – what is the nature of harm or trespass that is engendered by my
construction of friendship in my work? Those moments of bewilderment, which I have experienced as a worker, when I’ve wondered, ‘am I being a professional or a friend?’ are perhaps some of the critical moments that can provide rich opportunities to unravel what meaning has been ascribed to these concepts: where they have come from, and what effect does their oppositional construction serve?

Worker vulnerability: being human?

Deegan suggests that to truly nurture recovery in a program, “the rigid walls” separating worker and client must be abandoned: she raises the notion of staff vulnerability, suggesting that staff need to “embrace and accept their own vulnerability” as the first step towards understanding and connecting with the experience of those they are working with (1988, p.18). Similarly, Welwood proposes that rather than being something to fear, “mutual vulnerability” between client and worker/therapist “seems to be a crucial factor in how two people can affect each other… We could say,” he continues, “that vulnerable means ‘able to connect’” (1983, p.160). Perhaps it is precisely this possibility of ‘affecting each other’ that workers (and researchers, and clients) may fear, or feel threatened by: Welwood acknowledges that in the closeness of mutual vulnerability the client’s fears and problems may well mirror our own unresolved issues. He poignantly acknowledges how threatening it can feel to “drop the attachment to being an expert and… dig in and share the client’s world” (p.x). Unfortunately, he does not say much more about what this mutual vulnerability would actually mean, and how it would manifest in the day to day, hour to hour, reality of interaction.

Workers/therapists usually expect those they work with to gradually expose their vulnerabilities in the safe environment that has been created, in order to be able eventually to safely do this outside the program setting (Karasu, 1992). Indeed, several participants commented on how their relationship with their keyworker was somewhat similar to a maternal relationship, but one that met their needs and allowed them the freedom to reveal themselves. Welwood (1983) describes what he calls “basic vulnerability” as a rawness or nakedness which is felt at times when someone’s “world collapses,” when one’s outer shell or facade falls away. Surely this is an extremely uncomfortable and risk-filled state of being; however, one that may precede growth and that may, in itself – so long as it is experienced in a safe and supported environment with a trusted other – allow the client to experience a possibility of vulnerability which is not accompanied by panic. “Even someone who has poor
defenses or who splashes his emotions all over his environment, has still probably not made a friendly relationship with this soft, tender place inside;” to begin to do so, says Welwood, is an important step (p.158). He goes so far as to say that empowerment is not possible without a sense of real vulnerability. Workers may also benefit from discovering the possibility of vulnerability which does not give rise to disabling anxiety or thoughtless defensiveness but which holds potential for new awareness.

One program resident, when asked what sort of role she thought was the most helpful or supportive for staff to take, responded, “I’m not really sure. I know that I really appreciate it when (name of staff person) comes up and just sits in the smokers’ room, and has a cigarette and just chats. Like a friend. She’s very open in her own way. She talks about things that are real...like person to person...and she’ll admit in my IPP [weekly counselling session] sometimes 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 counselors are those that acknowledge their own struggles, ... within reason. ... I really find it hard to respect people when they don’t like to be vulnerable with me. 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” (AS 1 8). This was a view echoed in numerous interviews with residents and former residents: that what they valued most were the moments when workers were ‘more human.’ It is quite easy as workers to minimise such views as deluded or defensive responses requiring analysis on a psychodynamic level. Indeed this may be useful. However, it is also beguiling, even for workers who aim to establish egalitarian worker-client relationships, to – despite believing in the value of the ‘interpretive framework’ of clients – uncritically reject such views. Honest reflection on how we respond to situations such as clients telling us that they value us most when we are ‘human’ can be illuminating. What does that tell us about our practice: that we are being lured into unhelpful collusion or that at times it is simply being with an other that is therapeutic or empowering? From a critical reflective perspective, we would also need to be mindful of the diverse and changing needs of service users: some clients might find particular types of worker vulnerability burdensome, confusing or alienating. Karasu (1992, p.19) suggests that “an unfrightened therapist” can acknowledge a sense of shared humanity, which will positively influence the course of therapy. On the other hand, does openly
Chapter 5  Boundaries, vulnerability and authority

acknowledging a shared experience of struggle or vulnerability undermine the authority and professionalism necessary to be truly effective helpers?

In outlining the role of a skilled helper in mental health, Podvoll (1990, p.246) describes a way of being that he calls “basic attendance:” a role that seems to combine vulnerability, human-ness and a particular style of professionalism that is potentially both therapeutic and empowering. Basic attendance is grounded in the principle of “being present” – being both calm and alert with clients, “letting in the other” (pp.268-69) and working together on activities large and small – doing what is immediately relevant to someone in the process of recovery, whether that be going for a walk or engaging in a more traditional counselling session. Basic attendance also involves recognising the person’s history of sanity, finding energy and helping the person to find their’s, being open to one’s own learning as a worker and human being, and exploring together ideas of increased self responsibility. This therapeutic/empowerment role may or may not resonate with a worker’s idea of professional practice, or that of the agency or funding body. Elly Jansen, the founder of the Richmond Fellowship, speaking at the 1997 TheMHS Conference in Sydney, spoke of the delicate balance of allowing fluidity and flexibility, while at the same time maintaining useful professional boundaries. Workers need to help people learn they can do, she said, and by doing feel good, not simply try to make people feel good by what you do. Indeed these simple statements encapsulate some of the key tensions of anti-oppressive and empowerment oriented work that may emerge from the underlying desire ‘to help.’

Finch and Krantz (1991) suggest that programs which adopt a flattened hierarchy approach, require staff to reduce the “self-protective distance between consumer and professional,” placing far greater stress on staff than a more ‘traditional’ hierarchical setting. Campling (1995, p.95), writing about the flattening of hierarchies that deliberately takes place in a therapeutic community or other anti-oppressive environments, suggests that in some ways it is “an extraordinary political achievement [to]…voluntarily give up a significant degree of power to people more vulnerable and hurt than ourselves.” She suggests that the more hurt and vulnerable one group is, the more difficult it may be to ‘hand over’ power to them. Dominant Western ideology maintains that the ‘strong’ (as defined by those who are dominant) rule, and rule better. It is interesting to note that Moren’s (1994) contention that the “principle of distance” built into professional relationships – an “entrenchment in
official roles” – is probably a greater source of burnout than the “nearness” usually emphasised as creating emotional stress and burnout (p.293). Closely related to the issue of worker (and client) vulnerability is the issue of boundaries. As indicated in the preceding discussion, problematising and locating these concepts in practice can reveal contextual nuances that may shake – even slightly - the tree of accepted wisdom.

**Boundaries, containment, safety**

The issue of worker boundaries is a complex and contentious one. Boundaries are important, and workers need them. Indeed, it is because of their importance that they are worth critically reflecting upon, asking how they function and for what purpose. In residential services, at least those run by the organisation in which the program was situated, the issue of boundaries was often the topic of supervision sessions and prominent in staff minds. In terms of both relationships and the program environment itself, strong and reliable boundaries were crucial in creating and maintaining a safe and growthful environment. One very experienced staff member commented unequivocally that the structure of the program “provided profound containment...because of the high quality staff boundaried relationships, that nurtured people [and provided] reliability, warmth and caring...within that boundaried environment” (RT 16).

In a therapeutic community, or a residential psychiatric disability support service, the worker is faced with ‘the work’ of providing support and containment day by day, in a variety of activities and roles, sometimes working with individuals over a period of several years, on an almost daily basis. As previously mentioned, this can allow for a more holistic and comprehensive gaze by the worker, and more time for the service user to be in contact with workers; it also means it is possible for the worker client relationship, and the boundaries around it, to exist in a range of different settings and situations. Does a worker have different boundaries when on camp, than when facilitating a meeting; do a worker’s boundaries shift somewhat when sitting on the steps of a swimming pool with a resident they have known for several years? A response, upon reflection, may actually be ‘no’… depending on how workers’ boundaries are conceptualised and constructed. Or it may be that the worker has a certain boundary as ‘bottom line’ (i.e. that all interactions be focused on the well
being of the client… although this can be troubled also, in terms of how we conceptualise the ways in which well being is fostered) around which other boundaries are more or less flexible. For some workers, the worker-client boundary, in order to be consistently therapeutic, is a tightly monitored one: “I learned too often in the early days how important it was that I don’t make throw-away comments, and that I am always aware that I am here as a therapist.” (ID in SR 12).

Curtis and Hodge (1994) have specifically addressed issues of worker-client boundaries in the new community-based environment of human services. They provide a succinct definition of boundaries as “the highly personal translation of moral codes in our relationships with others” (p.21). While brief, this definition is quite complex: it points to the individual decisions we make as workers about how to enact a moral code within our work and relationships. Of course, social workers are bounded by the protocols of the agency and professional code of ethics; however, within those frameworks there is considerable scope for professional autonomy and discretion, vital in responding to the dynamic nature of interactions that occur. At the same time, workers in a therapeutic community are vested with the role and responsibility of providing the sort of containment required to create a recovery oriented balance of challenge and support.

**Boundaries that contain**

It is difficult to imagine an effective container without boundaries. With its origins in psychoanalytic theory (such as that espoused by Bion, Klein, Winnicott among others), the concept of being ‘held’ psychologically implies that a safe, reliable and nurturing relationship, and/or as Beitchman puts it, “a therapeutic place to be” (1995, p.54) creates containment that will not break despite the experience or expression of uncontrollable or destructive impulses (Morgan, 1998, p. 6).

The following self reflective comment was made by a worker when discussing staff’s role of containment in the program. “…when someone comes along and vomits [metaphorically] in the centre of the room and says ‘this [program] is yuk, you’re yuk’…the skill involved in working with that is to somehow hold that feeling or that experience…and gently give it back to the individual when it’s appropriate. Sometimes the person doesn’t want to hear it…but other times it’s useful… it’s about containment…the need to contain the space…and particularly, if material is directed at staff, to somehow hold our feelings, to hold our anger, fear or sadness… To contain too much could be interfering with the work as well… And is it about
containing the group, or is it about containing who? Containing the anxiety that YOU might be experiencing in the group...so sometimes its important to reflect on your own practice – is this useful for residents, whose need does this serve?” (OR)

Very much along these lines, Pachaly (1997) writes that the community – residents and staff – “function like containers in which affective and emotional rubbish is tucked and stored until it becomes more tolerable and can be taken back and integrated” (p.36). A particular type of community is necessary in order to be able to tolerate this or to function in this way. Indeed, as Caltagirone and Smargiassi (1997) observe, if destructive impulses are not contained, then the whole community can deteriorate rapidly.

In a therapeutic community, Hinshelwood (1996) affirms that containment is vital to contain the individual and the community. (Hinselwood (1996) also observes that staff need ways to contain their own anxieties, chief amongst which, according to Mawson (1994, p. 70) may be an experience of inadequacy.) While staff initially occupy a pivotal role in containing the client, the capacity to contain anxiety gradually transfers to clients themselves. At the same time, workers must ensure that the community and program itself provides a containing environment in which this process can take place. One staff member put it this way, “I [want]...there to be a very supportive environment at [the program], from which people can reach out into frightening areas. Returning to study is frightening...catching public transport and going to that strange environment... there’s so much to adapt to, that to have a safe environment to come back to... is really important...a safe place from which they can venture out. And then, having ventured out, all of that becomes the safe environment, from which they can venture into a new place of living. What’s important is there being a safe environment, within which they can explore what’s happening for them – other ways of looking at what’s happening for them, and other possible interpretations of events” (ID 117).

Hardwicke, in a fascinating article entitled “Doors in the mind: reflections of a resident therapist on the metaphor of doors in a therapeutic community” (1998, p.315), describes people’s stay in a therapeutic community as a journey, “traveling through house and mind in terms of opening and closing doors.” She describes the confronting transition experienced by people coming from the physically (and psychologically) constrained holding of the hospital (medication, secure structure, etc) to the Centre (her site of practice) where they are encouraged to begin to “think
symbolically” and feel contained by “emotional holding.” She observed that, despite its freedom in relation to the more restrictive and hierarchical hospital setting, the relative openness of the Centre’s environment and the demand to engage with others was experienced by some residents as understandably threatening. The (literal, physical) doors of the community, she says, and their openings and closings can conjure up associations with many things – safety, trespass, support or emotional violation, which residents are then confronted with – representing a complex interplay of both new experiences and familiarity.

This contradictory experience of a holding environment, Hardwicke found, in her case study, meant different things for different individuals at different times. For example, boundaries for one particular resident “did not make sense except as an excluding parental barrier … to be disregarded,” while for another resident they represented an ambiguous need “to be held and abused at the same time” (1998, p.320). In these situations/interactions, she says, staff are confronted with the difficult question of “how to keep the door open [to clients in pain] without getting filled up with denigration and hopelessness;” for many people, she concluded, the experience of safety was unknown – the task of staff, then, was to find ways to help residents make the transition from a “physically secure environment to a mentally safe one” (p.22). Thus the use of staff power and authority to create a safe environment, and to foster the experience of safe relationships, was particularly significant, requiring a high level of skill and capacity for critical reflection on the part of workers, to unravel and attend to the diverse meaning(s) individuals ascribed to the boundaries they encountered. Hardwicke’s account is highly psychological; critical practitioners would also be mindful of ways in which oppressive social structures and material realities had shaped personal meaning systems.

Indeed the capacity of the program and the workers to engender, provide and maintain a safe environment was an aspect of staff authority that appeared to be crucial for residents, although, as suggested by a staff member, whilst service users might identify the safety of the program as important, they may not equate this need or experience with a positive use of worker authority. Residents made the following comments, not in the context of having been asked a question like ‘was feeling safe here important for you,’ but arising organically in the flow of fairly unstructured conversation about their experience of the program. “The staff play a really important role in making this house feel, for me, safe…emotionally safe and supported…a lot of
people who are living here have been through some pretty severe traumas...some pretty horrific things have happened to their lives... I’ve been thinking about it...I’ve been really enjoying the summer and I love living in (suburb). It’s so pretty, there are parks, cafes, the beach... I feel so privileged to be living here... I deserve to be here...I’ve been through so much and this is really important, because I’m feeling PLEASURE in my physical environment” (AK 116).

Another resident commented that in the first months at the program, and prior to coming to the program “emotionally I was feeling unsafe, not secure in the world. Scared of being an adult, out there as a separate individual...making my way through life. So I wanted to feel safe, and I wanted to feel loved... or lovable” (AS 116).

One former resident, when asked what had been the most useful thing about being in the program for nearly two years, paused for a lengthy time and finally said, “maybe...I’ve felt safe there...physically safe, emotionally safe” (AJ 116). Another former resident commented “I found the most valuable thing for me, looking back, is probably a safe place to (pause)...to rest” (IR 116).

As one staff member described it, “Staff are helpful in facilitating whatever dynamic is going on...so that creates a safe space where people feel they can be themselves and express themselves and see the good that can come out of it” (EC 116). This view was reiterated by a former resident who said, “...if somebody found it hard to discuss an issue with somebody else, they could bring it to the community meeting, and it would be safe... you could bring your issue to the group and it would be amongst everybody, so you felt safer...the next step after that was being able to talk one to one” (OS 115).

**Ambiguity: moving out from behind the desk**

The therapeutic community is unique in its structure and ways of working; however, community based services in general – and there are many such services in the current environment - pose more general challenges to workers as their professional role adapts to and is challenged by new settings and relationships. Curtis and Hodge (1994) suggest that as more and more mental health and other human services are provided ‘in the community,’ the concept of boundaries will need to be revisited, as workers move out from behind the desk and into the homes and lives of service users in more holistic ways. They highlight how, in any organisation, both formal and informal rules, as well as workers’ own theoretical frameworks and values, will determine what staff behaviour is appropriate. Staff in community mental
health services, they observe, must accept that “ambiguity is part of the job,” although it is the responsibility of the organisation/agency to clarify, as fully as possible, their expectations of workers and the principles on which the organisation operates. They list a series of questions a critical staff team might ponder and discuss, to bring to conscious awareness taken-for-granted interpretations and actions: What are the intended effects of a particular type of (staff) behaviour? What are the potential benefits for the consumer? What are the benefits to the staff person? What possible problems might come up as a result? How could the behaviour be misinterpreted by others? How comfortable would you be with this action if it was published in the newspaper? (28). These questions are compelling and potentially confronting, but highly relevant to a critically reflective practitioner. How we manage our boundaries, despite the regularity of how often the word is mentioned, is often a private issue, but one which is directly connected with how we make sense of the ‘helping role,’ and shaping our preferred way of working, for whatever reason it has been chosen or adopted, consciously or unconsciously. How we manage our professional boundaries may have something to do with how we manage our boundaries in other aspects of our lives – with our various needs for protection, distance, or approval, which are played out in and tempered by, our professional roles.

Curtis and Hodge observe that community mental health workers are faced with decisions in their daily work activities that cut to the core of service provision and the very meaning of support. The pressure on staff to ‘do the right thing’ ethically is paramount; however, as Curtis & Hodge point out, decisions often need to be made by staff “for which there is little solid guidance” (1994, p.15). They give the example of the dilemma posed for a worker in deciding whether or not to have dinner with a consumer they are supporting in the community, and if so, where? They suggest that in many situations there are no clear-cut or consistent answers: the question, they suggest, is not whether the action is acceptable or unacceptable, but “when, to whom and under what kinds of conditions is it acceptable?” (p.16). Thus boundaries may be different from one setting, and one client, to another; this could be viewed in postmodern terms, as an acknowledgment of the contextual, temporal and situational contexts in which ‘truths’ are constructed. Curtis and Hodge also observe that such fluctuations may be hard to justify: “why is it okay to take John to the grocery store, but to expect Jane to get there by public transportation?” Even well intentioned program guidelines which, in line with modernist and bureaucratic
demands, universalise the range of appropriate behaviours associated with healthy
worker-client boundaries, may not capture the flexibility necessary to meet the
changing needs of service users in community support programs (p.26). One former
resident commented on how he had found it “easier when the clinical lines were more
grayed, more blurred.” He also observed that staff members used discretion in how
they related to different residents – a practice he seemed fairly ambivalent about. Staff
members also spoke of the flexibility, as well as the importance, of boundaries in the
residential setting. *Boundaries in a clinic are much more fixed: “the boundaries here
seem to be more in process – the line in the sand keeps shifting (e.g. when we’re on
camp)”* (OR 13). The boundaries are like an amoeba – if you poke at the amoeba’s
boundary, it moves away, but it doesn’t mean the boundary is gone – the boundaries
in the program are “clear but flexible” (ID 13).

Importantly, fluctuating boundaries, Curtis and Hodge suggest, need not be an
indication of weakness or professional incompetence; the challenge for workers is to
critically reflect upon how and why boundary decisions are made and their impact.
Indeed, they go so far as to suggest that if community support workers are not facing
relationship boundary issues in their daily work, they are probably not doing their jobs
most effectively: shifting relationship boundaries are *demanded* by the work, and it is
very important that staff teams (perhaps with service users as well) engage overtly in
such discussions. The more narrowly focused the intervention and the relationship,
the clearer the role of the staff person is, and hence their boundaries; in a residential
program which is holistic and multi-faceted in its nature, the capacity for staff to sit
within a tightly defined role, with rigidly defined boundaries, is perhaps neither
practicable nor effective. In “multi-dimensional relationships, the role of the staff may
be unclear to both the staff and the consumer…” (Curtis & Hodge, 1994, p.24), and it
is little wonder that confusion may arise, particularly if, as Bloor et al. (1998, p.220)
suggest, the helping professional is striving “simultaneously to establish both rapport
and distance.” From a postmodern perspective, this apparent contradiction would be
seen as one of many ambiguities that arise in the course of human interactions.

One worker expressed concern as to whether the changing nature of the
worker role – at least as it appeared on the surface – seemed to impact on resident’s
ability to trust workers. “*With the camp, and how the boundaries are different in that
setting – and similarly on a Tuesday – the wearing of many caps, the donning of many
caps in various roles – how do you think that affects the residents?”* (OR). Williams
& Swartz (1998) also discuss the difficult tension experienced in community mental health work, where, on the one hand, clients are in need of companionship and support, but are “also in need of structured boundaries and reality testing” (306), for example by stating, ‘I am not your friend, I am your worker’. They suggest a “limited reciprocity” between worker and client (p.310), although it is not entirely clear what this would mean in practice. Again, critical reflection could enable workers to problematise and explore what forms of reciprocity in their practice they (are willing to) engage in, and what values, theories or experiences these beliefs and practices stem from, as well as their potential for trespass in particular contexts.

Curtis and Hodge (1994), while clearly acknowledging that staff are hired as helpers, not as friends, explore the potentially negative effects of a totally non-reciprocal relationship on clients: “…when staff are always the ‘givers’ and consumers are always the ‘recipients,’ we perpetuate the idea that staff have what is most valuable and …hold the power to allocate or give based on their judgment… Refusing offers of reciprocity – whether it is an offer of a cup of tea… or of knitting lessons – may be as invalidating as outright stating to the person, ‘you have nothing of value to offer this relationship’” (p.25). This is a very strong power to wield – the power of the giver – the giver of that which is of value - and one which certainly bears consideration. Is it important for workers to retain this power? What purpose does it serve? This resonates with Almond’s concept of healing charisma, and the capacity for it to be shared, without detracting from the role or effectiveness of the prescribed helper. This lack of reciprocity was commented upon by several participants. One former resident commented on how he had received a lot of ‘help’ from support workers/mental health practitioners over the years, “whether I’ve wanted it or not… they’re always there, consistent, and I’ve never asked it of them. And when I tell them…please don’t go out of your way, I hurt them…And, in return to them, whether they helped me or not, I would like to help them… so, it’s a bit confusing” (TI FR 16). He went on to talk about how it was in his nature, as in other people’s nature, to want to give help in return, “so its hurtful to both of them, because the person who doesn’t want anything in return gets hurt, and the persons who wants to [reciprocate] gets hurt too.” A then-current resident had also felt hurt by this lack of reciprocity, commenting, “It’s a sort of one-way relationship, which is difficult to take, actually…Because to them [staff], they’re involved, they’re working with us…and they 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…. They ask for your trust, so you can go to them with problems…but then they don’t shoot that back to you. And you can’t share their problems because they feel like they ‘re staff” (AG 46).

The complex, ongoing and necessary task of creating and enacting boundaries that shape practice and the worker-client relationship requires skill, self-awareness and willingness to examine the trespass created by whatever form of boundary setting we engage in. Combining flexible yet clear boundaries with the level of containment required in a hectic and sometimes highly anxious and crisis oriented environment demands a sense of clarity around program philosophy and theoretical framework as well as a willingness to examine its fit with critical practice. There may be no hard and fast answers, but as Heaney et al. (1995) put it, “a well defined ideology can be a useful resource” (p.461); the question for a critical worker then becomes, how does my ideological premise fit with critical practice in this particular situation.

Worker authority

The concept and use of worker authority can trigger alarm bells for the critical practitioner. However, this may also be a productive site for deconstruction and thoughtful analysis of the contextual nature of what constitutes empowering practice. Healy (2000) suggests that modernist critiques of worker power and authority have not recognised the “subtle exercise of worker power towards the achievement of such things a group cohesion, collective focus and, even, the participants’ ownership of the social change process” (p.82). She suggests that the local operation of power and authority must be critically analysed within practice contexts in order to recreate “critical social work practices premised on the complexity, instability, and, most importantly, the contextual variability in processes of power, identity and change” (p.145). Such insights, she suggests, can be gained through critical analysis at the level of local organisations and practices of social work.

In their fascinating study conducted at Royal Park Hospital – The Understanding and Involvement (U & I) project –Wadsworth and Epstein (1996) found that the effects of worker power/authority depended on what was actually underpinning the worker’s actions. They came to the understanding that staff power and authority that was combined with a response of fear led to a desire to control – a form of power and authority that was experienced as oppressive and destructive by
consumers. Alternatively, they found that when worker/staff power was coupled with responses of concern and a desire to facilitate healing processes, different and more empowering possibilities were created.

Almond describes the healing process that can potentially occur in the therapeutic community setting as the “spread of authority downward,” the transmission of “healing charisma” throughout the community, shared by both staff and residents, the latter being seen as “actor, initiator, collaborator” (1974, p.xivi), rather than as reliant on staff to control and heal. According to Almond, the authority vested in staff by residents has less to do with set role hierarchies and more to do with “charismatic authority patterns” – an investment of authority in staff in equal proportion to service users’ belief that staff know something, and have a capacity to bring out charismatic healing potential in others. This healing charisma flows both horizontally and vertically: horizontally, making every member of the community feel strengthened and enhanced by being part of the community, and vertically, wherein a staff member, as a leader in the community, must “constantly sense whether he is effectively transmitting charismatic qualities to …the members of the group …by his inner sense of himself…and by the efficacy of the group in dealing with newcomers” (p.146). I suspect the use of the word ‘charismatic’ may create discomfort amongst service providers and users – generating visions of exploitation and even ‘cult-ism’. However the transfer of norms/culture to residents is something that I have observed occurring, and which programs do engage in, more or less consciously. Indeed, all human service intervention – consciously or unconsciously, overtly or covertly, imposes a certain normative framework on those who are intervened with.

As Almond (1974) puts it, “healing charisma is not limited, and a greater charisma at one level does not mean less at another…the charismatic aura of the individual leader is transformed into a style of interaction that may be shared by all members…” (p.330), what more traditional social work texts might describe as role modeling or skill sharing. The sharing of healing charisma also implies a belief in “the latent presence in the individual of an experience of himself as effective, worthy and good” (1974, p.329). Here, the comments of residents, presented earlier in this chapter, about (re)learning that they were potentially loveable or deserving come to mind.

Therapeutic communities, and all programs, consciously or unconsciously, represent and enact ideological, normative and moral positions, and use a particular
form of authority to do so. The therapeutic community does this perhaps more
consciously and overtly than other human services; as Kennard (1983) observes, the
therapeutic community represents a moral value for people who work there (just as, I
would suggest, a women’s refuge represents feminist moral values, about which they
are transparent and unapologetic in asserting their norms, which are considered
emancipatory). Services and programs – more or less overtly - express particular
beliefs about relationships and how problems might be addressed, which shape and
direct both workers and service users, providing clarity, whilst also, sometimes
creating barriers to growthful change and development. As Kennard puts it, the key is
to establish a balance between moral conviction and self appraisal (1983).

Almond suggests that the best protection against a misuse of authority “is to
insist that it be used openly … Authority used in the open,” he says, “is much less
likely to be abused, and less likely to be experienced as oppressive” (1974, p.348).
He acknowledges that it is probably impossible, whenever professional roles are
assumed, to entirely avoid issues of authority: “any judgment on the acceptability of
another person’s behaviour implies an imposition of one’s own views” (p.348). Even
those prominent in the anti-psychiatry movement of the 1960s, Almond reminds us,
acknowledged that all human interactions carried such impositions. Almond
concludes that “once we choose to involve ourselves with patients [sic], we face the
existential truth that there is no ‘neutrality’” (p.349).

The authority of staff in the program appeared to create an environment and a
culture, a structured program and attendant expectations, and bottom-line non-
negotiable rules of behaviour. The structures of a program are devised - or evolve -
around a particular way of making sense of people’s experience and their needs and
what will facilitate meeting their needs. The program environment is potentially a
very strong social context; as such, Weick suggests, it will “provide the norms and
expectations that constrain explanations” (1995, p.53); this is indeed a powerful act,
an act of author-ity. Particular meaning becomes attached to certain experiences,
along a continuum of healthy/unhealthy, responsible/irresponsible; positive ways to
leave the program/destructive ways to leave the program. Workers are powerful
sense-givers in this process of meaning ascription. Like Law’s theory of ordering, in
which powerful persons embody and enact patterns of deletion as well as possibilities
for action, the ascription of meaning or sensemaking proposed by Weick, defines
particular ways of speaking and acting and of constructing the ‘things’ of a situation.
Similarly, Bloor et al. (1989), writing specifically about therapeutic communities, describe the treatment process as one of reality construction – the work, they say, is unapologetically interpretive (the therapeutic gaze always making sense of things in particular ways), dominating, and selective (only certain cues being extracted from a myriad of possibilities). I would argue that this happens in all human services, but often less consciously acknowledged or articulated.

While worker authority in some settings may be experienced as a coercive sort of power over – reinforcing a disempowered, oppressive position – it would seem that it can also be a source of safety, opportunity and enablement. By exploring how the authority of staff is experienced at the local level (Healy, 2000) a useful critical analysis can begin, which may lead to greater understanding and/or changed practice. Authority may reside in the role assumed by an individual, (or group or institution), or it may reside in a person based on their personal qualities which confer a certain leadership (Long, 1992; Almond, 1974). It seems possible that authority which is used to contribute to the performance of a task (Miller, 1992; Long, 2000), particularly if it is a task which is mutually and respectfully explored and agreed upon, may be experienced as something beneficial. Writing specifically about community mental health services, Curtis and Hodge (1994, p.17) suggest that the way in which staff use their authority – “as a tool to restrain behaviour” or as a “resource for teaching self management and decision making skills” is the crucial consideration.

The difference between power and authority is subtle and slippery, and at times the two words can be used interchangeably. Both, arguably, can be used to create conditions for oppression or emancipation. According to Banton et al. (1985, p. 36), “power is generated in the structure within which relationships take place,” serving a complex range of both positive and negative functions. Authority implies an embodiment of some sort of right to possess and enact power, invested either in a particular role, individual or category of person, or bestowed upon someone who is regarded in a particular way at a particular time as a leader. Again, this may serve a complex range of both positive and negative functions: from a critical postmodern perspective the use of authority would need to be analysed contextually.

Can worker authority be part of anti-oppressive, critical social work practice? Is worker authority permissible or necessary for the creation of a recovery oriented, containing and supportive environment? Is it possible for staff to hold and exercise authority in a non-abusive way? Many of the characteristics of empowerment-oriented...
programs – transfer of skills and expertise to service users, encouragement of critical thinking, emphasis on interdependent activities, enabling individuals and groups to take more active roles in decision making, and acknowledging and building upon strengths – require leadership, structure and program or service culture purposefully generated by staff (Cox and Parsons, 1994, cited in Cox & Joseph, 1996, p.180). Banton et al. (1985, p.141) discuss the therapeutic use of what they refer to as “directiveness,” which creates the conditions in which, for example, conflict can be safely expressed and addressed rather than ignored or suppressed. As one very experienced staff member put it: “The most healthy sign of a service like this is that [challenging staff authority] can occur publicly...it’s very hard on staff... but its real and we must not try to protect our clients from this ambivalence” (RT 8).

The “special position” of the worker (group leader or therapist) allows the worker to challenge or comment on actions of group members and interactional dynamics, and to direct the content of, for example, group sessions in ways that are considered useful for participants. The often disturbing nature of emotional material when it is expressed, particularly amongst a group which may be particularly vulnerable at that point in time, may require a group leader (for lack of a better phrase) who can withstand and perhaps understand such expression and create a space for its exploration. In this sense, workers become the guardians of efficient communications (Bolten, 1991, cited in Fainman, 1995), using their authority to facilitate what Habermas (1980, cited in Rossiter, 1996, p. 31) referred to as an “ideal speech situation” in which the intention is for all to participate equally. Fainman (1995) likens the leader to a “‘native guide’ who provides facilitative management in relation to the terrain and the problems that may be encountered on the terrain, but does not direct “the destination of the therapeutic journey” (p.108). While this form of leadership appears ideal from an anti-oppressive standpoint, according to Fainman, it is an approach that “provokes much resistance” as it involves “navigating between the clinical Scylla and the managerial Charbydis…” (p.108), a tension consistently experienced and expressed by staff members in the program.

Bloor (1988) also suggests that authority can be an exercise of power without domination: a particular form of “orchestration” in which staff plan and anticipate events. He observes that without “the presence of teachers or elders who can transmit the wisdom of the community and train others to become teachers” the community will deteriorate (1990, p.312). This is evident in the (therapeutic)
community/Psychiatric Disability Support service where sensemaking is transmitted from ‘old’ worker to ‘new worker’, from ‘old resident’ to ‘new resident’. The preservation of community norms, according to Almond, is vital to the recovery process, and the authority of staff as a consistent reference point is vital in preserving and transmitting these norms (1974). Davis (1996) suggests that issues around worker authority are best understood in terms of how they assist clients to explore and potentially adopt a more positive idea of “taking authority for one’s own actions” rather than seeing power (their own or others’) as “something someone wields over another to abusive ends” (p.161). Thus the community becomes a setting where a more positive experience of one’s own authority can occur.

One program staff member commented, “The staff do have power and there is authority…” and that staff work with residents to develop their understanding of self in relation to authority and limits (EG 15). Bloor (1998) suggests that dissent amongst residents in relation to staff authority can be used therapeutically; this undoubtedly requires a high level of skill and should not be used imprudently. One former resident observed, commenting on an experience she had whilst in the program: “As well as giving people freedom, the staff do need to have a solid role in containing and defining what happens in the community...Sometimes it was almost like the staff took an experimental approach, like ‘let’s just leave this and see what happens’...and that doesn’t work. That is actually exploitive of the people in the community. You have to define boundaries, and you have to say ‘this is acceptable, and this is not’... I’d often see that people who come here, it’s like you’re a child and you really need to have some boundaries set for you, and some limits...if you don’t do that properly, then you’re really asking for trouble” (RD 115).

From his own experiences working in therapeutic communities, Winship observed that the “aggregate experience of authority that the clients brought to the community...was essentially a negative one”; thus the therapeutic task of the community was to “create, nurture and maintain a system where authority was disciplined but also caring and holding” (1996, p.39). According to Winship, as residents gradually felt heard and responsible in the community, they realised that they had power and authority to influence the world around them. Authority became less distasteful and alien as they experienced it within themselves – a new experience for many whose previous experiences of authority were around punishment and abuse.
at the hands of various authority figures – including parents, police and the mental health system itself.

Knowles (1995, p.102) suggests that “(w)ithin a cared for and controlled mini-society members get to have their developmental moments,” which, for various reasons they had not experienced previously. Almond describes a particular resident’s experience thus: the therapeutic community provided “authority figures against whom he could safely pit himself, nurturant figures who did not depend on him, a peer group who could tolerate his ambivalence” (1974, p.109). In a well-functioning and containing therapeutic community, an authority is demonstrated that is neither angry nor punitive; the individual could be mad or bad and the community as a whole could respond with a range of emotions, attitudes and expressions: disappointment, sadness, caring, and even anger, but the expression of which was contained within a safe and supportive space. As one former staff member commented, “That’s what I love about the program – people can lash out and say horrible things, and we might say ‘don’t speak to me like that,’ but the next day we say ‘I’m here again for you’ – just like I was yesterday. And just like I will be tomorrow. And I think for a lot of people it stops some of the battles that they’re so used to doing, and they can actually stop battling, and start thinking” (ME 51).

The ambiguous nature of worker authority

Sennett (1980, p.3) locates authority as one of the “emotional bonds of modern society,” a connection between people that is “felt into being” (p.12). This was evident in the comments/stories of project participants. He suggests that all people have both a need for, and some fear of, authority. The fear centres on relinquishing one’s freedom, and becoming “abjectly dependent, because we want so much for someone to take care of us” (p.15). This may be experienced as an “act of seduction”… of yielding to the desire for security. At the same time, Sennett goes on, the desire for “guidance, security and stability do not disappear when they are unsatisfied” (p.16). Losing independence was indeed a fear that individuals grappled with when they entered the program. For one resident, who was about to leave after a very positive stay, the most difficult thing about entering the program had been a feeling that she was giving up her independence. “It was a big thing for me to sacrifice… coming here…because I’ve always been really independent.” However, she added, “You can turn it around and just use the support as much as you need it”
(RA 42). Thus losing independence had been reframed into the opportunity to use support as one wished to, a much more empowering possibility.

Another resident had also gradually transformed her fears of becoming dependent, saying that initially she had felt judgment and “fear of being connected to a place and program that’s to do with people not being well and being supported, and being dependent...there was a lot of fear about that, and a lot of those fears were valid. But now that I’m stronger, I feel so much more appreciative of what I’ve got from here. And I also know that it’s what I make of it... ” (AS 44).

Although both these individuals described what ultimately seemed to be an empowering experience, structured programs, in which workers assert their authority through the creation and maintenance of those structures, are involved in imposing norms that might be construed or experienced as controlling. Almond (1974, p.152) sums this up well, asking, “Are we simply exchanging the authoritarian system of the asylum for the dictates of [another] monolithic system of brainwashing?” He observes that the community norm system exerts a strong pressure to conform; however, he also observes, similarly to Orlie’s concept of inevitable trespass when acting in the world, that every intervention “seeks in some way to influence...and that the danger...lies not in the use of social pressure itself, but rather in the ends toward which it is used and the extent to which the individual is controlled or abused in the process” (p.52).

Indeed one former resident used the word ‘brainwashing’ in her interview, suggesting that at times the program line was so strong that “the idea kept coming into my head, that this is what communism must be like – the party line...you could go up and talk until you were blue in the face...You know, they would say two and two equals five and you would not be able to convince them that it was anything else!... I mean, in this world they’ve created, everything’s going to make five...Well, who are YOU and what’s the point?” (NA 54). This is a serious statement that needs to be taken on board by workers; it suggests the potential need to be more transparent about the ethos of the program, its theoretical underpinnings and that the way it functions as one way amongst many that was chosen for particular reasons, not a grand narrative of truth. In a healing community, Almond says, the goal is not brainwashing, but changed behaviour which will gradually lead to more personally satisfying and independent lifestyles (1974, p.153). The same former resident quoted above, like the
two individuals previously quoted in this section, also described how she had gradually learned to use the program as a tool to achieve her goals.

The norms of a community - or any program or service - do stem from and perpetuate, more or less overtly, a particular underlying belief in certain principles of what is helpful and what is healthy – they say something about the way the problems of service users are made sense of, which is then translated into programmatic aims and structures, and cultural norms. Community norms, enacted and reinforced by the staff and the program structures themselves, do, as Almond states, “instruct members in how to act in a variety of… situations, and in how to think about their difficulties” (1974, p.141). The danger, given that every practitioner is drawing on some set of assumptions, beliefs, values or theories to interpret and intervene, is when this process is unacknowledged, unarticulated or unhelpful, or ‘applied’ without question. While the individual process of critical reflection is highly desirable for practitioners, so too is the more public or shared process (i.e. in staff groups, or meetings that include service users) of naming the assumptions, values and theories that underpin practice and an exploration of its consequences with the aim of reconstructing better practice. As Rossiter (2001) suggests, there is no “space of innocence” for social workers; given this, she talks about “how we might develop a space that allows us to assess the… governmentality…that creates the potential for trespass in all of our daily actions as social workers,” by maintaining an “ethical vigilance over the inevitable trespasses of our work” (p.3). Rossiter concludes that learning to tolerate a troubled professional identity, doubting the innocence of the desire to help and privileging doubt over certainty are as important as any knowledge or skills brought to the practice setting as workers strive for “better imperfections” (p.9).

Sennett suggests that the nature of authority itself has to change; he observes that in some cultures there are particular rites of passage “which imbue the person with equal strength to those who formerly were the protectors” (1980, p.161). (This resonates with Almond’s ideas around the sharing of healing charisma.) Curtis and Hodge (1994) ask when, if ever, the roles of professional/helper and client/consumer end. There seems to be no ‘rite of passage’out of craziness (Estroff, 1989; Barham & Hayward, 1991). Does the ascription and function of the roles of staff and client established at one point in time mean that such roles must be played ever after? How much outside of the prescribed role of ‘worker’ and ‘client’ is allowed to ever become part of the relationship, and is this fixed in time, along with the identities that have
been created? One former resident, after a long pause in the midst of our conversation about professionalism, said, “...I always felt I was not as worthy as the professionals in the place. And this idea also, that it didn’t end when you left the community. It carried on through your whole life. I have this feeling that I could meet (name of former 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.’ Because that’s professional information. And this feeling that I’ve done something, or something’s happened to me in my life, 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! That’s precisely the kind of thing that should be prevented... It’s just another form of stigma" (NA 48).

One former staff member also reflected on the ongoing nature of worker and client identities, ‘I went last night to a farewell dinner for someone who I worked with, and there’s a feeling of knowing each other quite well, from seeing each other for at least an hour every week for the last nine months. And that’s more than, apart from the person I live with, more than I probably see anyone in my life. And then there’s this kind of like process of saying goodbye, but for what reason? ... I know that was in my mind when I was leaving... I was terribly worried about how I was going to do that and not damage people in the leaving process. That I would be another person that left them, another person that’s showed them they’re no good to stay around. ... It made me think a lot about how I say goodbye to people... Last night this guy [resident] said to me, ‘I’d love for you to come around and see my flat.’ Now, why not? We’re not friends, but we know each other...yeah, it’s a strange thing...” (UR 46)

Importantly, in the process of transition suggested by Sennett (1980), the legitimacy of the elders (those in authority) is not diminished by the ‘child entering into their own author-ity; the legitimacy and authority of the elder changes, as the legitimacy of the once-child will change when their children grow up. “This is ‘non-embedded’ authority par excellence… authority exists, but not inflexibly in one form”; in this construction, only illegitimate authority would be identified with permanence (Sennett, 1980, p.162). “No one is strong forever...authority is not a state of being but an event in time...To be conscious of the link between strength and time is to know that no authority is omnipotent” (p.167) (my italics). While such an understanding is more difficult to envision on the level of large-scale bureaucracies, it
is not so difficult to envision at the program level. Sennett suggests the use of “active-voice in [revealing, exploring] the chain of command”: unveiling where responsibility and decision making lie, exploring the application of ‘rules,’ and the relationship between nurturance and control, and perhaps engaging in temporary role exchange to explore the other’s experience. This is a way of acknowledging that people have a right to be nurtured, “and that they have the right to negotiate this nurture face-to-face with the powerful…[while acknowledging that, in Western culture] to declare openly that we need someone else, that we have a right to another’s strength, seems to make us most vulnerable…” (p.186). In one interview with a former resident, I reflected back to her that it sounded like she had experienced a process in the program of gradually feeling that she had developed “more power to have things in a way that you felt okay about?” She responded, “Yes,…I felt that I had shown them [staff], and that I’d earned my right to live as I liked. Or to have certain wishes, and they were respected more than when I first came. Because I had gone to that effort to really show the whole story – ‘This [part of me] ISN’T how it is; THIS is how it is’…” (NAI 10).

Sennett’s notion of authority as temporal, located and dynamic is potentially a useful one, and one which is both critical and postmodern. Winship suggests that just as workers (and human beings, generally) have to wear different hats, so do service users or residents – sometimes needing to assume responsibility for household and other demands, at other times being able to be nurtured within a safe and containing structure. Again, it is skillful and critically reflective decision making by staff, in collaboration with clients, that is required in order to acknowledge and respond to the context. For service users to be allowed to ‘regress’, to temporarily abandon certain responsibilities, staff need some sort of authority to contain and manage. Along this line, residents, former residents and staff used words like “asylum, in the true sense of the word,” “a retreat,” and allowing oneself a “time to recover” and “get my life together again,” as important aspects of their experiences in the program. Levinson (1996) makes the interesting point that “democracy needs good leadership, and can only be maintained from a position of power…without strong leadership the structure is driven and dismantled by various defence mechanisms which oppose a therapeutic culture” (p.51). From this view, leadership or authority is vital to the preservation of the therapeutic culture itself.
Schimmel (1997, p.124) stresses that individuals can only develop needed insights into their behaviours in an atmosphere of “tolerance, respect and caring” – which the whole community contributes to, but which the staff are primarily responsible for. The therapeutic importance of staff exercising appropriate authority, he says, cannot be denied: “the legitimate authority roles of staff” in being responsible for the nature of the structure and activities of the program, as well as the emotional environment, are vital to the well being of the community and the individuals within it. Staff decisions about when and how to intervene in community life are crucial, both to the well being and functioning of the community and the safety and growth of residents. Staff intervention can be more or less active; sometimes, according to Savalle and Wagenborg (1980) staff can avoid intervening which leads to prolonged unproductive periods, where the community may become increasingly polarised, resentful, fragmented or apathetic. During such times, a number of people may leave the program. The decision about when and how to intervene is crucial and requires great skill. It is also possible for staff to become overly interventionist, closing off real, open debate and conflict resolution prematurely (Savalle & Wagenborg, 1980; Kennard, 1983) and suppressing individual or community material rather than working with it.

Indeed it has been suggested that the culture of inquiry which is crucial to a truly therapeutic environment can actually be lost when democratisation is “used defensively to block thinking,” when voting “becomes a substitute for discussion” (Norton, 1992, p.17). I have experienced this only too painfully myself, when, during community meetings, as facilitator, I have used my authority to opt for the easy road of voting (majority rules), rather than the potentially uncomfortable and conflictual road of discussion (consensus). Norton points out, and experience tells me this is so often true – much activity within organisations (and, I might suggest, some ‘helping’ activity generally) is actually designed, consciously or unconsciously, around the avoidance of emotional conflict. While a vote does appear democratic, and potentially even empowering, cutting short discussion is potentially neither empowering nor therapeutic.

Creating a sense of order: participants’ voices

It has been suggested in the second half of this chapter that worker authority, if critically enacted, can be used to co-create and sustain an empowering environment. Quotes from participants have provided insights from the program level; this
concluding section explores the experiences of service users in relation to the structure of the program, imposed as it was, by program staff who believed it to be a generally beneficial use of their authority.

Caltagirone & Smargiassi (1997) refer to the “parental role of imposing order” which staff assume as a necessary component of a therapeutic community. This is a means of providing containment and channeling energy, as well as encouraging active engagement with the environment. This sense of order, they stress, is vital for both staff and residents, as without structure, timetables, and ‘rules,’ the complex life of the community can become chaotic and unfocused. The external setting/structures are considered to act as a temporary replacement for the internal structures, which had been disrupted.

Many former residents (who had been in the program in its more highly structured days) commented that the structure of the program was crucial for them. While not directly asked by me whether they thought the structure of the program was useful, the comments came out in general discussion around why they had come to the program initially or what they had found particularly valuable or challenging. The following are some the comments of residents that illustrate this point.

“...structure is very important to me, because I don’t have much motivation...doing lunch or chores is very useful because otherwise I don’t think I’d do anything with my life – I’d be in front of the TV all day” (MA 18).

“Having to be up at 9, then cleaning and groups...I’d be completely lost if I wasn’t ready to go back to work or school...just sitting there staring into space...Also, for bridging – from having to leave my job and having so much more spare time...the daily routine...made it easier for me to go back to work as well...” (RA 18).

Having to adhere to the program was identified as the one thing that helped this former resident get his energy levels back up – “even the cleaning, although that used to annoy me” (RE 18)

“When you got up, you knew you had things to do...with too much free time, you get into a rut...I would have just sat in my room and read” (DN 19).

The timetable “gave me regularity...instead of ‘just couldn’t be bothered’...although sometimes I really didn’t want to, looking back it was very beneficial” (UM 20).

One long-serving former staff member put it like this: “One of the goals of the structured model was that people would internalise some of this structure...such that
they can develop their own capacity to structure their own internal world...at least their own external environment, to some degree...that is a very happy scenario, when it can take place...” (RT 20).

A number of residents and former residents expressed considerable ambivalence about program structure. One commented that he had hated the structure initially and simply did not have the energy to participate. He thought that being forced to do something lowers one’s own motivation, while at the same time acknowledged that structure did force people to contribute. One current resident, who had been in the program for a few months, observed that residents had felt resentful of the return of a structured timetable (and staff) after the Christmas break, however also commented that the staff were important “in formalising and maintaining structure...without staff the program would, over time, fall apart” (AK 15). And another resident, who had been in the program for approximately twelve months put it this way: “I don’t like structure...didn’t like it at school...and that’s what I’m coming up against now...but I have to learn to accept it,. Because when I’m without it, I fall down...bizarre, isn’t it?” (AG 17).

In the view of some residents and former residents, staff had not exercised enough authority, and needed to impose even more structure. Some of the issues raised included an occasion when there had been illicit drugs on the property and at least one resident thought that staff had left too much decision-making to the residents to respond to the situation (MA 14); another former resident felt staff did not intervene enough to resolve conflict and left residents to deal with it on their own (RB 15). Another former resident commented on occasions during a men’s support group when he felt the group leader did not exercise enough authority: “...group session leaders should support the honesty of participants while also showing open verbal anger at those with negative put-downs of others’ real situations...[Group leaders have to take charge and “shut up people who are being unconstructive.. the dominant people have to be mellowed a bit, and the people who are compliant can be egged on a bit” (RE15). Yet another resident suggested staff needed to be more vigilant in pursuing residents who did not pull their weight in relation to housework, saying that this was important for the individual themselves when they leave the program and are trying to live with others (AS 14).

On the other hand, in a sensemaking reversal, staff in the newer less structured program described the benefits of having less structure that residents were expected to...
conform to. One new staff person put it like this: “now there is a more permissive type of culture... in which people’s real internal motivation comes out... which is exactly what would have happened when they left the program... at least we can work with it now” (EC 17). Another staff person who had briefly experienced the old more structured program, commented that she had been concerned that people would become too dependent on the program structure and that when they left, they would be “left high and dry because their life was so full of activities for two years that when they left there’d be a huge hole...[and they would] go from one form of isolation to another” (UR 74). This staff person also commented that she had had difficulties with the more structured program because it impinged on the development of a worker-client relationship that could be developed more easily in informal time “just hanging out.” Another staff person who had experienced both the old and new program was uncertain: “I think we shouldn’t be setting the boundaries and being responsible...people have their own ways of living and being, and if people don’t want to be up at nine in the morning, then surely that’s [not for me to say]...on the other hand, you think, well why have a program if it’s not structured... I don’t know” (AC 16).

While therapeutic communities were initially developed as a reaction against the authoritarianism of institutional settings, Caltagirone & Smargiassi (1997) make a useful distinction between “pathological authoritarian models” and those that are therapeutic in their imposition of order and structure. Authoritarian models that are pathological, they explain, aim at control rather than the “development of expressive, relational and reflective capacities in the client” (p.172). Workers in the pathological model become rule enforcers, and there is little collaboration between staff and clients/patients. I will argue in my chapter on sensemaking and the creation of culture, that a program may become pathological when the original meaning of certain rules and rituals becomes lost, due to a lack of transmission of culture, or as a result of a different way of making sense of client needs. (Caltagirone & Smargiassi also point out, rules, guidelines or structure do not necessarily preclude participative or collaborative models: ‘rules’ can be developed and maintained more or less therapeutically and/or collaboratively, for example through reflective processes, interactional learning and clear expression.) Another pathological authoritarian model is one in which communities become anti-therapeutic due to a very poorly defined setting with little structure: where residents pass the time “browsing, looking for
cigarettes or coffee,” where their “liberty” does not give them a greater opportunity to express themselves and their needs, or be responsible, but, on the contrary, “leads to the expression of their negativity” and to the “liberty of remaining impotent and desperate” (p.172) (my italics).

In an interesting study referred to by Forrest (1994, p.33), undertaken by Bachrach (1980), over 60% of participants reported that staff did not make enough of an effort to get people out of bed and establish routines. Rather than having their sense of autonomy and self-directiveness enhanced by the lack of structure, the participants reported exactly the opposite: “the lack of structure and direction from the staff was described as extremely problematic.” While residents were expected to take advantage of the autonomy offered in the residential setting, actually DOING this was too difficult for many – they simply were not able, especially directly upon exit from psychiatric hospital care, to self direct or self motivate, and were also unclear about what staff expected of them. “They reported experiencing lethargy and boredom and feelings of helplessness and hopelessness which accentuated their inability to self direct” (p.33). When working in the program, I was aware that the ‘unstructured weeks,’ which occurred between cycles, were variously experienced as very difficult for some residents, and as a welcome opportunity by others, both experiences providing useful material for critical reflection.

Moos and Burnett (1996, p.169) comment that one of the major changes which has occurred in the therapeutic community environment in recent years has actually been an increase in structure, in recognition that many residents found self directed programs unproductively “anxiety provoking”. They suggest that service providers need to learn how to “strike a workable balance between institutional order and individual freedom” and that these needs may change for individuals over the course of their involvement in any program. Knowles (1995) suggests that the structure, nurturing and containment of the therapeutic community allows the creation of a “warm bed of evolution” where the weekly timetable (including, in her community lots of groups where attendance was expected and firm guidelines regarding absenteeism) is an attempt to “mimic the concentric circles of life” (p.98), in which people spend time alone and in groups, and balance work and play, creativity and routine household tasks. According to Norton (1992, p.13), while the formal predictable “time-space structuring” of the therapeutic community does impose
constraints on community members’ behaviour, it is consciously chosen for its capacity to engender a culture that is safe, growthful and empowering.

Concluding comments

Like Norton, Campling (1995) suggests that the object of the therapeutic community is to help clients become both thinkers and feelers – to develop a reflective capacity and ability to integrate emotions, which can only be done in the context of a safe and supportive environment. If, as Halton (1994) suggests, painful feelings can be “tolerated long enough to reflect on them, and contain the anxieties they stir up, it may be possible to bring about change” (p.196). At times when someone cannot do this for themselves, he goes on, another person may temporarily contain their feelings for them. The community may be called upon, willingly or unwillingly, consciously or unconsciously to contain a range of difficult or painful emotions on behalf of community members, which is challenging to all concerned.

Boundaries created between staff and resident groups can be used as a defence against anxiety, or be part of a “healthy, effective structure” which is openly discussed amongst the entire community (Millard and Oakley, 1994, p.329). Often, in reality, it may be both. The way boundaries are defined, by whom, and how they are communicated may be extremely important. Campling suggests that managing boundaries is about more than limit setting – “managing boundaries well is about taking time” to reflect, hear different views, to struggle actively with confusion and fear (1995, p.95), even if it goes against ‘traditional’ notions of professionalism and authority.

My own experience as a worker and as a researcher, has led me to believe that boundaries of some sort are vital, but establishing and maintaining them is also painful and confusing at times. It can be hard to know what this pain and/or confusion means: what notice should be taken of it? At times worker-client boundaries have also been experienced as painful and confusing to clients, and rather than openly acknowledge and initiate dialogue around this, I have taken the ‘easy’ way and not been willing to confront the issues. How can workers know what boundaries are truly beneficial? Certainly the majority of boundaries are created – we enact them, we make them real: we ‘knowledge’ them into being, consciously or unconsciously. Boundaries can be liberating or restrictive, enabling or disempowering, promote
clarity or confusion, or all of the above! Critical postmodernism opens our thinking to encompass a range of dynamic possibilities that can be explored for their anti-oppressive potential through critical reflection on practice.

Boundaries can be rigid walls or something more permeable, and, depending on the context, varying degrees of rigidity or permeability may be more or less empowering for both worker and client. What is useful is to problematise the construction and impact of the boundaries that are constructed – whether those of a worker-client relationship, or those of a community or service itself. It may well be possible to maintain a clear sense of one’s role as a worker, insofar as that contributes to the health and wellbeing of clients, in such a way that does not deny a sense of commonality, shared wisdom and continual mutual growth. It may be possible to have healthy boundaries that allow for the movement in and out of new ideas, new possibilities and critical self-reflection. It may be possible to have boundaries that are more like living, breathing and responsive membranes than lifeless, fossilised, or impenetrable defences.

To deconstruct the notion of boundaries it is also useful to ask how our boundaries are used to define ‘us’ and ‘them’, what is it that we want to keep out and what we want to let in, and honestly question what purpose this serves; how do the boundaries we set and the distance between ourselves and clients make us better workers; what is the nature of trespass that is inevitably created; how, specifically, does our sense and enactment professionalism assist in the generation of relationships which facilitate human flourishing? Do our professional boundaries, as Podvoll asks, “block our hearts” and, if so, what might this lead to? Do we erect impermeable walls, out of “…a fear of losing…individuality, or job description, or what can be called one’s ‘therapeutic ego?’” (Podvoll, 1990, p.269). Are the walls we erect strong and flexible enough to both protect and contain, as well as to allow ourselves to be touched, changed and continually open to new learning; would this be a healthy form of vulnerability for both workers and clients? If there are many ‘truths,’ critical reflection is vital not only to reveal our assumptions around boundaries, vulnerability and worker authority, but to see how they manifest in both the process and outcome of critical and contextual social work practice. The next chapter looks in detail at the therapeutic community experience and the significance of the environmental context, again, through literature and participants’ voices, interwoven with and from my own perspective.
In this chapter I examine the notion and nature of ‘community’ and the significance of the environment as conceptualised in mental health literature and as perceived by program participants. In particular, I reflect on the construction and experience of therapeutic community. The therapeutic community and perhaps even the word therapeutic may not immediately seem to fit with some understandings of critical social work practice. While therapeutic communities certainly target the social milieu of an individual in relation to their well-being, they do not necessarily or overtly seem to acknowledge or challenge the role of wider social structures in shaping personal experience, nor do they appear, on the surface, to grapple with issues of oppression and privilege. Unfortunately the word therapeutic is often aligned with Freud and psychoanalytical approaches, which have been rightly critiqued by critical theorists and practitioners as individualistic and overly pathologising.

However, on another level, as discussed in previous chapters, the therapeutic/community approach sees the development of critical thinking and empowerment as essential to individual growth and recovery, with workers valuing multiple perspectives, dialogue and mutual inquiry and working to maintain an environment in which these values are fostered. Therapeutic approaches, I suggest, need not necessarily be shunned by critical practitioners; indeed, community has always been acknowledged in critical practice as a key site for emancipatory change. Critical psychology and critical social work both emphasise empowerment, consciousness raising and the questioning of taken-for-granted assumptions that shape practice, more or less consciously reproducing dominant hegemonic culture. As White puts it, critical reflection on the trespass engendered by our theoretical perspective and our practice allows and encourages us to “to review our assumptions, and to render visible some of our everyday taken-for-granted practices…[to] become more aware of the effects of these ways of thinking and acting…[and] take responsibility for the real effects of our work on the lives of those persons who seek our help” (1995, pp.12-13).

Profitt (2000) discusses how her work with women who have experienced violence and abuse recognises the transformative process that allows women to move
from the personal experience of victim/survivor to more collective action. In her individual and group work with women, the therapeutic process they engage in is one that attempts to create emancipatory discourses and spaces, by challenging disempowering self perceptions, affirming strengths, reconnecting with others, making conscious the invisible and unspeakable, finding ways to express and work through contradiction and pain, and coming to accept oneself through shifting structures of identity and challenging hegemonic and disempowering constructions of experience. This personal healing or therapeutic work, she observes, is often vital in enabling people to move on to collective or political action.

Roszak argues that the formation of social movements or what he calls “situational groups” – networks that came together around political action – is actually, in some ways, also a vehicle of self discovery, providing members with “the therapeutic companionship of those in whom they can see themselves, those with whom they can most securely be themselves…And that, as much as anything politically practical, is what people want desperately to find” (1979, pg. 15). He goes on to suggest that such networks are the “political offspring of therapeutic exploration” (16). He gives the example of anti-racist political action, and suggests, using a somewhat different language to current theorising around interrogating white privilege, that it takes “a therapeutic sense of politics to excavate the irrational anxieties” that have been projected onto marginalised – in this case, black - persons. This can occur, he suggests, when people are willing to go beyond the “cover stories that cloud our lives and begin to demand …introspective honesty” (18). He suggests that new therapeutic approaches are based on optimistic and forward-looking psychologies of growth and self-expression, that can assist people to come into a new consciousness about themselves and others. “Even more efficiently than police force,” he suggests, “it is distrust of self that makes people vulnerable and obedient” (97). Both Roszak and Profitt are convincing in suggesting that liberation is both a personal and collective aim, a process and an outcome; critical practice, then, may range along on a continuum that embraces both.

Having said that, I acknowledge that this chapter – and indeed the entire thesis - may be criticised by critical practitioners for not adequately acknowledging the potentially oppressive or privileging power of the social environment beyond the immediate social milieu. I accept this criticism while still believing there is much to learn by exploring the web of relations making up the more immediate surroundings
of an individual, which is, of course, always embedded within wider social arrangements and discourse. ‘Community’ itself – as an entity and a concept – can certainly be idealised, with issues to do with individuation, power inequalities, and difference glossed over. This criticism or danger, as Ife (2002, p. 14) points out is an important one, and as he suggests, the notion of community must be “based on more substantial grounds than simply an ideal.” In some respects, all human service organisations (and, for that matter, educational institutions) are communities of sorts that foster certain individual and collective experiences that are more or less liberating.

Communities, like organisations, can maintain and reflect dominant discourses, or challenge them through an attempt to create different more liberating discourses. It seemed that for many participants in this research, the therapeutic community experience, although not without negatives, was largely felt to be beneficial and indeed, in some ways, represented an opportunity to participate in a form of community that, unlike where they had come from, offered the potential for reflection, engagement, companionship, support, safety, and challenge. This generally positive view of the program may also reflect the often-desperate position individuals had found themselves in before coming to the program. In this chapter, as in previous chapters, the voices of participants are positioned alongside material from relevant literature, to explore the (therapeutic) community experience in the context of the program. I start this chapter by looking generally at the significance of the environment to the individual, particularly in relation to entrapping or enabling niches, and then move on to a discussion of the nature of community, and particularly, therapeutic community.

Significance of environment to growth and well-being

The notion that “a healthy social milieu would lead to remission and even recovery” underpinned even the early days of moral treatment based in the asylum (Moos & Burnett, 1996, p.167). However, as medical science advanced, emphasis on individual pathology and treatment came to the fore, and the emphasis on environmentally based treatment declined. The rise of psychoanalysis and other developmental and biological theories consolidated the notion that the roots of psychological disorders lay within the individual, and minimised the significance of
current or past life context. This aligned well with a general sociopolitical trend in Western countries away from collectivism, accompanied by the rise of managerialism and bureaucracy. With the emergence of the anti-psychiatry movement, the therapeutic community gained credibility as a practice model, and the pendulum swung back again to acknowledge the importance of the social milieu, enhanced freedom of expression and a rejection of custodial controls (Moos & Burnett, 1996; Whitely, 1979). Again the pendulum swung, and in the late 1960s, the therapeutic community lost favour, coming to be viewed as a potential threat to the established order of clinical, medical-model mental health services (Kennard, 1998).

Paradoxically, the current emphasis and reliance upon community based mental health services, as governments divest themselves of providing these services in psychiatric institutions, has precipitated a resurgence of residential services in which an environment of some sort is being created; although the word therapeutic may not be used, the service surely would be aiming to develop a holistic health-inducing environment, often described in terms of support or rehabilitation.

Taylor (1997) usefully develops the concept of the “ecological niche” to include the “social niche,” which, he says, can assist in understanding how a person’s immediate environment can be a source of strength as well as disempowerment (p.218). Simply described, a niche, he says, is a space in the environment that can be filled by some object; a social niche is “the environmental habitat of a category of persons, including the resources they utilise and the other categories of persons [sic] they associate with” (p.219). Some social niches are comfortable, Taylor says, others are not; some are ‘chosen,’ while others are imposed. He goes on to make the important distinction between the degree to which any of these social niches are “empowering” or “entrapping” (for example, a chosen niche, whilst reflecting self determination may be quite destructive); he acknowledges, and this is crucial, that many niches will be a dynamic mixture of the two. This ambiguity is reflected in comments made by participants later in this chapter.

Entrapping niches, according to Taylor, generally have certain characteristics in common. They are highly stigmatising (eg ‘crazy,’ ‘on parole,’ ‘on welfare’) and identify individuals solely on the basis of one social role (usually in terms of deficit); they are difficult to escape from, restrict interactions with non-niche dwellers, contain few expectations for personal progress, few incentives to set or work towards long term goals, few opportunities for reflection on one’s interpretations or perceptions,
little chance to learn skills or develop expectations that would facilitate escape, and sparse economic resources (1997, p.221). Going through this list, the characteristics of entrapping niches resonate with the social positions of many structurally oppressed groups.

While community can be a source of strength, solidarity and personal growth or healing, it can also cut people off from wider social niches. Communities serve to create inclusion as well as exclusion. In some senses, the program itself was potentially entrapping: indeed, some residents and former residents commented on the stigmatising nature of living in this particular community/residential program, and their struggles with that. Whilst the community was experienced as supportive, residents also commented that their residency itself was a constant reminder they had “this illness,” making it difficult to “normalise things” because of who the peer group was. One former resident described feeling “different from everyone else, cut off from society” although also acknowledging the program provided safety and opportunities. Another former resident reflected that she had found it very difficult to tolerate the behaviour of some community members whose behaviours at times were particularly ‘in your face,’ and from whom she felt a “a million worlds away”. Eventually she described finding a greater sense of tolerance, but still found it very confronting “to bring your friends over when you’ve got people wandering around the house, absolutely insane... and you’re trying to say, ‘oh, I’m not insane, I’ve just got issues I’m working through!’” Another former resident commented that living in the program had become difficult after he returned to work: however, the disjuncture between his ‘normal’ going-to-work persona and his persona as a resident he acknowledged had actually served a useful purpose in helping him to leave the program. Thus entrapping aspects of a niche, when consciously realised, served as a sign to move on to what was considered a more enabling niche.

Some residents also commented on the ‘unreal’ nature of the program, particularly so, perhaps, for those who missed (and had previously had) a family environment that they were strongly attached to, but where they could no longer live for various reasons. For several residents, this inability to go home, except on weekends or on pre-arranged outings, was experienced as a continual difficulty. A sense of social isolation seemed particularly strong for a number of residents on weekends and in the evenings (non program time when no staff were present). One resident compared the program to being in Dr. Who’s ‘Tardis’ – where a sense of
unreality pervaded, highlighted by a lack of ties to neighbours and the rest of the community, and having an ‘abnormal’ household where there were many adults but no children or dogs. Another resident commented that it was difficult to make such an institutionalised setting homey, and gave the example of having three toilets all together in cubicles, which he found distinctly un-homelike.

Taylor (1997) quotes Dante at the entrance to hell in suggesting that the motto for entrapping niches, might well be “‘Abandon all hope ye who enter here’” (p.221). However, often those who come to occupy these niches are those who are potentially in transition from one niche to another (eg prison to community, nuclear family to some other form, hospital to community, etc) and in need of particular types of support. It is potentially useful for workers and service users to identify that skills developed to survive in entrapping niches often do not work well in other niches, nor do they enhance prospects of escape. As a member of the Melbourne Consumer Consultant Group put it, “I know heaps of people who have stumbled around out there for years and years and years, looking for things they know they need” and never finding them (1997, p.110). Staying with one’s family, they observe, may not be a viable or empowering option either, and may even create a continuing cycle of “being helped into helplessness” (p.83). A critical postmodern analysis would usefully highlight that what is an enabling niche for one person at a particular time in their life, for example a family setting or a therapeutic community, may be entrapping for another at a particular stage of their unique journey.

Enabling niches, in contrast, do not stigmatise people or treat them as outcasts. Rather, they facilitate access to others with different perspectives which might expand the person’s social world. They do not define individuals by a limited ‘social category;’ there are strong expectations of change and personal progress, good reality feedback is provided and there are opportunities to learn skills and develop expectations that will aid movement to other niches. Taylor refers back to the days of Jane Addams and Hull House, and suggests that if social work can “take credit for one major social invention, it would be the planned construction of enabling niches” (1997, p.223). He also describes the emergence of therapeutic communities in the 1960s as an attempt to create such niches, initially within mental hospitals themselves. Within enabling niches, people themselves are acknowledged as key resources; the enabling niche aims to provide opportunities for cooperation, learning, resource sharing, and the important development of what Taylor calls “support pods” (p.225) –
all of which can offer a range of opportunities and experiences to facilitate growth and achievement. The ability to experience “success” within such niches can be a major source of empowerment, increasing an individual’s sense of both personal competence and agency (Sullivan, 1997, p.196).

Like ‘recovery,’ the concept of ‘enabling’ and ‘entrapping niches’ is one all human beings can potentially relate to, having all had experiences of varying degrees of both types of niches, in which we can recognise the qualities listed above and identify their impact on us at that particular point in time. Again, a critical postmodern perspective is useful in acknowledging that niches may be both enabling and entrapping. Working with a client to identify how their social environment(s) may indeed, at times be both enabling and entrapping in various ways, could be useful in validating and relieving some of the disempowering aspects of ambiguity and seeming contradictions of experience.

Zubin (1987) suggests that an individual’s social network is a “protective factor,” potentially capable of supporting a person during periods of vulnerability. In their study of networking amongst young adults who had experienced psychiatric upheaval, Harris and Bergman (1994) observed that the young people in their study often had small, unstable and fragmented social networks, which were generally unable to provide either consistent support or to be called upon in a crisis. Admission to hospital, they suggest, may, at times, despite the associated trauma, be the only way a person in this situation can access a more stable network, if only temporarily. Older friendships with people who don’t know how to react to (or are frightened by) their friends’ illness experience are likely to disappear or be weakened considerably. Relationships with family members – if such relationships existed – may be greatly strained as well. The community setting of a residential program may, apart from anything else, allow a reconnection with others and the beginning of trusting oneself again to communicate and sustain friendships with others, to realise again (or discover for the first time) that it is possible to be liked and accepted.

Moos, along with various co-authors, has also written extensively about the relationship between social context and psychological well-being and change. He looks at a number of different dimensions of programs: relationship dimensions, personal growth dimensions, system maintenance and change functions. He observes that social environments are dynamic entities situated in time and place, and that environments which are relatively supportive and well-organised and which
emphasise personal growth dimensions such as self-direction, self understanding and skills development tend to contribute to individual growth (Moos & Burnett, 1996). The residential rehabilitation model itself is “embedded in the notion that nobody exists in isolation” (RFV Annual Report, 1997-1998, p.17). Moos has also engaged in some interesting exploration of what he calls the power and “evanescence” of environments, that is, “the extent to which individuals’ experiences in one environment influence their mood and behaviour in other current environments and in future environments” (Moos, 1996, p.198). He questions if new contextual factors (i.e. when a person has left one environment and moved on to another) obliterate the effects of the previous environment. He suggests that the significance of environment may be so great that the environment in which individuals find themselves after leaving a (therapeutic) program may actually be more significant to any ‘outcomes’ than the characteristics of the program they’ve left. It is important, he suggests, to identify not only the qualities that characterise powerful environments, but also the personal characteristics of individuals that may make them more less open to environmental influences; an individual must, he observes, be “ripe to undergo maturational change” (p.198).

However, as a number of former and current residents commented in my project, it can be very difficult to know if someone is ready for the program or what effect the transition to an intensive and structured program might draw forth; it is also worth noting that some individuals may need a period of involvement in a program – or even considering involvement - to arrive at that turning point. Thus the environment may variously provide containment, safety and opportunities for growth. The notion of a “therapeutic place to be,” often missing both ‘in the community’ and in the medical model of services – a place which is safe, supportive, challenging and enabling – will now be explored further, first through an exploration of community, then a more specific focus on a consciously created therapeutic community.

Community

At its best, community provides an opportunity for the development of interpersonal relationships, collective exploration of shared and individual issues, the opportunity – perhaps even demand – for participation and responsibility, as well as opportunities for feedback. As well as the protection and opportunities that may be
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provided by communities for personal and collective well-being they may also bring with them challenging experiences and expectations that any of us may fear or wish to avoid at times (for example, around conformity to certain norms, or demands for reciprocity or responsibility). The possibilities latent in a community, as Morgan (1998, p.4) suggests, may be both liberating and frightening. The capacity of a created community to facilitate and enhance opportunities for personal growth and collective well-being will be discussed in the next section of this chapter, when I look specifically at therapeutic communities. This section will look more generally at the notion of community and its relationship to individual well-being and identity.

Pardeck et al. (1994, p.364) provide a useful and deceptively simple definition of community as “a domain where certain assumptions about reality are acknowledged to have validity.” In this light, sensemaking and meaning ascription are considered to be paramount features of community. Ife (1995, pp.90-91) defines community as a “form of social organisation” characterised by five qualities: an interactional scale that is small enough for people to know each other and the structures of the community, a concept of membership which implies some positive sense of belonging and identity, an expectation that members will have some obligations to the community as a whole, where people interact on a number of different levels, and where it is possible to create a unique culture which is valued and produced by community members. All these factors can combine to create a health inducing, enabling (and/or possibly therapeutic) environment. It is interesting to note the somewhat sardonic comment made by a former resident, who said, half-jokingly when talking about the support offered by the community, “I guess when I say community I more specifically mean the residents, rather than those evil interlopers that come in from nine to five!” (IR 5), at which we both laughed, but it did raise an interesting issue, as to who are actually considered to be community members.

Marris (1974, p. 93) talks about what he calls “tribal associations,” which “create boundaries and help define relationships.” He makes the interesting observation that these boundaries and associations do not eliminate experiences of uncertainty or conflict, but that they protect community members from having to “confront confusion as an aspect of their own uncertain identity unmediated by any given sense of where they belong…” (93). Thus communities, embodying a form of ‘tribal association,’ have something to do with identity creation and belonging, which can serve as a form of grounding. These associations, according to Marris, may create
collective identification, and can be invented, particularly when one’s sense of identity is precarious, to “externalise the ambivalence of loss...[to] create a framework in which actions can have meaning although the ambivalence is still unresolved” (97). Indeed this formation of community around loss was acknowledged in the 1997-1998 annual report of the program’s parent organisation, where the sense of community engendered within programs was observed to be “premised upon deep sadness and fear” in terms of the individual experiences that brought community members together (RFV, 1998, p.17). Collective identification can also contribute to an oppressive experience, as individual difference can be subsumed by community norms: in the culture of inquiry that is meant to be the hallmark of a therapeutic community, workers must be mindful of this potential – the line between the well being of the community and the individual – while often not conflictual – can at times be a fine one.

The boundaries that exist or are created around a community are a significant aspect of the environment, and express, as Cohen puts it, a “relational idea” of both similarity and difference (1985, p.12). Within the community are its members who presumably share something in common. The community boundary also serves to separate those inside from those outside, marking them as different from those outside the community. The boundaries of communities, suggests Cohen, are constructed symbolically, in terms of the meanings ascribed to them by individuals. Previous quotes in this chapter highlighted the ambivalent nature of this experience at times for some residents (for example, the separateness of the community might provide a much needed time out, or an additional source of stigma, or both). It is important for critical workers to be aware of this potential for ambiguity and fluctuation, and openly engage with what might appear, in modernist terms, contradictory experiences or interpretations; from a critical postmodern perspective, the impact of binary oppositional thinking would be explored, with the potential to reconstruct meaning in ways that acknowledge the capacity of environments to be both entrapping and enabling.

Psychologist Jerome Bruner in his book *Acts of Meaning* (1990) looks at connections between culture and community; cultures, he says, act as “symbolic systems” that construct meaning and provide a framework from which to interpret reality. Community, Cohen (1985) says, is the place where one learns and practices how to be social; the commonality found in community, according to Cohen, does not
necessarily mean uniformity – indeed “the triumph of community is to so contain…variety that its inherent discordance does not subvert the apparent coherence which is expressed by its boundaries” (p.20). Ideally, community may be seen as a dynamic process of inquiry rather than “the result of inquiry,” according to Tinder; the evolution of community, presumably, lies …in the very process of searching for the truth” (1980, p.31). Although I would change ‘the truth’ to ‘truths,’ the interesting suggestion here is that ‘community’ can almost be conceptualised as a verb, rather than a noun, highlighting community as a dynamic process rather than a fixed and static outcome.

In this construction, contrary to some views that collectivism necessitates conformity, the individual does not need to be ‘sacrificed’ in the interests of community. Tinder (1980) suggests that while it is often assumed that individuality and freedom are incompatible with community, “no one desires, or can realise, individuality and freedom in isolation. One achieves selfhood,” he goes on, “only for, and in the presence of others…communal activities…make selfhood and freedom real through communication”(p.34). It could be asked if personal identity is something that even exists prior to the experience of inter-relationship. Bruner also highlights the fundamental role of community in the creation of individual identity, concluding that “…selves are not isolated nuclei of consciousness locked in the head, but are distributed interpersonally…”(1990, p.138).

Open discussions amongst community members (and here I am including the staff) around conformity and dissent and the balance between individual and community rights are useful, from a critical perspective, as program staff and residents, to make this tension more transparent and open to dialogue. At times, when I worked in the program, staff did have certain rules that were non-negotiable, and considered vital for community safety, for example around alcohol being consumed on the premises. Residents knew, when they entered the program that no alcohol was allowed, and agreed to this protocol in entering the program. However, from time to time the policy would be questioned. Spirited debate would often come back to the core issue of balancing individual freedom and community well being and safety.

White discusses the complex inter-relationship between community/environment and individual identity in terms relative to his narrative theory, saying “if the stories that we have about lives are negotiated and distributed within communities of persons, then it makes a great deal of sense to engage
communities of persons in the renegotiation of identity” (1995, p.26). According to White, other individuals who are actors in the world of any individual can play a part in authenticating and valuing “preferred identity claims” which may be emerging as the person attempts to reconstruct their life and self-image in more empowering terms (ibid). Being on the receiving end of feedback in the process of (re)constructing identity was experienced differently by different residents, at different times. One staff member commented that being in the program community was often the first time an individual had received so much feedback as it was consciously encouraged and facilitated in the therapeutic community model; feedback from the community, she commented, had the capacity to “explode one’s myths about oneself” (myths ranging from believing oneself to be unlovable, to being a chronically ‘sick’ person incapable of getting better). Some people, she observed, remained frightened of giving or receiving feedback throughout their stay in the program (UR 21). The capacity to both give and receive feedback may be, to some extent, a learned skill; people may need some guidance and structured, facilitated opportunities for dialogue in order to make it a productive, non-damaging experience. Critical reflection on practice might enable workers to examine this further, not only in their expectations of service users, but also in relation to their own abilities, as workers may also find it difficult to give constructive feedback or to receive it themselves. (This can be theorised in many ways, for both workers and clients, ranging from experiences of having been silenced as a child, to gender role socialisation, to wishes to be ‘liked’ at all costs).

One resident commented that while she had been initially frightened of receiving feedback from other residents (believing it would all be negative), she was learning to take feedback on board and to critically examine its usefulness. The same resident commented that groups in the program were facilitated in ways that felt safe and promoted trust in oneself, enabling her to look at some of her own material.

“Living with fourteen other people, you have to look at things.” For her, she said, “it took confrontation to say, ‘hey, you better have a look at this’, and everyone was doing it [opening themselves up to feedback]…” (AG 12). Another former resident reflected that learning to be assertive in the program groups became a transferable skill, which gradually enabled her to respond more assertively to situations outside the program setting (OS 16).
One former resident, who had been a relatively quiet member of the community, made the following, quite profound, statement: “…if you’re ever in a mental illness state, to get out of it you need to relate to people. And people help you – they show you a mirror of who you are. Even if it’s a painful one…. The program can’t offer any miracles, but it can give you a way of finding yourself… a foothold, where you know where you are, what you think… and that’s a starting point for finding out other things, like what you’re good at ... To converse and to get out of your own problems... to try and find a way out, like light through a tunnel – to see hope, and that their lives are meaningful and they have something to live for…” (YK 19).

Community may, in some respects, be more symbolic than structural in nature, and individual members of a community are, potentially, able to impute their own meanings on it: ideally, all can “express their co-membership of the ‘same’ community, yet assimilate it to the idiosyncrasies of their own experiences and personalities” (Cohen, 1985, p.74). Each community member, Cohen suggests, will have a “unique orientation” to the community. Community then exists, in this vein of theorising, in the minds of its members, providing “a medium for the expression of very diverse interests and aspirations” (ibid, p.108). This is a very liberating notion of community indeed and one, which resonates with postmodern thinking, validating a dynamic range of subjectivities and truths. It is, to some extent, an idealised notion of community, which needs to be held in conscious awareness and carefully tended. As one former staff member put it, in relation to the program, “the frame of reference will be different for each individual... it will be whatever [name of program] meant to them” (ME). I have certainly observed this to be true: indeed it seemed that the meanings attached to the program/community I worked in varied from oppressor, to liberator, to everything in between – sometimes by the same person over time (or even in one day).

While the possibility to ascribe individual meaning to the community experience is certainly relevant, at the same time, it must be noted that unequal power relationships within a community (for example between staff members, between staff and residents, or between residents), may limit possibilities for challenging dominant discourses. One resident commented that she felt the word ‘community’ could be used to whitewash underlying issues and suggested that, despite efforts to involve residents in decision making, the “staff really do pull the strings” (AK 23). Abbey (1996/7,
also cautions that the language of community can obscure power relationships within the community. She goes on to argue that assuming a shared reality may render invisible the different experiences of some community members. One staff member acknowledged that in the program, ‘community’ might, in some ways, be more of a “staff word,” and somewhat idealised, whereas for residents ‘community’ may be more of a “fragmented experience” (EC 23). At times, staff members, particularly in the new program – after its restructure and staff turnover – mused that there might be too much emphasis on ‘the community,’ contending that separating out the individual person and their goals was more important: as one staff member suggested, “the community needs to be able to adapt to the needs of all these individuals... in achieving their own goals” (ID 32). However, it is possible that the ‘individual’ and the ‘community’ can be overly dichotomised: engagement with community processes can potentially enable an individual to move closer to their goals. An acknowledgement of interdependence may be useful, as human beings are necessarily intertwined with others and dependent in various ways (see Ife, 2002, p.224).

Having explored some of the various constructions of community in general, the next section looks specifically at therapeutic communities, as consciously created community mental health services, relying again on theory-stories from participants and relevant literature.

**Therapeutic community**

Therapeutic community is a purposefully created community in which the community itself, and the interactions and processes within it, are considered to be the primary therapeutic or growth-generating tool. Like the concept of recovery, which implies movement and the possibility of change, the transitional nature of the therapeutic community suggests movement is possible and indeed anticipated. The aim is to create the type of environment described by Deegan (1988) in which recovery is nurtured, where hope is consciously built into the program and where clear messages are conveyed about the individual’s value and uniqueness (Kruzich 1985), all of which have been described as key aspects of a recovery-oriented environment. The primary task of the program is described thus: “…to provide a safe and supportively challenging environment within which individuals can develop social and other independent living skills and raise the quality of their life through a process of personal growth, self-management, interactions with others in the house...
and involvement in the wider community” (RFV Service Profile, 1998). The program approach is described as one that “…combines structure with time for residents to develop their individualised goals. The foundation stones of the program include safety, developing a sense of connectedness through community, support continuity, structure, work and commitment” (ibid).

As briefly mentioned in the introduction to this chapter, the therapeutic community as a service delivery model has a history that stems from its beginnings in the U.K. in the early 1960s. The therapeutic community challenged existing models of psychiatric hospitalisation and rehabilitation that were considered oppressive, objectifying and disempowering. The therapeutic community movement aimed to provide services that functioned on a number of levels: as the location of a therapeutic process, as a setting in which people lived and worked, as a containing and supportive environment, as training for life, and as a space for re-planning one’s life (Caltagirone & Smargiassi, 1997, p.167). This was meant to be achieved through a characteristic structure and weekly timetable, as well as particular expectations of the behaviour of staff and residents (Millard & Oakley, 1994, p.321). Residents, as community members, were considered active agents in their own process and development.

Residential programs today – some of which may be direct descendents of a therapeutic community origin – may resemble to greater or lesser degrees ‘purer’ notions of therapeutic community; indeed, politically, programs modelled on the lines of therapeutic communities may not wish to use that descriptor, as other labels, such as psychiatric disability support services have become more politically acceptable and embrace a more eclectic range of program types. Program ideology may also fluctuate, depending on the theoretical orientation of the staff group at any given time - particularly the program manager, who as well as drawing on a range of possible theoretical orientations is also accountable to policy-making and funding bodies. My view is that the program under discussion has gone through periods of more or less strong grounding in a therapeutic community model, largely due to the program manager and staff team orientations. I would also argue that any community (group of people with shared experiences within a common boundary with some sense of common aims) that is purposefully created to be supportive and developmental is a ‘therapeutic community’ of some sort, despite the political incorrectness of the language. Any residential support service will have some underlying notion that there is something potentially therapeutic about people living together, and will have (to a
more or less conscious degree) some way of organising the setting based on theoretical principles. As Schimmel puts it: complex interpersonal and community processes occur in all residential treatment facilities, influencing the outcome of treatment in positive or negative ways,” however the therapeutic community, he says, is one of the few places to *acknowledge and actually analyse these processes* and to consider them a primary medium of work with clients (1997, 121).

Indeed, in its theoretical development and practice, the therapeutic community aimed specifically to create a culture of enquiry (Norton, 1992) for both workers and service users. While therapeutic communities may have lost political favour for a time, as Kennard (1998) puts it, “they’re back,” being re-discovered by community based organisations and being used effectively in many diverse settings. In Victoria, while ‘therapeutic community’ is not necessarily a term used often in the current political and ideological climate, it actually resembles very closely what recent governmental reports recommend community mental health services be like, and indeed, the program’s parent organisation, once an international vanguard of the anti-psychiatry movement, is now, in Victoria, the largest provider of psychiatric disability support services in the state.

The role of staff in a therapeutic community is challenging: conflict and emotional struggle are considered a normal part of the process for individuals within the community setting. As Campling writes, community members *need* to actively struggle – “not just conform to rules, in order to really change in a lasting way” (1995, p.94). Emotional struggles are considered to be part and parcel of the therapeutic community experience, which may be quite different to mainstream constructions of anxiety and conflict as something to be avoided or controlled. Here it is interesting to return to Marris' discussion around “tribal associations” in which he suggests that such conflicts can be seen as the “working out of grief” which is necessary in recovery from loss. Conflict, he says, can represent the “the desire for things to be as they once were, but the knowledge that they cannot…” (p.100). It takes skill for staff in a therapeutic community to constructively handle conflicts that arise, to avoid seeking premature or ineffective resolution through action or retreat (Norton, 1992). Within a therapeutic community, workers have a particular way of interacting with residents that combines both the functions of support (or ‘therapeutic’ interactions) on one hand, and management of the program on the other. This can cause some difficulties, which have already been alluded to. One experienced staff member
identified the two main roles of staff as that of authority/management, and that of therapy/support, saying “this is often where the role conflict occurs for the staff team, and also with the residents. I don’t think the two [roles] are divorced, because the managerial function…has its therapeutic effects… But when you’re actually using authority… when, for example, someone’s not attending the group or is starting to withdraw from involvement in the program, it can prohibit the client speaking… It can actually prohibit a space to talk, because of your action in the role of using authority. For example, drinking alcohol [not allowed on the premises] …not to forget that there is actually a psychic significance of the subjective experience of the client that needs to be supported, even though I might need at that time to look at saying, ‘no, you cannot do this’… How can I continue to offer a space where something that can be talked about? (EG 118). Workers in a therapeutic community attempt to work alongside residents, jointly engaging in activities and actively facilitating community processes. So, how is the work of a therapeutic community, engaged in by residents and facilitated by staff, conceptualised, enacted and experienced in the specific program setting?

**Unravelling the therapeutic nature of community**

Strong theoretical underpinnings ground the therapeutic work of a community; according to Bloor et al. (1988), at its core, the work of a therapeutic community is *redefinitional* – “the transformation of mundane events in the light of some paradigm of therapy” (p.196). Within the therapeutic community, mundane events of living - such as shopping, cooking, cleaning house, and maintaining the garden – which are valuable in themselves, also provide an opportunity to go deeper into one’s experience of those activities, particularly if they involve other people. Although he uses words and phrases which may be alienating to some (for example, suggesting that healing environments represent the “joining of heaven and earth”), I return again to Podvoll’s (1990) work and his suggestion that such programs/settings work “from the outside in,” where the activities of “creating and tending a homesite…are unique in their ability to shift one’s allegiance to sanity…[providing] the opportunity for work, relaxation, friendship and art…a microcosm of human action, which can become a healing circle…” (p.297). The attitudes of staff and the maintenance of a household, he says, have a way of “…relaxing one’s personal territory,” and allowing one to “open up to experience of others…” (p.309). Although the goal of independence - as constructed in modernist and economic rationalist terms as the ‘up’
side of the independence/dependence dichotomy - is often touted as the most worthwhile goal for adult individuals, perhaps the goal of healthy interdependence is actually more realistic and even beneficial for all human beings.

Indeed, modernist binary oppositional constructions of dependence versus independence may not always be helpful as they tend to deny context, history and process, and suggest that one binary opposite is preferential to the other without acknowledging context and ideology, and the many and often unacknowledged spaces we all occupy along the dependency continuum. Norton, who has written extensively about therapeutic communities, suggests that the individual community member achieves internal progress and growth through the experience of affecting and influencing other community members, and tolerating contradictory thoughts and feelings towards others (1992). Beitchman, a contemporary proponent of therapeutic communities as he has observed their effectiveness, suggests that participation “in a therapeutic group life…[actually] allows for [independence]to develop in a positive way” (1995, p.57) (my italics). He also suggests that the feeling of belonging engendered by active participation in community life and involvement with others is a cornerstone of individual growth.

Millard and Oakley (1994) observe that, rather than imposing meaning on service users, therapeutic communities aim to provide a setting where people are able to “experience and behave,” then to reflect on and examine these matters with others (workers and other residents) while being encouraged to try new more satisfying ways of being (from a narrative perspective, ‘re-storying’), with subsequent community reinforcement and feedback. Programs or environments that are oriented toward recovery need to acknowledge and be structured in ways that, as Deegan says, allow people to fail, try, fail and try again. It could be argued that any healthy environment, whether it is a university, human service agency, or artists’ workshop, will acknowledge ongoing learning and growth, ‘set-backs’ and ‘progress,’ as part of a dynamic state of well-being.

One former staff member commented on the program’s capacity to ‘allow’ people to make mistakes. She spoke of one former resident who had been asked several times to leave the program for a temporary period, due to not following the program guidelines around safety, or drug and alcohol use. Although his behaviour was not always accepted, “we always said we’ll have you back… you can come back. And there was never any question about that. And he might have had to face a
community meeting where he had to talk about [what he’d done and how it had affected people] but there was never any question that he was still accepted… every time he came back he was so shocked that we were allowing him to come back… because too many people… in his life had just said, ‘oh, we give up, we can’t deal with this any more’… I think we allowed his process to be played out, as he needed it to be. And he couldn’t then turn around and say, ‘oh, you kicked me out, so I hate you,’ and focus on that. … But because we were allowing him back and saying we’re still here, he faced the actual material, what was his material that he was dealing with…” (ME 7).

It is useful to deconstruct ways in which a client’s ‘failures’ are interpreted and responded to – whether by a worker, a service, or a bureaucracy - as to some extent it reveals the (perhaps unconscious) meaning systems that underpin professional or organisational understandings and actions, and possibly reveals more empowering interpretations and responses. Are ‘failures’ a necessary part of the healing journey - our own and clients - or a sad reflection on one’s own capabilities? Just as workers’ sense of hopefulness may be communicated to service users, so might their sense of what it means to ‘fail,’ and indeed what actually constitutes a ‘failure.’ Communities may reinforce particular meanings around failure and success; for communities that consider themselves to be therapeutic it could be very useful to engage in critical reflection on how they construct and convey – consciously or unconsciously – the meaning of ‘failure’ and ‘mistakes’.

Edward Podvoll, whose book The Seduction of Madness is probably one of the best texts I have read about the experience of psychosis itself and the role of a supportive environment in a person’s recovery process, states clearly that recovery “can only take place within the context of a sane environment” (1990, p.126). Thus practitioners must ask, what might a sane environment look or feel like? What is often considered to be one of the cornerstones of society, and hence, one could argue, a particularly sane environment is the family home, or the school, which, unfortunately for many does not provide a safe, affirming or nurturing space. According to Podvoll (1990), a sane environment is one of compassion and appreciation that permits the unfolding of the person through various stages of transformation. Indeed, for many residents, the program was an environment where they experienced compassion, friendship, empathy and appreciation; for some this seemed deeply meaningful. One resident described how the shame and fear of having
had a psychiatric episode and being hospitalised was something she profoundly needed to process, in order to move forward. She didn’t think she would have been able to do this, if she hadn’t been surrounded by people in the program who had had similar experiences to herself and with whom she was bonding. Otherwise, she said, the illness experience would have remained “locked off inside me”; in the program she was gradually able to articulate what was going on inside herself because she felt the environment was a trusting one, in which others were also sharing their experiences (AK12).

The Melbourne Consumer Consultant Group (MCCG) (1997, p.65) also suggest that debriefing from the trauma of hospitalisation is critical to recovery, likening the hospital experience and its aftermath to post traumatic stress that can be “carried around” by the individual for a very long time if sufficient opportunities to debrief about the experience are not available. Sorting through some of the “terrible memories that are hidden by drugs,” they suggest, is a necessary part of recovery, particularly as a person withdraws gradually from medication and faces the core issues that remain. To facilitate this process, the MCCG suggests, real normal two-way conversation” in the context of a trusting relationship can be pivotal – something, they observe, that rarely occurs between service users and mental health staff. Being able to “use the resource of another person, to get you through the day or night” (GEM 13), “having others accept and appreciate you, and listen to you” (TI 14), experiencing the “empathy of others” (IR) and being able to be “honest” – not hide her real feelings – “and be accepted by others” (OS 16) were described as significant and positive experiences for residents.

One resident described how, initially, when he got ill, he thought he was the only person in the world to have felt like he did – he felt totally different to everyone else; at the program he realised there were others with emotional issues, and that they were working hard on those issues (IV 15). Learning that it was okay to be around other people, and to even need other people, was important for several residents. When she first came to the program, one resident described being very dependent, not having anything outside, having to be around people all the time, unable to spend any time alone. “I really needed a sense of community, after being alone for such a long time, yet always having a secret love for people” (AS 42). She went on to reflect that now she saw that some need is actually healthy, and that having friends to talk to, to be supportive and to be vulnerable with, was allowing her to be more her “true self”
We need each other, that’s what I’ve found... that’s what life is about – relationships”.

Another resident had discovered that she too, enjoyed the company of others, and that making friends and doing things together, such as going camping, was an important part of her recovery process (AG 11).

Perhaps a feature of a sane environment is that it is a place where people can discover “that they live in a community…not just in their head” (Millard & Oakley, 1994, p.315), where the simple act of participation in a community activity can, for some persons at particular times in their lives, have a profound effect. Several residents commented on the difficulty they experienced, initially, being around so many people, even though one of their reasons for coming to the program was a realisation that they needed to change a pattern of isolation. One resident spoke of how he had lived alone for the past several years, sleeping most of the time, with low self esteem and unable to cope in social situations (DA 9). Another former resident reflected on how, although coming to the program had been personally very challenging, the process of being in the community had helped him to let go of some of the “unhelpful, excessive introspection” he had been caught up in, to allow him to ‘get out of his head’ (IR 14). He too had discovered his “paradoxical need for companionship”. Another former resident commented, that, although she too was unhappy about coming to the program, simply being able to sit around and “have people walk in and out of the room” had been a breakthrough in her capacity to be with others (NA16). Other residents also commented on the usefulness of having structures in place that made them get out of their own heads and relate to others: “sometimes I had to force myself to be with others, but I knew if withdrew to my room, my room would become my world,” resulting in a familiar downwards spiral (OS 17). Another resident reflected that when she first came to program, she was “so much in my own land,” – one of her most valuable experiences in her two years at the program was learning to trust and relate to people again (LC 42).

One former resident commented that just being a different place and meeting new people almost immediately made him more awake, after living with his parents with their established patterns of (non) communication (despite lots of love). After leaving the program, he continued to come back to community meal, because even though he could “afford to go to a restaurant, if I go to a restaurant I don’t talk to anyone... so I would go there [community meal] for group therapy... I could sit there
Chapter 6  Therapeutic community

and read the newspaper with other people... listen to music and smoke cigarettes” (REG 18).

The ‘classic’ therapeutic community was based on the belief that individual issues inevitably surface and are expressed in interpersonal relationships (Schimmel, 1997). As described previously in this chapter by a former resident, Pachaly (1997) observes how the “internal reality of a person can mirror itself in the outer reality of a group or a therapeutic community and thereby can be recognised, understood and integrated” (p.27). Indeed the therapeutic community has the potential to provide this opportunity; as Kennard suggests it provides the “best setting bar none for the aspect of therapy that goes on between sessions…Whatever the explanatory concepts offered to residents in a therapeutic community…it is the next jointly prepared meal or evening social that will put them to the test” (1998, p.328). These words are extremely important. They highlight how it is the engagement in everyday activities and experiences, with the opportunity to reflect on them in a supported and safe environment, and try new possibilities, that makes the therapeutic community stand out as a modality of worth and effectiveness.

Indeed in the recent report commissioned by the Commonwealth Government (Jablensky et al., 1999) as part of the National Survey of Mental Health and Wellbeing, it was strongly suggested that the community (and by this, thankfully, they acknowledged not just an idealised open-armed generalised community, but community-based programs, therapeutic housing and support services) may well be an antidote to isolation, and as such, vital to recovery or greater well-being. Again, we are reminded of the entrapping or enabling niches spoken of by Taylor (1997) and Sullivan (1997). There were many comments by program participants – staff and residents – to illustrate and affirm the therapeutic nature of engagement in and reflection upon ordinary everyday activities within a lived and immediate community experience. Some staff suggested that living with other people and having to relate to them was the most essential part of the work, despite (or perhaps, at times, because of) the difficulties inherent in community life. One worker put it this way: “...the tensions that arise are inevitable... it’s the experience of those tensions where the most growth occurs, as it’s in a space where there is the opportunity to reflect on those experiences. A lot of the work for staff is facilitating residents’ reflection on their own part in creating community tensions – owning their own stuff, to explore projections and blockages – whilst treading the fine line as a worker not to be too
invasive and acknowledging the need for some defences.” Conflict, he suggested, was part of building community – a vehicle for clients increasing capacity to communicate, to be flexible and to see oneself as separate as well as connected (OR 19,20).

Another staff member contrasted the community experience with other forms of ‘counselling’ or therapy: “It’s easy for people to front up to a counsellor’s office once a week and not really change much, whereas here, there is the power of peers and of group process” (AC 21). Residents commented that having to do shopping and other household tasks forces you to go out and “not hide away” (IV 24), and that when issues like washing dishes came up, staff encouraged residents to look more deeply at their underlying issues and how issues could be worked out productively through dialogue (AG 9). Within the community, one staff member commented, some residents felt valued and important in keeping the community running, while others felt marginal and inconsequential: either way, she said, observing how an individual felt in relation to the community was a “huge observable clue” about how they managed themselves in relation to other people – “their contact style, which staff can work with in the community setting and give support in situations where they know the person has difficulty” (EC 21). This provided opportunities for challenge and support not readily available in more conventional settings.

Working on interpersonal relationships within the community setting was an aspect of the program that was commented upon by residents, former residents and staff. One resident commented that “dealing with stuff that comes up between people” had always been problematic for her; living in a community, she said, you have to deal with it because you’re living and working together. She felt she was learning about openness, and learning to communicate, within a structure that creates “forums to communicate” but within which “the socialising comes from us [residents]” (AG 12). She also commented on the importance of having people still willing to talk to you, “even when you’ve blown it.”

The role of staff in facilitating a safe environment in which to deal with interpersonal issues was also acknowledged by residents and former residents: one resident commented that she was grateful to be living in a community where resolving difficult issues between people as facilitated by staff (AS 9). One former resident observed that by learning to bring things up in a community meeting, a step was taken “on the way to having self confidence to bring things up with people” on a one to one
basis without facilitation (OS 9). Reflecting on his experience in the program, after over a year, one former resident suggested that to be more effective in communication is probably the thing most people suffering with mental illness want most, “unless you’re going to be a hermit”...learning to communicate again, he felt, had been a significant stepping stone in meeting his goal of returning to university (IR 15).

Regardless of the content of formal groups in the program, one former resident suggested that it was the group process that was vital for the creation of community, and that the staff were vital in facilitating this (RDNA 17). If people found it difficult to speak in groups initially, one former resident recalled, “usually with those people, the more they got to say their piece, the more they tended, generally, to open up” (UM 18). Another former resident put this interesting spin on the issue: “It’s good practice to learn how to discuss and be conversant... before that, my parents would get angry at me for not talking, but there would be nothing for me to really talk about, because I didn’t do anything that I thought was of any value. And now, I see a lot of things of value... ” (YK 18).

In Irving Yalom’s fascinating and entertaining novel, Lying on the Couch, one of the characters – a psychiatrist – comments “Sometimes I see a patient in individual therapy for years and then put him in a therapy group and I’m astonished at what I see. Is this the same person? All those parts of himself he hadn’t shown me!” (1996, p.213). (With varying implications, the same holds true for clients seeing staff in various settings where they may be seen in a different light, engaging in ‘normal life functions’ particularly when away on camp.) The high degree of face-to-face contact amongst members which is part of life in a therapeutic community is based on principles of group psychotherapy, where all relationships, interactions and activities are potentially grist for the therapeutic mill. The intensive and long-term nature of the program (i.e. two years is a suggested time period for a resident to be in the program) is based on the notion that time is required for the healing process (Langsley, Hodes & Grimson, 1993).

People enter the therapeutic community (or residential psychiatric disability support service) for various reasons; however, for most residents, there is some element of choice in entering the program, based on some notion that life at the moment isn’t working for them, that the program may offer some help, and with some idea of the principles and commitments which underlie the program and the expectations placed on residents. Elly Jansen (1980, p.24), founder of the Richmond
Fellowship, observes that the principles upon which a therapeutic community is based, are somewhat paradoxical: part of “either the charm or the exasperation of the work…”. She describes the principles thus:

- “entering the community is in fact “an agreement to join after the fullest possible exploration of the issues
- for an agreed purpose which is shared by the other members
- the purpose being to obtain help with psychological difficulties
- within structures especially designed to illuminate personal problems, by involving people directly in community living and encouraging face to face encounter” (p.24)

She describes the key aspect of the therapeutic community as dependence gradually leading towards greater independence, opportunities for reality testing, reorientation away from a sick role, opportunities for the testing various ways of being and engaging with others, and engagement with group issues, all of which are compatible with critical practice, if carried out in a critically reflective way.

The transitional nature of the program implies that residents may go through a series of phases: after settling in (which can take several months) residents are encouraged (indeed expected) to gradually engage more fully with community activities, develop and work towards goals, and finally, gradually disengage from the program. In the period of disengagement, and indeed before it, residents are encouraged to gradually establish links in the wider community. Strauss (1989) refers to the concept of ‘mountain climbing,’ to describe using a foothold in one life context to provide support while taking another step out into another context: this is a key aim of the therapeutic community, although one which may be interpreted and engaged with quite differently, according to the sensemaking framework of staff.

Experiences of the community as a stepping stone were commented upon, unprompted, by several participants. One former resident commented that often when a person comes to a community like that of the program, they had lost any community they had been connected to previously, if they had one. Hence “you need to re-connect... an important step that then allows other things to happen” (RDNA 17). A staff member stated that the notion of community was the “absolute fundamental” basic philosophical underpinning of the program. He saw the community as vital to the re-establishment of social ties after the rupture experienced as a result of psychosis: this, he said, was a symbolic rupture which led to the erosion of social ties.
with family and friends, making a new formation of community and kinship essential. The program community, he said, provided a re-establishment with others, which in turn allowed a linking back into society – “that’s what its continuing effect is, when someone leaves, that this place ends up being somehow... a symbolic rejoining back into a life with others” (EG 22).

The structure of the community, if effective, enables the daily life of the household to proceed in an orderly and predictable fashion, which provides stability, opportunity and support. (A typical weekly program, from the time when I worked and continuing through to the beginning of my research project is attached in Appendix A.) All therapeutic communities are somewhat different, but in practice, have a number of common features, in that they rely on an informal and communal atmosphere where group meetings assume a central position, the work of maintaining and running the community is shared, residents are recognised as “auxiliary therapists” and a staff and residents share, to greater or lesser degree, authority for decision making (Kennard, 1983).

It has been observed that it is quite difficult to pinpoint which elements of a therapeutic community are the most effective for residents. Indeed residents and staff both commented on this, when asked. One resident, after some two years in the program said that she could not deny that the communal aspect had something beneficial for her – something healing which was difficult to pin down. She mused that things could be happening that was not consciously aware of at the time, and that one needed to be patient (LC 13). A former resident who described his stay in the program as very productive, found it difficult to identify precisely what aspects of the program were most helpful, saying “…I think its more the idea of a program that I found of primary importance, than the actual individual pieces of it. I think I would say that while I did find them useful, it was the general idea of some kind of structure that wasn’t too restrictive but did provide a framework...being forced into situations where you have to sit around and communicate with other people – that was probably an important thing...its more a macro thing than a micro thing that I found useful...I wouldn’t describe any individual group or idea or reason for that group, as being the guiding force. It was more general, more higher level stuff” (IR 3).

Almond commented that indeed it was “the process, not the specifics, that are the essence of healing community” (1974. p.xiii). Perhaps this difficulty in pinpointing change-inducing components is one of the reasons why, as Manning
suggested in the 1970s, the efficacy of the therapeutic community has been difficult to quantify: as he said, “the knowledge that some unknown thing is effective is not very useful” (1979, p.304) particularly to twenty-first century funding bodies. Pachaly (1997) also suggests that it is the whole process combined, including the group living together as “co-fellows” and the “continuous discussion and fight for values and emotional struggle within relationships…” that together contribute to a holistic experience (p.37). Indeed, it must be recognised that this is a challenging process: even while recognising the importance of re-connection after the isolating and traumatising experience of psychosis or emotional upheaval, it can be an extremely demanding and painful process to reconnect. Despite an awareness of the need for change, as we all know from our own experiences, it can be difficult to actually abandon what is familiar and risk something new. “Motivation-hygiene theory” (a terrible name which has hopefully been discarded) divides need into two categories: pain avoidance needs and growth needs. The energy it takes to satisfy pain-avoidance needs may, at times, sap us of the energy required to fulfil growth needs (Earls & Nelson, 1988, p.280).

Miller (1990), who writes about mental illness as a form of spiritual crisis, suggests that once someone has “travelled into the depths of their psyche, they [may] have difficulty coming back” (p.40). She observes that some people may desperately need the opportunity to tell their stories, to put their experiences into words, before moving forward. Like participants’ comments presented previously in this chapter, members of the Melbourne Consumer Consultant Group (1997) also recount experiences of coming out of hospital and really wanting to talk, but feeling isolated and disempowered, with no healing opportunity to talk about their experiences. One former resident commented on the support offered by the community due to shared experiences: “It can be very alienating to be living out in society with people that have very little experience of mental illness. It can. I found it quite useful [in the program] to have that avenue of empathy...the different perspectives, just seeing the different ways different people have dealt with it...I found that very useful” (IR 5).

Integrating the illness experience into an ongoing narrative of their life was a crucial point raised by a number of participants. “I got sick at 21, and now I’m going on 32, and this was my fourth hospitalisation... accepting that is really hard... I want to talk about that in my IPPs [individual counselling sessions with keyworker] (AG 70). Another resident commented that coming to terms with her illness had been part
of her reason to come to the program – “I knew nothing about mental illness... people need time to talk... about how they felt about becoming unwell... with someone whose really good at listening” (RAM 70). One staff member commented that part of the work of staff was to help residents normalise some aspects of their experience: “once the person has a particular set of labels... they really start to fit everything into it,” including relationship issues and other developmental experiences (EC 70).

The therapeutic community offers many opportunities for sharing experiences: with key workers in a one to one setting, as well as in groups of varying sizes and purposes, and in informal conversation. Skilful facilitation by workers can assist in the creation of a safe space for the telling, and sometimes accompanying the person through the experience. It is also very important for workers to know when to encourage and when to step back: sensing, as one resident put it, “what they feel is enough for them... if they feel it’s important to go on a bit more. If they think it’s worth it. If they're comfortable and liking it at the stage they are, or if they like to go further ahead” (TI 1/7). The sharing of experiences and reflections can also be a source of wisdom and inspiration for community members - staff and service users - which can then lead to new possibilities for action (Dulwich Centre, 1997, p.13). One project team member from the Power to our Journeys group at the Dulwich Centre put it this way: “Community building and linking, telling and re-telling [of stories] is a powerfully creative activity in the formation of lives” (p.13). The group also acknowledges the significance of community where a recovering individual’s new and preferred stories of healthy identify can be reinforced, validated and acknowledged by others in the community, as well as providing an opportunity to reach out to others after isolation in one’s own world, and to speak with other project/community members rather than burdening family and friends with sometimes painful or difficult experiences.

Indeed, the gradual awakening of “compassionate urges” – caring for and about others – may be an important step towards greater wellness; as Podvoll puts it, “if ever there is an antidote to madness, it is here, in an opening out,” after the deep feeling of isolation and “woundedness” which may be experienced after psychosis or psychiatric upheaval (1990, p.145). One former resident described his experience of feeling like he was inside an eggshell, and gradually, through involvement with others, felt he was beginning to break out (IV). Another resident observed that through trying to help others, he was getting a better sense of himself, beginning to
feel he had something to give, including empathy to others (DA 12). Feeling needed and feeling part of something was important to a developing sense of self confidence (RAM 13). “Often… I’d sit and just listen, because I’d have nothing say… And that’s the problem – I didn’t have any feelings, about anything. And so I’d get involved in other peoples’ things, by listening and that would help me to think I was part of something. That I was interested in something, and I wasn’t just doing nothing” (YK 19).

Deegan also acknowledges the power of the presence of others when “despair can be challenged through example… where hope is contagious” (1988, p.18). The encouragement and validation of others’ stories, struggles and achievements is a social and political act, as well as potentially empowering for the individual teller and those around them. It challenges the modernist/medical model discourse of who is allowed to speak and create knowledge (although the assumption and enactment of ‘giving validation’ itself must be acknowledged as a form of power – the power to include and legitimate). One of the potential values of the community experience, then, is that community members become, as Almond puts it, active participants “in the charismatic flow…” (Social workers may baulk at Almond’s terminology – a response worthy of critical reflection in itself; however ‘participation in the charismatic flow’ could be rephrased in more familiar terms such as those used in community development around skill sharing and mutual empowerment.) This may include things like confronting each other in ways that are tolerable and potentially constructive, accepting feedback, negotiating tasks and responsibilities, acknowledging one’s impact on others, or turning up to meetings where attendance is expected.

As attention is diverted from inner turmoil to active participation in the community, new strength arises for dealing with the “inner side of … crisis” (Almond, 1974, p.148). Thus, residents not only assist each other by taking on healing or support roles, but also help themselves. The expectation that they will do this is actually built into the principles and structure of the program, so that “almost every interaction … conveys … that he [sic] is expected to be competent and to be a therapist to himself and others” (147). At the same time, it is precisely this willingness to share healing charisma (or professional expertise, or the power to know something) that professionals may sometimes find difficult. Indeed, it may be that in certain (or even many) contexts or situations some individuals – due to their role,
maturity, resources or knowledge base – are more able to proffer assistance or support than others. However, critical approaches suggest that the assumptions, values and biases that underpin the taken-for-grantedness of this ownership of expertise are worthy of analysis. Just as workers may sometimes have expertise to offer to managers, or siblings may more effectively reach each other than parents, or students may know more than their teachers, hierarchical social roles are always limited and do not embody whole persons or what they have to offer to any situation.

This flow of healing charisma, according to Almond, “draws upon the latent presence in the individual of an experience of himself [sic] as effective, worthy and good” which may have been experienced in an archetypal or unconscious way, or have occurred at various stages in the person’s life. Becoming an active part of the community, from this perspective evokes “powerful, partly preverbal subjective experiences of being at once in the presence of larger…forces and being important one’s self” (329). This energy, says Almond, can be generated through the type of interpersonal relationships fostered by a therapeutic community, which make individuals feel they are capable of being more than they think they are. This view resonates with more recent theoretical approaches such as narrative and strengths based approaches and critical postmodern attentiveness to the fluid and dynamic nature of identity. While this section has highlighted some of the challenges of involvement in the therapeutic community, it has, for the most part, suggested that the experience was generally a positive one for individuals. The chapter now concludes with a discussion of some of the more problematic aspects of the program and difficulties of living in this setting.

**Difficulties of life in the community**

However important the presence of others who have had similar experiences may be, it is also necessary to acknowledge that for some people, at certain points, community life, especially with others who are also recovering from psychiatric upheaval, appears to be extremely difficult. Millard and Oakley affirm that while, for some, being in the company of others who have had similar experiences and may have similar needs can be a source of relief, others might find the atmosphere of the therapeutic community and its collectivist nature oppressive (1994, p.322). For some, it was the oppressive nature of being in the company of ‘sick’ others that was particularly confronting and difficult to experience. One resident commented that it was very difficult to handle other residents’ issues, such as suicidal thoughts and
actions. She felt it placed too much responsibility for other community members onto residents, and recalled a specific incident where she had made herself vulnerable by responding to another resident’s distress by calling an ambulance, which they later had resented her doing (BMA 26/27). Another former resident, reflecting on her experience in the program, also felt that the trauma and crises of other community members had a major impact. She recalled a period where the community was constantly being rocked by a resident’s deliberate overdoses and the difficulty for community members in knowing that the person needed support but also being worn down by the person’s behaviours. This former resident had also found it difficult to live with people whose behaviour she did not approve of and to which she had not been exposed before, for example drug taking and prostitution. She found it hard to know how to befriend people in this situation, and felt very sad watching their “vicious cycle” (OS 29-30). Several former residents commented on the difficulty of coping with other residents’ anger and/or unpredictable behaviour (BOR, RB), as well as living with people who, other than an experience of psychiatric upheaval, they had very little in common with. In this sense, the constructed nature of the community around a specific commonality brought individual differences into sharp focus.

Stokes (1994), drawing on Bion’s groupwork theory, observes that experiences of being and working in groups are often powerful and overwhelming; individuals experience the tension between the wish to join together and the wish to be separate (p.19). Indeed, while acknowledging participation in groups within the program (women’s group, men’s group, support group, etc) to be beneficial a great deal of the time, residents and former residents also commented on the difficult nature of group participation, which was compulsory within the program prior to its restructure (the compulsory nature of groups will be discussed in some detail in the following chapter, in relation to sensemaking). Indeed, one former staff member commented that she did not know, herself, if she could have handled the intensive nature of some groups (UR 23). Residents and former residents commented on the draining or exhausting nature of living in the community, particularly participation (or lack thereof) in the more therapeutically oriented groups (AG, YK). Part of the difficulty of the groups was their confronting nature, in terms of receiving feedback and “your weaknesses coming through” (AG 23). One former resident regretted that she had done some “stupid things” because she had felt angry and frustrated about being confronted in a group setting (YK 32). Another former resident described how
she had felt fear and anxiety at times when confronting community members about their behaviour, for example, when staff had suggested taking an issue to the community (BMA 26), and another former resident recalled how some residents had been laughed at or treated harshly in a group setting, without, as he perceived it, adequate staff intervention (REG 30).

Other difficulties of group and community processes were the difficulties experienced when trying to support others when feeling unwell oneself, as well as the lack of commitment by some community members to group participation, when people “couldn’t be bothered trying to participate” (UM 31). Whilst the very personal disclosures of some group members were “hard to hear,” this was sometimes mediated by them making “you feel you weren’t alone” (YK 31). Another difficulty of group participation and process in the therapeutic community setting, expressed by several community members, was that you “didn’t go home” after the group, because you were already home (AS, OS, EC), creating a sometimes uncomfortable tension between group members who had disclosed various things in the small group setting, and were also co-residents in the wider community.

The demands or responsibilities placed on community members also felt onerous to some, or even most residents at various times during their stay. Demands to participate in groupwork, speak and express opinions, shop, cook and clean were sometimes difficult to fully embrace or even superficially comply with. As touched on earlier in this chapter in the more general discussion of community, community expectations could feel more like a burden than an opportunity. As one former resident commented, it was challenging that the community had “so many expectations of you... [and] when you do something wrong, the whole community is on your case” (BMA 26). Several former residents also commented on what they experienced as pressure to conform to community norms, which for one resident equated at times with getting “lost in a sea of mediocre thinking” (YK 32). One former resident commented on the pressure to collude in self-destructive behaviour she had observed on some occasions within the resident group, when powerful members exerted pressure to remain stuck in a “sick way of being”; “some peoples’ agenda was to stay sick” and individuals, at times, would bond and support each other around that, for example by getting stoned all the time and actively undermining the rest of the community whose agenda was to get better (RDNA 31). Another former resident commented that the capacity of the community to be supportive fluctuated
according to who was there and each person’s own changing needs (IR 27). On another note, a number of residents commented on the difficulty of the transitory nature of the community, in which people were continually coming and going (REG 31, LC 25, IV 25). And, even in a house full of people, it was still possible to feel lonely in a community, if connections with others were not strong (YR 26).

Here, again, it is worthwhile reflecting on one’s own experience of community life or attachment: as a human being – whether ‘worker’ or ‘service user’ – we have all no doubt experienced some sense of frustration, alienation or even rebellion in relation to various communities we have been connected with. As a parent attached to various school communities that my children have been part of, I have often, over the years, not conformed to conservative expectations of what ‘good mothers’ do or what ‘ideal families’ look and act like. Similarly, as a social worker or as an academic, I have at times expressed radically different views to those of my colleagues – who, in some ways, are part of the communities I am connected to. I have also rejected involvement in a range of communities I might potentially have become a member of, because I did not want the responsibility associated with belonging to that community nor did I want to be totally identified with that group, nor, at times, did I believe I could live up to their expectations (ranging from Quakers or Buddhists to academics!). At other times, community membership, solidarity and connection has probably saved my life, or at least, been an important source of well being on many levels.

Despite its difficulties, it seems that a (therapeutic) community can provide a unique opportunity for containment, solidarity and individual growth. Caltagirone and Smargiassi’s (1997, p.167) five definitions or images of the therapeutic community, briefly alluded to at the beginning of this chapter, seemed to be embodied by the program: as the location of a therapeutic process, as a setting, as a nurturing environment, as training for life, and as a space for replanning. Each of these images is very thought-provoking; each function is seen to be necessary to the therapeutic functioning of a community, and, when absent or conducted inappropriately, according to Caltagirone and Smargiassi, can actually lead the community to become anti-therapeutic. A healthy community, they say, is a place where residents are active agents in their own recovery, where they are able to express themselves and move forward, and where they receive support to find a new image of self which is personally meaningful, all within a safe environment.
While much of the discussion in this chapter has been around the therapeutic community, there are also, I suggest, some ramifications in this discussion for work in human services generally - and particularly residential services – where workers are involved in supporting individuals and (more or less consciously) creating programs that are thought to be beneficial and empowering. The complex social environment of the individual, whether it is a consciously structured program/community or not, is important due to its capacity to entrap or enable, and to engender connections that are needed with other human beings. For workers to be mindful of these complexities and open to critical reflection on ways in which they facilitate healthy or oppressive environments is an important part of critical practice. In the following chapter, the creation of culture within an environment will be discussed further, as a more or less conscious act of sensemaking, exploring the powerful, yet often mundane, act of imposing order and meaning on lived experience which is an unavoidable part of any (inter)action.
Chapter 7

Sensemaking, meaning ascription and creation of culture

“...in every interplay, we ...also catch (by interpretation) latent imperatives, codes, which the actors [are] not aware of...” which carry the message: “now, let’s apprehend reality this way” (Moren, 1994, p.284).

“...sometimes you become so encultured at [the program]... it just became so much a part of my life and who I was...” (former staff member, ME 55)

In this chapter I explore the concepts and practices identified in its title, how they are relevant to social work practice, and how they are enacted in the program setting. As a worker in the program I had directly observed, experienced and participated in a culture creating and nurturing process, wherein there was both a great deal of freedom as well as an expectation that certain community norms would be maintained. My awareness of the existence of a program/community culture and the significance of particular components, however, did not mean that I had a very clear theoretical understanding of culture generation, nor had I deeply considered the related themes of sensemaking and meaning ascription and the power of workers within that process. Like other chapters, these interpretive vehicles or frameworks seemed to ‘suggest themselves’ as a result of my concurrent reading of texts and transcripts, and the areas in which I was teaching.

It is difficult to know, and perhaps it doesn’t matter, whether what ‘emerges’ from interview transcripts, particularly when the interviews have been very loosely structured, actually reflects some underlying essence or theme that is being communicated from a number of people, or whether what the interviewer notices has more to do with their own mindset, theory-base or what they happen to be reading at the time. In the case of this thesis, it is probably a combination of all these factors. In this discussion, I begin by exploring the creation of culture in practice settings, and specifically in the program. I then go on to discuss the ascription of meaning in organisational settings and use Weick’s (1995) concept of sensemaking to further flesh out the therapeutic community process. While a great deal of this discussion is
illustrated by reference to the program, aspects of it are also potentially relevant to human service work generally.

**The creation of culture in practice**

In general, social workers and human service practitioners of any sort (and here I include those who are usually categorised as providing ‘objective’ or medical-model clinical services, such as psychiatrists and psychologists) can be seen as agents and creators of culture within their agency, program, organisation or institution. This is a powerful role and function, which workers/professionals may be more or less mindful of – they may create culture more or less consciously or thoughtfully. As a group, members of a team or organisation may discuss and try to uncover the wider sociopolitical contexts, theories, values and assumptions that underpin the culture of their service, or it may be considered a given, outside the realm or interest of workers or management to critically engage with. Rossiter, however, places the creation of culture firmly and overtly within the realm of social work practice, describing social work as a “site of cultural production” where power and help are interwoven and where social relationships are enacted (1996, p.29). It could be said that culture is enacted in structure: the structure of a therapeutic community encompasses the client group, the selection of residents, the therapeutic program, the hierarchies of decision making, the community’s rules and the way they are ‘enforced,’ and how the staff function and relate to residents and each other (Norton, 1992). As discussed in the previous chapter, the therapeutic community aims to consciously create and maintain, from a specific theoretical perspective, a particular kind of culture (often referred to in therapeutic community literature as a ‘culture of enquiry’) which is deemed to be potentially beneficial to service users. In so doing, workers exert both a gaze and a role of authority, which, arguably, are also considered both necessary and empowering for clients in this setting.

As discussed in a previous chapter, the worker’s gaze, more or less consciously, utilises certain understandings to select and interpret what is gazed upon: this selection and interpretation then leads to or warrants particular actions, interactions and relationships. For example, seeing a client as a victim of past trauma, rather than something else (eg a ‘sick person’) will not only sensitise the worker to particular aspects of the client’s lived experience, but also will likely impact on the
type of relationship cultivated, the goals of the work and the structures put in place to facilitate goal attainment and well-being. According to one experienced worker, staff’s understanding “of what mental health is, impacts fundamentally on how the program is run – we can’t run away from that; the assumptions in our attitude to practice intervene at every moment” (EG 66). One former staff member commented upon how, when she first came to the program, the staff team engaged in a thorough review of program culture and structure – which were considered dynamic entities - “to look at the foundation stones which were necessary – what we HAD to provide... we looked at what needed to be addressed, and then we would come up with the strategies for addressing it... which came out in the form of a structured weekly program... I don’t think that it’s THE way... it has been A way, that has constantly, in my mind, been up for debate...” (RT)

Program or organisational culture is also a product of, and potential agent in the (re)production of, wider social practices and relationships, which may be experienced by various people at various times as oppressive or otherwise. The social practice of the worker-client dynamic, for example, reflects to some extent what is going on in the various fields or social layers that actors are embedded in. Some consciously created cultures attempt to challenge oppressive dominant social orders, by deliberately aiming to create different kinds of relationships and subject positions, such as the critical social worker striving to facilitate empowerment, or the worker in a therapeutic community attempting to facilitate a recovery oriented environment. This being said, it may also be that despite a worker’s, program’s or organisation’s espoused values and beliefs, the service they provide may be experienced as something different.

**What is culture and how does it operate within a program?**

Generally, culture can be thought of as a set of shared meanings and values that generate a certain arrangement of subject positions (relationships in which various roles and powers are ascribed/assumed), prescribed norms of social practices, and a language which is shared – at least to the degree which allows some meaningful communication. A given culture may also suggest a shared sense of ‘success’ or ‘the good life,’ and identify individual or group behaviours and outcomes as desirable or undesirable. While some program staff members were unapologetic about their role in establishing firm guidelines for expected behaviour within the program, others expressed more ambivalence: Interviewer: “There’s something about the way an
environment is structured that communicates a certain expectation of behaviour…”

AC: “Yes, which then falls into a bit of a value judgment about lifestyles… an expectation that people will be up at nine o’clock could be construed as my own middle class value judgment… I struggle with that – wanting someone to take hold of their life… but not wanting to impose my lifestyle” (AC 65). Workers may struggle with their ‘power’ to create culture, wondering if it is empowering or disempowering; indeed this struggle was consistently commented upon by staff. The way in which this struggle is experienced or perceived – as a sign of incompetence, for example, or as a healthy interrogation of practice – is something that may vary based on the individual and their theoretical orientation and experience, but may also be shaped by the view of the organisation or the team around uncertainty.

Gubrium and Holstein (1995) suggest that culture provides “a set of understandings that participants regularly take into account in assigning meaning to life experiences” (p.52). I made the following comment to the same staff member as quoted above during one of our conversations: “It seems like the way that staff conceptualise the program is really translated to the residents, and if the staff team has a strong conceptualisation that it’s important to fully commit to the program activities for six months, then they had a rationale for that that they communicated to residents, and so that became important to the residents.” AC: “Yes, yes!” Pardeck et al. (1994) suggest that culture becomes “the interpretive cement that sustains certain norms;” they define community as “a domain where certain assumptions about reality are acknowledged to have validity” (p.364). If workers are making assumptions about reality that carry such powerful connotations, conscious awareness around this process is certainly desirable.

Culture, according to Cohen, is continuously in process – continually being created and recreated through social interactions. Culture, he says, “has neither deterministic power nor objectively identifiable referents…[similarly] behaviour does not ‘contain’ meaning intrinsically, rather it is found to be meaningful by an act of interpretation…” (1985, p.17). Wiley in her fascinating account of a highly structured therapeutic community in California, suggests that reality itself can be consciously created through community culture (1996): in the case of the Quaesta community – a world was created which was thought by its creators to be different both to “phantasm” (the world the client wishes to leave) and to the everyday world (the world the client is not yet ready for).
Importantly, Gubrium and Holstein (1995) also remind us that within the same culture, different ways of knowing, by different actors within the cultural milieu, will still lead to different interpretations of behaviour and experience. Indeed, different members of a staff team may have different interpretations of community process or individual behaviour or needs. Whether the team should present a ‘unified front’ or make their differences known, may be made sense of in various ways. One staff member suggested that it was important for residents to be exposed to differences in the team, “to see that everybody’s different, because that way they don’t get this fundamentalist line of… how to do things… it broadens a sense of permission to be able to be different from each other and from the staff… it’s how we manage the differences…” (EC 65). Again, a team may need to discuss their approach to this issue, and grapple consciously with how they will ‘manage’ differences amongst themselves. Unless this issue is consciously grappled with, teams run the risk of splitting, undermining each other, or developing unhealthy team relationships which are conveyed to service users in various ways.

At times of staff turnover, differences amongst team members and team approaches as a whole may be cast into sharp relief. This shows not only different approaches to how a program should run, but also the constructed nature of a culture or program, which can be significantly altered depending on the theoretical basis, assumptions and values informing it (as well as wider policy directions). During the course of this research project a major staff turnover occurred in the program, and staff were confronted with difficulties associated with negotiating cultural transition. “What I’m struggling with... we previously had a structured program, and part of me saw that as really beneficial... because most people had very little happening in their lives before they came in... but I guess the thoughts now are more about perhaps people can be doing their own study and this and that straightaway... they may not need this structure to be provided... I sit between these two models at the moment” (AC57).

Another former staff member described the shift this way: “the focus changed, because the staff perspective changed... it went from being more psychoanalytically driven to Gestalt driven... it’s a staff-initiated thing” (UR 57). Another staff member also commented on this transition and the new culture that was emerging, actually naming it in those terms. “…having less compulsory groups is something about shifting culture... from a strongly community focused culture, where the community
supports each other and everybody knows where everyone is...[but the new culture suits some residents better] – they don’t have to be confronted all the time...[it’s easier to see then] how people survive or founder without structures that they have to go to... rather than their lack of motivation being masked by the fact that they have to go to all the groups. The work is different” (EC64).

Sawyer and Woodlock (1995) speak of culture as the discursive ‘glue’ that holds an organisation together (similar to Pardeck’s ‘interpretive cement’). This glue, they say, significantly influences staff behaviour and conveys, even unconsciously, what leaders are most concerned with: a pattern of basic assumptions which are considered valid, and are passed on to new members as the way to perceive things. This was certainly the case in my experience at the program. One experienced staff member observed that when new staff came to the program, “…they, of course bring ideas about the work with them, but I see now the language that they use changes... and this parallels with residents too, from the beginning when they come in, to how they are on exiting, the change that occurs... a transmission, in a symbolic sense... and through the words that are spoken... I think it is the culture, but it is so determined by words... a culture of words, that travel” (EG 55).

Basic cultural assumptions often become taken for granted and drop from awareness (Sawyer & Woodlock, 1995). However, as Sawyer and Woodlock (1995) point out, they provide an interesting framework through which to view organisational culture, in terms of saga (beliefs and values tied together in a relevant story about the organisation’s past), heroes (which represent program ideals and values in human form), symbols (tangible proof of cultural values/beliefs, such as physical site and language used) and rituals (the translation of culture into action). It would be an interesting and revealing community team or organisational exercise to go through this framework from saga through to ritual and, both personally and as a group, critically reflect upon or interrogate not only how different individuals identify these cultural assumptions within their practice setting, but also perceptions of their impacts.

**Culture and metaphor: meaning and symbolism**

This leads to another useful and illuminating way to explore culture within an organisation, service or program, through the use of metaphor. Alvesson (1993) suggests that culture can be variously conceptualised, manifested and experienced as a “compass” (providing direction), as “social glue” (holding a potentially disparate
group together around a set of norms), as “sacred cow” (not to be tampered with), as “blinders” or as “world closure” (legitimising certain possibilities while excluding others). Of course, any one culture can have aspects of all these, and will generally be a complex mix; again, only conscious and critical reflection on the part of service providers can reveal how these metaphors are enacted within their organisation, and their effects. Culture, Alvesson concludes does not necessarily imply clarity or consensus: while it “provides direction,” it also “prevents us from seeing” (1993, p.120). In relation to therapeutic community culture specifically, Hinshelwood suggests that ideally the benefits of the ‘old’ are retained alongside openness to innovation and critical reflection on ritualised practice (1996). Indeed, one staff member commented that maintaining a particular culture within the program had both positive and negative effects: while it provided the basis for structure, there was also the danger of “conservatism that is inevitable in any institution, that is, resistance to change” (EG67).

Richardson provides a metaphor for metaphor itself: like the spine – “it bears weight, permits movement, is buried beneath the surface and links parts together into a functional, coherent whole…the experiencing of one thing in terms of another” (1994, p.519). Facts, she goes on, only make sense “in terms of their place within a metaphoric structure” (p.520). As workers, then, it may be particularly useful to name and unravel the metaphors underpinning practice: are clients broken and in need of fixing; is the psyche more like a machine or a butterfly; is social work a remedy or a tranquilliser; are helpers more like gardeners or police? (Richer (in Kvale, 1992, p.118), rather uncharitably suggests that all of psychology with its powerful interpretive powers is a “branch of the police,” with psychodynamic and humanistic psychologies being the “secret police.”)

Not only do workers’ metaphorical constructions have the power to guide workers themselves, they are more or less consciously shared with or transmitted to clients or service users. Hill and Levenhagen (1995) suggest that metaphors provide a means for individuals and organisations “to create and share understanding…[they] establish images, names and an understanding of how things fit together…[allowing] individuals to predict and control their environment,” at least to some extent (p.1059). The very role of ‘client’ or ‘resident’ is created and sustained, through particular language and actions. Pardeck at al. (1994) and Rossiter (1996) draw attention to the linguistic construction of reality, for both clients and workers; they suggest that it is
important for workers to be attentive not only to their own constructions of reality, but to the client’s interpretations to better understand the experiences and actions which result.

Local culture – or the culture of a program – provides a way of interpreting and framing experience that is reinforced within the cultural milieu (for example, in the case of a therapeutic community, group settings). Cultural norms and meanings ebb and flow, are constructed and deconstructed, according to the contributions of participants (Gubrium, 1989). Along this line, one experienced worker said, “The personalities of the staff group of the time can make the program what it is... which on the one hand is probably as it should be, because we’re working with people, and it’s not like we’re machines making a thing that’s always going to be the same... there’s nothing wrong with the ebb and flow of a program, according to the residents who are there at the time, and the staff” (ME 55).

As well as being temporal, the culture of an environment is also historical – every system has a developmental history (Moos, 1996); indeed each program, as well as the parent organisation itself, has a very particular history which impacts on the present service. The program involved in this research resides within an organisation founded in the groundswell of the ‘anti-psychiatry’ movement in Britain in the 1960s and 1970s, in opposition, and creating an alternative to, the medicalised and restrictive treatment modalities of the time. In discussing the historical origins of the culture of the organisation, one staff member observed, “there is something about the symbolic formation of any program, that continues to have its effects above and beyond the people who pass through it. There is something in the act of founding something that has such a weight, that somehow continues through time... that actually precedes and exceeds the people who are actually involved... Ways, for example, of being able to talk about the work... You see that not just here, but in the [whole organisation] – it’s formation was against the medical model... and that continues to have effects amongst every individual who’s here... and I think part of that is the debt to its formation and why it was established... fuck the doctors and fuck the medication!” (EG 55).

In a simple yet profound statement, Geertz (1975, cited in Cohen, 1985, p.17) suggests that “…man [sic] is an animal suspended in webs of significance he himself has spun.” As workers within contexts, our spinning is necessarily relational. Saleebey highlights the interactional nature of meaning construction,
emphasising that individuals are not simply passive recipients of meaning, that there is always “an interplay between structure (culture) and agency (selfhood)” (1994, p.352). Workers must be seen as co-creators of culture and meaning, but perhaps, as discussed previously, actors with particular powers (social, managerial and therapeutic) to assert their meaning constructions and to create culture. (In some more bureaucratic settings, it must be noted, the power of social workers to create culture may be more limited.) One staff member reflected, “it’s part of being with people; you can’t help but reframe your experience by the way someone else frames their world… in terms of a staff member, you [a resident] can be influenced by that, especially if you have any confidence in their competence” (EC 58).

In ways that are more or less liberating or oppressive, culture gives meaning to action by imposing particular symbolic systems – “its language and discourse modes, the forms of logical and narrative explication, and the patterns of mutually dependent communal life” (Bruner, 1990, p.34). While this is particularly evident in the therapeutic community – indeed, ideally, consciously used therapeutically – it is applicable more generally to helping professions. Through a willingness to “re-envision the culture they daily enact” (Wadsworth & Epstein, 1996, p.15), critical workers can consciously move closer to being the sort of “culture carriers” their emancipatory frameworks espouse.

In order to ascertain the type of culture that is continually being created, workers need to critically reflect upon or problematise their own experience and practice in the organisational or program context, as well as create opportunities for feedback from others (e.g. service users) on the type of culture they experience. The following quotes, although not necessarily named by participants as referring to ‘culture’, give some idea of the sort of culture people experienced at the program and their awareness of it: a culture, which to all intents and purposes appeared overall to be an empowering one, and one in which staff appeared to have a strong role in creating and maintaining. The first set of comments is from residents and former residents.

“There’s just an accepted norm here that we look at ourselves” (AG 53)

“Everyone’s opinion is just as important as the next person’s… that’s the way staff feel about it – sort of like their values in the world… It builds up confidence, feeling like you’ve been heard” (RAM 53)

“Being made to reflect and to have input into groups” was good (REG 53)
“People here are really learning to talk about their problems and their vulnerability and their fears... it’s unusual [for there to be that openness] and really nice... different to family dynamics” (AS 54)

“The philosophy of the program is maybe around encouraging people to get on with their lives... not pushing too hard, but pushing nevertheless” (AJ 56)

“My feeling is that the program is much more geared to someone with a recovery goal and someone who doesn’t want to work within that traditional illness paradigm... yet it was inclusive too – if the illness paradigm was where you wanted to work from, as an individual, I think that was also possible” (IR 61).

Staff members and former staff members made the following comments, which also paint a picture of the culture of the program.

“The program is known for being therapeutic... exploring experiences that people have, rather than just reacting to where they find themselves... The therapeutic nature of the program is around engaging in day to day experiences with a capacity to reflect on whatever that might be... whatever the engagement is in, there is some place for that to be talked about and looked at” (EG 54/66).

“The philosophy is about acceptance and consistency, even if someone yells at everyone and walks out of a meeting slamming the door, they come back and the program is still there, accepting them” (ME 56).

From time to time it is important for workers and teams within a program or organisation to critically reflect on what sort of culture they are involved in creating. From a postmodern perspective, with its emphasis on fluidity, diversity and the significance of local context, workers might frame this question in site-specific terms. How does our language and our interpretations (posing of ‘problems,’ ‘interventions,’ and ‘goals’) shape the experiences of those we interact with? How do the meaning systems which we, consciously or unconsciously, impose create trespass – in what ways do they help and/or harm? As Saleebey succinctly summarises, “meaning can inspire or oppress” (1994, p.357); just like the professional gaze, power and authority can be used to empower or otherwise, as can the culture created in agency settings. Often our best intentions as workers, unless critically and courageously analysed, do the opposite of what we intend. In the next section of this chapter, I look further at how workers are involved in making and sharing meaning, which is expressed in the culture, structures and expectations of the program.
Meaning ascription and clarity in the program/organisational setting

In the deep structure of communication, according to Moren (1994, p.284), messages are built that instruct people “on how to conceive of the task [they are meant to be engaging in] and the conditions required for carrying out the task.” Although he is referring to organisational imperatives directed to workers within organisational settings, these sub-texts about reality that are conveyed - but often not interrogated - impact on both workers and clients. Arguably, in a therapeutic community or perhaps any intensive residential setting, the degree to which meaning ascription and its attendant definitions of reality impact on service users is particularly strong. Goodchild suggests that the power that operates through social formations (such as conventions, values, language or ideals) and the relationships that express or embody them serve to shape “desire, the unconscious and ultimately consciousness” (1996, p.5). The meanings that have been ascribed by those with the power to do so, form a sort of “grid through which one interprets reality, and through which new relations will be formed” (p.6). In relation to human service workers, Moren (1994, p.285) proposes, “the flow of imperatives” includes such things as “Keep your distance! Do not get emotionally involved!” Such norms, often defining rules about relationships, are transmitted – consciously or unconsciously – by workers to service users, more or less overtly. Sometimes, Moren suggests, the codes become confusing, for example when a worker believes their task is to “stand up for inequality” but at the same time they are expected to “maintain the difference between normal and deviant people” (1994, p.285). The confusing nature of these codes may be intensified in community settings where the lines between management and support, or social control and personal freedom are potentially blurred. Rossiter (2005) suggests that critical reflection on practice can engender the kind of distance necessary to make sense of social workers’ often difficult and contradictory location. She suggests that social workers are often caught between competing discourses (such as repressive risk discourses on the one hand, and progressive sexuality discourse on the other) that limit thinking and create difficult, sometimes painful, positions. Critical analysis, she observes, can help generate alternative perspectives “outside the terms of the oppositions” (4). Stepping back from immersion in the often dichotomised (either/or) construction of our practice creates possibilities to change our – and our clients’ – positions through creating or tapping into more fluid anti-oppressive discourses.
The “therapeutic community impulse” is a form of social organisation which, through its discourse and the culture it creates, defines what is sayable, as it simultaneously creates subject positions and ascribes meaning to actions. This impulse, according to Kennard (1983, cited in Hinshelwood, 1996, p.176), flows through schools, psychiatric hospitals, prisons, and day programs, expressing itself in attitudes such as egalitarianism, “psychological mindedness, toleration of the expression of conflicting ideas, and a kind of shirt sleeves informality about the business of helping people.” He observes that it is an impulse that focuses on the quality of relationships and communication between people, “on the way they naturally set about dealing with one another…[and] contrasts with others, for example the impulse to make people as uniform and easy to manage as possible… [or] the impulse to look after people in a protective but controlling way…” (Kennard, 1983, cited in Hinshelwood, 1996, p.177). Kennard’s therapeutic community impulse parallels the recovery vision described by Anthony (1993) – in which a particular type of service and working alliance is pivotal, envisioning the sort of culture Almond described in 1974, whereby existing organisations could be restructured to reflect a different, more enabling view of social life and interactions. This reorganisation, he suggested, could apply to prisons, hospitals, factories and even families – re-visualising them as potential ‘healing communities’ whereby persons might find guides to greater meaning and satisfaction (Almond, 1974, p.387). While ‘healing communities’ may not, as words, fit neatly with the more political discourse of critical social work, the underlying principles are, I would argue, complementary. Indeed, this impulse – towards the creation of an enabling communicative environment - as described by Kennard, could be found at the very core of critical social work. Somewhat paradoxically, as identified in the Learning Together Project, some aspects of this impulse are now being expressed in public policy discourse around mental health service delivery. At the same time, this sort of ‘shirt sleeves informality’ is something that social workers have, in some ways, struggled to distance themselves from, to gain legitimation within modernist constructions of professionalism.

Meaning ascription within programs, services or organisations may variously challenge or maintain dominant sociopolitical discourses. Alvesson (1993, p.80) uses the evocative phrase “cultural traffic” to describe how people within organisations are influenced by wider contexts; his “multiple cultural configuration view” (p.118) assumes that “organisations can be understood as shaping local versions of broader
Chapter 7  Sensemaking, meaning ascription and creation of culture

societal and locally developed cultural manifestations in a multitude of [overlapping] ways.” He suggests that by acknowledging the multiplicity of social contexts that impact on and contribute to the configuration of a program, service or organisation, ambiguity or uncertainty becomes more tolerable. Thus many different levels of extra-organisational fields (or meaning systems) may combine in sometimes-contradictory ways in a local culture or organisation. Within human services or healthcare organisations, this may manifest in impulses or services related to control of clients, alongside manifestations or impulses on the part of staff toward client empowerment, or with staff operating from potentially contradictory theoretical paradigms in their practice: for example working from a feminist standpoint in which oppressive gender issues are highlighted (and the individual de-pathologised) and also working within a psychological model where the ‘problem’ is located in some aspect of the client’s past psychological experience.

Meaning systems within an organisation are also shaped by what the organisation considers to be its primary task: this task will at least partially be shaped by powerful external forces. At the same time, critical reflection, informed by postmodern critiques of the fixed nature of power highlights the potential for workers to reconstruct their own agency in more empowering and hopeful ways. From a psychodynamic perspective, Kets de Vries (1991), in his intriguingly entitled book, Organisations on the Couch, suggest that organisations – or indeed professions – often do not seem to have a clearly identified primary task. Even so, they suggest, the “rule of psychological urgency” can be applied by an observer to unravel unifying themes of the organisation, even when organisational members find its articulation difficult. This framework implies that, “somewhere within the text [conceptualised very broadly as anything that can be ‘read’ about the organisation] it is always possible to identify the most pressing need or needs” (p.17). An observer, looking for meaning-making with an organisation, Kets de Vries (1991) suggests, can be likened to a “cryptographer,” engaged in reading “all types of data” (p.5) in order to gain an understanding of what the primary organisational task might be, through the expression of the task in practice. As well, a critical observer might detect a more or less consciously formulated organisational task or meaning system by observing the way in which needs come to the surface within the organisational setting, and how those needs are interpreted and responded to.

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The primary task of an organisation (or program) is defined by Roberts (1994) as that which holds the group together; it is strongly linked to the group’s self identity. In human services, she acknowledges, the difficulties of defining such a task can be great, as helping organisations generally have multiple tasks, many of which are considered important or even essential; thus many and varied needs would be continually surfacing and submerging. As previously identified, primary tasks may be experienced as conflictual. Many agencies and/or organisations have mission statements, which provide a general starting point for analysis and reflection. The primary task for the program I researched is stated as follows in the organisation’s compendium of service profiles (RFV, 1998):

…to provide a safe and supportively challenging environment within which individuals can develop social and/or other independent living skills and raise the quality of their lives through a process of personal growth, self-management, interactions with others in the house and involvement in the wider community.”

Following on from this, the “program approach…[is to] combine structure with time for residents to develop their individualised goals. The foundation stones of the program include safety, developing a sense of connectedness through community, support, continuity, structure, work and commitment.” While such a statement provides a useful and necessary starting point or theoretical grounding for practice, a wide latitude remains for interpretation around the meaning of key principles or concepts, how they are enacted relationally and the intended and received impact of those actions.

According to Roberts (1994) it is important for human service workers (teams and organisations) to consciously consider what is actually the intended or desired different state that they want their clients to achieve. While this seems simplistic and obvious, it may be surprising to discover how differently individuals within a service might conceptualise this, and the act of articulating such a basic premise may be useful. Roberts suggests that much of the confusion experienced within helping organisations, as well as external perceptions, has something to do with an inadequate conceptualisation of the primary task(s) of the service, resulting in workers feeling little sense of guidance about what they should be doing, how to do it or whether they are succeeding (1994, p.30). In his comparative study of mental health services in Sweden and Australia, Johnson (1991) reported that the study’s strongest finding was that most participating staff members, directors, planners and advocacy groups could not state their program goals or the goals they thought should ideally be sought in
community mental health services. Mawson (1994) suggests that the confusion over primary task in helping services is exacerbated by a wider lack of clarity in society generally regarding what constitutes meaningful ‘help,’ what services are doing, what they should be doing and how to go about reaching their goals. Some organisations, he suggests, may assign themselves impossible tasks, which then become the glue which holds the organisation together, as a form of defence against the ultimate ‘failure’ to achieve the impossible.

While flexibility, professional discretion, intuition and acknowledgment of contextuality are vital to critical practice, some sense of clarity within and amongst workers around the meanings ascribed to and embedded in program interactions, relationships and structure is important in enabling containment, consistency and purposefulness. Millard and Oakley (1994) observe that this sense of clarity is particularly important in settings where collaborative, partnership type approaches are undertaken: a clear theoretical model, they propose, is vital in a program where worker-client hierarchies are flattened to any extent, to enable, as a bottom line, staff to contain their own anxiety in the face of clients’ problems. This clarity is crucial for service users as well. One staff member made this comment, “As a facilitator, if I don’t know the purpose of the group, I feel quite dumb... I don’t know what can and can’t happen in this space. In terms of the team factor, and the program, it’s about being clear what each program structure is for... being clear with people, because without clarity I don’t think they can feel safe” (EC 58). Indeed, individuals who have suffered psychological and/or other trauma may be particularly vulnerable, as both their own personal meaning systems and those shared with significant others may have been at least temporarily destabilised.

Because workers are involved in face to face work a great deal of the time, in a myriad of settings and activities that often demand an immediate response, some sense of clarity is necessary to inform ‘on-the-spot’ interactions. These decisions might be anything from how to respond when individuals (or the entire group) are actively negative towards participation in the program; whether or not to ‘get involved’ with certain interpersonal disputes and in what way; the ‘place’ of staff in residents’ space; the purpose of various groups; or what to do when on an out-of-town group excursion someone gets angry and takes off on their own. While an underlying sense of theoretical or philosophical/ideological clarity or purposefulness may not provide absolute, inflexible ‘answers’ to every situation (nor should it attempt to), it
does at least assist the staff person to make sense of diverse and dynamic situations, in order to respond with some degree of consistency and thoughtfulness to unpredictable situations. Indeed a sense of theoretical clarity may actually allow for all sorts of creative possibilities to unfold – for workers to be able to embrace the ambiguity and diversity inherent to human experience and interaction, grounding and providing the psychological resilience vital to critical social work practice.

The need for clarity can also be usefully problematised, particularly if it is constructed to mean lack of ambiguity. In an interesting discussion around the need for ‘order’ and clarity in organisational settings, organisational theorist Deborah Meyerson (1991) suggests that the ambiguities inherent in any culture are often suppressed: by ignoring what is “unclear, unstable and ‘disorderly’ (that which is more fragmented, intractable and difficult to control)” she suggests that (modernist) organisations de-value and avoid conflict and reject the messiness of multiple legitimate meaning systems. De-legitimating ambiguities not only stifles diversity, but, she goes on, makes individuals within a culture less able to tolerate ambiguities within themselves. While Meyerson seems to suggest that clarity implies consensus, from a critical postmodern perspective it seems that clarity and difference need not be antagonistic. Both can potentially flourish and be valued in the same setting: while they may produce tension, it can actually be a fruitful or creative tension, if acknowledged and consciously worked with. In the program where my research was conducted, the capacity to embrace diversity, ambiguity, and fragmentation existed side by side with the need for some sense of clarity and workable order: this dynamism indeed may be one of the hallmarks of a culture of inquiry – a learning environment.

This again raises the question of how important consensus is amongst/between staff, in relation to how they, as a group and individually, make sense of clients’ issues and what they consider to be appropriate or effective relationships and (inter)actions. Schimmel, in his 1997 review of therapeutic communities, suggests that unresolved staff conflicts “over patient management [sic] and community ideology” have a ripple effect outward onto residents. Unresolved conflicts within the staff group, he goes on, “may activate profound unconscious fragmentation anxieties” amongst residents (1997, p.126). At the same time, diverse opinions and the discussion which may ensue, can also be a fruitful opportunity for a staff team: as Heaney (1995, p.449) suggests, in relation to community mental health services
generally, increased ideological awareness and debate can enhance program/service functioning. However, a split amongst the staff team, if ongoing and unresolved, can negatively affect the health and containing capacity of the program (Hinshelwood, 1996). An interesting comment made by a former resident resonated with this idea that team issues rippled out into the program: “At times it seemed the program sank... the whole notion of fostering independence became blunted... I never figured it out, but I felt it had something to do with what was going on in the staff team...” (RDNA 61).

Levinson (1996) asserts that a sense of clarity amongst staff is a crucial aspect of therapeutic work: while this sense of clarity need not always be manifested in external structures, Levinson suggests, it must be processed and integrated internally. Therapeutic work, she says, relies on the structure and culture of a program, but also on “the process of all the separate parts of the treatment becoming integrated as a whole in the minds of staff and patients [sic]...[a form of] mental work of integration [which] requires internal processing” (p.55). Thus the various aspects of a program and the underlying theories, values or assumptions, must be integrated, to some extent, in one’s own mind. One worker, reflecting on the process of clarification that needed to occur when a new program structure was put in place, said, “With the new program, we [the team] have become a lot clearer on the group focus. I came in [to the program] when it was a bit fuzzy... there had been heaps of staff changeover... I’m sure it [the program] was clear at some stage, but not by the time I got there... I guess we had to dissect [program structures]... they’d lost their clarity... the boundaries were blurred” (EC 58).

I remember how long it took me, as a new worker, to begin making sense of the program: why did the staff respond in certain ways, what meaning was being attached to actions? (One worker suggested that for her, as a new staff member, there was not so much a learning curve to negotiate, but a learning cliff, in terms of orienting herself to the program’s theoretical and practice framework.) The staff team when I worked in the program was quite psychodynamically oriented, and strongly informed by therapeutic community principles, which were largely unfamiliar to me. The basic principles of a therapeutic community (e.g. the emphasis on the community as therapeutic vehicle, the centrality of group meetings and the complexities of group process), required a particular theoretical grounding that allowed for purposeful interaction within a challenging setting. As I began to understand the underlying
theoretical framework and hence began to have a greater sense of clarity around the work, I was more able to connect my responses to a particular way of sensemaking. Without this, I stumbled from one situation to another, unable to work productively or convey to service users – through thought, word or deed – what the program was on about. As I became more clear and grounded in a particular way of making sense, I actually felt much freer to exercise the independent judgment required on many occasions; having identified and internalised a “unifying theme” (deVries et al., 1991), I was empowered to be a more active, speaking subject. When, much later, a totally new staff team formed almost overnight – a team with quite different theoretical orientations – the sense of the program became obscured: only the surface products remained. “It was very hard for me to know what the philosophy had been previously…” (ID 59); “…before, I think there was some sort of exiting process [a structured process of leaving the program], but I never actually saw it happen… it wasn’t very clear” (UR 58). Without having participated in the sensemaking processes that had slowly resulted in the evolution of the program to its then current state, the program/structure was largely meaningless: it is this process of sensemaking that I will now turn to.

Weick’s sensemaking approach

In further exploring the process of meaning ascription and the creation of culture, Weick’s work on “sensemaking” (1995) provides a valuable and illuminative perspective, which can be useful in theorising both the program under study, and other organisational settings. He refers to sensemaking as an interpretive process – “the reciprocal interaction of information seeking, meaning ascription and action” (p.5) that provides a framework within which to identify and understand experience. Sensemaking, as Weick points out, is used as a way of managing chaos through the generation or provision of a consistent viewpoint or meaning-making framework that selects certain cues as points of reference. Leaders or powerful persons of all sorts (in Weick’s organisational studies, managers) generate or construct the reality of a problem situation and create structures within which to work, becoming “sensegivers” who provide some sort of acceptable interpretation of the world. Thus, reality becomes an “ongoing accomplishment,” in which the leader/sensegiver “embodies the
possibility of escape from what might otherwise appear to…be incomprehensible…chaotic, indifferent or incorrigible…” (p.15).

Workers (as well as managers and policy makers), as more or less powerful sensegivers in human services, “set the problem” by deciding what to pay attention to and impose a “coherence which allows [them] to say what is wrong and in what directions the situation needs to be changed” (p.9). Sensegivers have the power to draw attention to one thing over another, extracting cues from a myriad of possibilities and asserting their meaning and significance. This resonates with the views of Curt and other social constructivists that ‘truth’ is actually knowledge into being – with attendant consequences. Weick observes that “the same portion of a flow [of events] might be labeled either a problem or a solution…,” as workers establish “points of reference” and assign meaning to these points. In a residential support service, where the flow of daily life goes on constantly around one, workers choose, more or less consciously, what to attend to, and ascribe particular meaning to it, with its attendant trespass and conduct warranting potential. For example, amongst the many things that happen in a day, a resident misses an important community meeting – what meaning is ascribed to this action and what response does it engender? Workers in the program, particularly those who had experienced both the ‘old’ program and the ‘new’ program, were actively struggling with what sense to make of such an action. The first quote conveys this sense of struggle while the second and third quotes convey quite different ways of making sense of group attendance, and workers’ responses to absences.

“…Previously, in the old system, we would have gone and rapped on doors and chased people up... but [new] workers feel that it’s not our job to be making people responsible... that people won’t learn to be responsible if we’re setting the boundaries all the time... it’s a continual question in my mind as to the best way to go...” (AC 100)

“The authoritarian role I hate. I find it hard to set boundaries in which people are beating up against them kicking and screaming. Now [in the new program] I think there’s a lot more of a permissive kind of culture... people’s real internal motivation comes out... you can knock on the door and they can just go ‘yeah’, and turn over... and I don’t know if what we’re seeing now isn’t really good... because that’s exactly what would have happened the minute they left the program... and so at least we can work with it now...” (EC 101).
“...It’s been a struggle for me, and I think for the team as well... I still struggle with issues around attendance, and what’s going to be useful... with residents not attending groups... You’ve got less first hand information or experience of a resident in the life of a group... seeing them in group settings contributes a lot to the one to one work... [in the old program] residents who weren’t attending groups... stood out a lot clearer than in the situation now... When groups were compulsory and residents weren’t turning up... there was always the question ‘why?’... when the groups were compulsory it would be probably raised that same day by a passing staff member or maybe one of the residents... it was easier to keep track of how a resident might be experiencing life... whereas I think when contact around attendance is less of an issue, people might experience more isolation or might not reach out as much” (OR 105/06).

Within the sensemaking framework, workers’ interventions make sense according to the way they construct problems or the ‘things’ of the situation, and convey this sense to others. Weick suggests that the power to create ‘sensible’ environments is, for some workers (he gives the example of police), absolutely crucial: indeed, the only way they can do their job – they need to have the capacity and authority to “enact an environment with which they can cope and which makes sense to them...” (p.167). I suggest that this is also deeply true of the therapeutic community environment, or any psychiatric disability support service, where people are struggling on a daily basis with the trauma of psychiatric upheaval and its aftermath, and where staff are challenged on a daily basis to respond effectively to a range of situations from crisis intervention, to working one-on-one with clients’ deep and painful issues, to conflict resolution, and the myriad of other aspects of a therapeutic residential service. The power of workers as sensegivers is undoubtedly also magnified by the continuing and ongoing contact with residents within their living situation on a day to day, week by week, and sometimes even year to year basis. At the same time, a critical practitioner or team would engage in conscious problematisation or critical reflection on the nature and impact of their sensemaking.

Weick (1995) describes in some detail, seven properties of sensemaking, all of which are extremely interesting, but for the purposes of this thesis, some seem more relevant than others and will be drawn out in more detail. The first property he identifies is that sensemaking is “grounded in identity construction” (p.20). This has obvious implications for this study, as the (re)construction or healing of an
empowered identity may be an important process for people who have experienced psychiatric upheaval. In stressing the interactive nature of identity construction, Weick draws attention to the way people learn about their identities by projecting them into an environment and observing what happens. This has obvious links with the theoretical premise of therapeutic communities that individual issues emerge within the relational environment – the core of community experience, and also resonates with White’s narrative approach that emphasises the creation of preferred narratives and the role of others in supporting those reconstructions.

Retrospectivity is the second property of sensemaking proposed by Weick – that is, that attention is generally directed backward, and that the ways in which people speak about (and make sense of) the past is influenced by their current sensemaking: in other words, we ascribe meaning to past events from our current position. For example, in retrospect, a particular event or experience could be variously conceptualised along a continuum of “dangerous threat” or “valuable opportunity.” Again, this has strong parallels with White’s theories around re-storying and re-framing one’s life and experiences in ways which allow forward movement, and Podvoll’s ideas around nurturing a person’s history of sanity, islands of clarity and innate tendencies towards wellness.

The third property is referred to as “enactive of sensible environments” – in other words, that people contribute to the production of the environment they are part of: through their actions people “create the materials that become the constraints and opportunities they face” (p.31). Weick (1995) cites Follett (1924) who says there is “no result OF process but only a moment IN process”: enactment, according to Weick provides breaks in the stream of existence/experience, imposing categories on certain segments of one’s flow as a way of coping “with pure duration” and setting aside some moments as more significant than others (p.36). Although this seems to ignore the significance of external and/or structural factors to personal experience and identity, the fourth property refers to sensemaking’s social or relational aspect, emphasising that sensemaking does not only take place at an individual level, but also via social interactions that reinforce and legitimise certain patterns of sensemaking. It is interesting to note that one former resident, reflecting on his time in the program commented that when he had moved in, there were lots of other new residents at the time as well. “We didn’t really know… (pause) how everything happened properly and stuff… with so many people new, there weren’t as many people to run it as it
always was, and for me to come and tag along” (UM 61). The ongoing nature of sensemaking is the fifth property identified by Weick: “sensemaking,” he says, “never starts…people are always in the middle of things…to understand sensemaking is to be sensitive to the ways in which people chop moments out of continuous flows and extract cues from those moments” (p.43). Here is meaning ascription par excellence. Workers can be very influential in highlighting certain moments as consequential or not (the missed community meeting, the attempt to reconnect with family, the visit to the grave, the capacity to sit in a room with five other people without panicking).

The sixth sensemaking property flows on from the fifth, that is, that sensemaking is about the extraction of particular cues, and the determination of what these particular cues actually mean (Starbuck and Milliken, cited in Weick, 1995, p.51). For example, what do workers think it means when someone says they ‘hate support group’? One staff person observed that ‘hating’ something, or one aspect of a program, is not necessarily ‘bad’; it can have many meanings, and, as a result various responses may be made. Does the group need to be re-evaluated? Is there something about the group that the person is finding particularly challenging, and is this a ‘clue’ for the worker? Does the person hate the group because they are not involved, and might encouraging greater participation be ultimately empowering?

Finally, sensemaking is often something that seems to occur quickly: people are more likely to “see products than process” (p.50). This is of particular relevance to the transmission of sensemaking, particularly across sensegivers. The process of sensemaking that goes on in a program/therapeutic community results in particular products, which are visible in program culture, ‘rules,’ and structure. It may be that when a staff team changes over (i.e. a new staff team comes into being without much of a ‘handover’) the product remains, but the process has been lost. As previously discussed, this results in empty rituals, rules that don’t make sense, and a general lack of clarity about the meaning and purpose of program structure. The products of sensemaking are not components of a recipe that anyone can step in and ‘do’ without knowledge of the sense that underpins them, although this may often occur, which would go some way in explaining the unproductive tension, conflict and poor communication that occurs in programs, teams and organisations. The program I worked in, and where I conducted my study, was built around and on a whole history and evolution of meaning ascription and enactment, which was strongly influenced and kept alive and meaningful by the collective sensemaking of staff, led by a
manager with strong theoretical orientations, as well as the philosophical and historical essence of therapeutic community principles/theorising.

The culture and structures of a program emerge and are enacted based upon particular ways of making sense of people’s experiences and how they are to be responded to. When, for example, the sensemakers/sensegivers are withdrawn, without adequate in-depth transmission of the underlying sense behind the structures, then the structures become meaningless or perhaps even counter productive (anti-therapeutic and/or oppressive). The existing structures make no sense to the new sensemakers/givers– i.e. to the staff themselves, and hence what they are able to transmit to clients. How can workers give or share sense if the structures don’t make sense to themselves? Programmatic expectations then, cannot be reinforced, by even a tenuous certainty on the part of staff. When workers are confronted with the ‘products’ of sensemaking processes to which they were not party or feel no affinity with, those structures appear meaningless. In discussing the struggle to keep a culture of enquiry alive in a particular therapeutic community setting, Levinson (1996) talks about how programs, rituals and structures can become hollow without deeper understanding, without integration into one’s meaning-making system. It is useful to note that within a therapeutic community, or perhaps any organisational setting, while the word ‘ritual’ is not in common usage, it is a revealing word to apply as it creates metaphorical images, nuances or insights that can illuminate taken for granted practices. A ritual can be anything from the way a meeting is conducted, to how or if special events are celebrated or achievements acknowledged. Rituals, or lack thereof, can convey useful messages about what is valued or ignored by the organisation, whether overtly articulated or not.

The culture of the therapeutic community, which is itself the therapeutic medium, is significantly maintained by the community’s rituals as well as the program structure: while the whole community is involved in sustaining the community’s structure and rituals, staff hold the primary and ultimate responsibility for this. The structure and the rituals within it perform a “cultural function” in that there are particular meanings and thinking behind them – particular ways of making sense of things. However, “…fixed items on the agenda, and the language habitually heralding them, potentially part of a therapeutic ritual” can become “hollow sounding and exert little or no actual containing or transforming effect” if the meaning and sensemaking behind them is somehow lost. Indeed, when rituals lose their meaning, the culture of
enquiry can actually be subverted (Norton, 1992). Now, I turn in more detail to ways in which sensemaking occurred in the program, as a way of exploring a range of staff and service users’ experiences, and of highlighting ways in which sensemaking occupies a pivotal role in the service.

Sensemaking in the program

As previously mentioned, when a major staff changeover occurs in a quite intensive program, without an adequate transmission of the sense of the program – its ‘rules’, its structure, its rationale, its rituals and shared sense of purpose – not only can that sense not be conveyed to residents, but the rituals, rules and structures appear meaningless and become non-therapeutic, or worse. When the new staff team (including new manager) came in to the program with what seemed to be very little crossover with the old team, what had previously been clear and theoretically grounded program structures were constructed or made sense of as problematic. “When I came in [to the program, as a staff person]...there was a strong sense of people having to do as they’re told and being dragged out of bed, late for meetings... it was dragging the chain, rather than engagement in their own rehabilitation process...” (ID 102). It could be theorised that the rituals and structure which were in place had become empty. “It sounds like it used to be a lot easier for staff to be in control. There was this ... [push to] ‘keep track’... knowing where everybody was” (ID 102). Here ‘keeping track of people’ was being made sense of as ‘controlling,’ rather than, for example, supportive. Even residents who had never experienced the ‘old program,’ had made a certain sense of what it had been like, based, it would seem, on the transmission of a particular sense by others (i.e. new staff): “…the program is more free-form [now], whereas before it was more regimented, like, ‘come here, do this ’…” (DA 53).

The sense make by workers is critical in what is transmitted to residents, particularly if they are temporarily less stable than they might usually be. One story told by a new staff member centred on a particular requirement of residents in the ‘old’ program to ‘ask’ the community for permission for the resident to be absent from certain communal activities/responsibilities in order to pursue their own independent interests (for example, to enroll in a job-readiness class which meets once a week, attendance at which would mean that they would be absent from, for
example, shopping responsibilities on a regular basis). The sense behind this ‘rule’/‘ritual’/‘product’ could be variously constructed and conveyed with vastly different connotations:

‘Asking permission’ from the community implied an acknowledgment that everyone was needed for the smooth running of the household and that their absence would affect others: not only were they needed but they had an impact on others;

‘Asking permission’ from the community provided an opportunity for the resident to share something of where they were at, and why they wanted to do the activity, and for others to give feedback (which was sometimes to question the person’s readiness for such an activity, many other times to offer praise);

‘Permission’ was virtually never refused, but it did create a discussion around how the person might still be able to fulfill some aspect of their responsibility to the running of the community, in the knowledge that their absence meant something.

When new staff came into the program, the sensemaking behind this ‘ritual’ was lost: the product remained, but the process of sensemaking behind it was gone. ‘Asking permission’ to do something outside the community appeared ridiculous: controlling, disempowering, and counter-productive. In the ‘old’ sensemaking framework, an understanding of the therapeutic life of the community and the individuals within it underpinned the sense of the arrangement. ‘The community’ itself had been assigned particular significance. The ‘new’ sensemaking, which incorporated less of an emphasis on community --or a different construction of the importance of the community experience- may have been more along the lines of:

‘Asking permission’ infantalises residents who should be free to do what they feel best to achieve more independent living and well being;

‘Asking permission’ to be absent from community life puts too much emphasis on an insular and inward looking community, when residents need to be more involved in establishing links to outside activities.

The way that staff – as sensegivers – ascribe meaning to the components which make up the life of the program is transmitted to residents. The example above illustrates very different ways of making sense of a particular ‘ritual’/practice. In Weick’s sensemaking terms we can look at the situation like this: In terms of identity construction, the emphasis may alternatively be on the individual who is part of the community, or an individual who lives with others but is basically independent. In terms of meaning ascription, the practice of ‘asking permission’ can be seen as
degrading, disempowering or meaningless OR as an important learning experience in responsibility, belonging, and creating dialogue resulting in a sense of empowerment. The social nature of sensemaking is illustrated by the importance of the way in which staff as a team perceive the practice, and then convey the expectations of the program as well as the meaning behind the practice. The ongoing nature of sensemaking can be seen in how this ‘portion of the flow’ of daily life in the program is labeled, and how that label changes over time. The notion of extracted cues can be seen in terms of how this example illustrates the nature of what is attended to as important in the wider flow and culture of the program, and in the development and well being of individual community members.

This sensemaking process can also be seen in relation to the setting of ‘rules’ by staff within the program. In the ‘old program’ there had been a rule that there was no TV watching during the day. When this rule was made, it carried a certain ‘sense’ with it (i.e. that residents had agreed to enter the program in order to ‘work’ and engage in certain activities and pursuits during the day that did not include watching TV). The ‘watching TV during the day’ issue emerged in the ‘new program’ with different sense being made, not only about the content of the ‘rule’ but its imposition: “This morning at get-together, the residents seemed to be wanting me to tell them whether or not there was a rule that the television shouldn’t be on during program hours... And I said to them, ‘I think this is something you need to decide yourselves’... And from the sort of reactions I got, I think people found that very difficult – they wanted a decision made for them” (ID 101). The staff person then went on to sensemake around this issue: “They’re all likely to be in situations where they’ll be sharing with someone else... so if I make the decisions for them, how are they going to know what to do when it comes to sharing out there in the community” (ID 101). A different way of making sense around the unapologetic use of worker authority to set a bottom line policy around TV watching during the day might be along the lines that, at times, the external provision of guidelines and structures, may allow for the development of internalised structures which can then be carried forward with the individual. At any rate, the sense made by the worker/team is conveyed to the residents. In this case, not watching TV during the day had become an empty rule, or even a negative imposition of authority.

Other examples of sensemaking in the program can be seen around mundane yet potentially meaningful or even therapeutic activities such as:
Cleaning groups: Sensemaking version A: staff and residents doing house-cleaning together can engender a sense of camaraderie and collaboration; it can be a shared informal time which is more conducive to some residents really ‘talking’ than a more formal setting might be; it can be an opportunity for skill sharing (i.e. actually learning how to clean); cleaning at an organised, set time actually ensures that an important aspect of tending to a household gets done; ‘enforced’ structure is useful to someone whose internal and external life may have become quite chaotic.

Sensemaking version B: cleaning in groups at set times denies individual autonomy and decision making; cleaning with staff infantalises residents; cleaning with staff at a set time is overly authoritarian and assumes residents are not capable of being responsible or motivated; staff should not be involved – it’s not their house.

Compulsory attendance at groups: Sensemaking version A: groups are an important part of the program’s structure (which is communicated to and accepted by applicants in agreeing to become residents); people have come to the program to work; even if someone sits in a group for months and never speaks, they may still be listening and readying themselves for greater contribution; people may be making an unhealthy choice by not attending groups resulting in further isolation and spiraling downwards. The following comments came from former residents whose time in the program happened to coincide with the time when program culture was strongly around compulsory or expected attendance.

“…You’ve got your people who stumble on groups being good by accident... kind of like what I did... ‘oh, all right, maybe it’s okay’... whereas if I hadn’t had to go I might not have had to face that...” (NA 104).

“I wonder how people will cope if groups aren’t compulsory...having to decide to go to the group –are people ready to do that?... by having the staff in the groups, facilitating the group and making sure that people do get a say... are those people going to miss out on the ability to speak out?” (OS 104).

“...I think I have to be pushed a bit... because my motivation wanes...there’s something about [the program] helping you to push yourself, even when you don’t feel like doing it...because we had compulsory cleaning and you had to, we did it. And there were times when you didn’t want to do it, but I worked out, ‘well, this is part of the agenda’” (IV 5).

“[it] got me up, doing something constructive... when I was in down moods I really needed to go to groups, even if it was difficult...” (OS 20).
“But what about the people who don’t go? It seems to me they might miss out on something valuable…” (RDNA 110).

“…Having groups non-compulsory is the path of least resistance for residents” (IR 19).

“… Even if residents complain, it’s beneficial in the end…” (BMA 18).

Sensemaking version B: people should be able to exercise choice about whether they do or don’t attend; groups can feel quite intrusive to some individuals; the group is better when people want to be there; staff insistence on attendance is a mis-use of authority. The comments below reflect active sensemaking on the part of members of the ‘new’ staff team as to why groups should not be compulsory.

“…Having less compulsory elements is something about shifting culture…and for some residents it suits them better… they don’t have to be confronted all the time [or experience] this high anxiety in groups” (EC 105)

“Another thing – when it’s not compulsory, it’s really easy to see how people flounder or survive without structures that they have to go to. Its easier to work on their motivation, where they’re at, if they want to stay in bed all day… rather than that being masked by the fact that they have to go to all the groups…” (EC 105)

“…Some groups, like therapy groups, aren’t for everybody… and, when you think about it… it’s not a safe environment – you’ve got to live together… it’s not like a group of people who don’t know each other, who come together just for that purpose, and there’s no implications to what they say once they leave… these guys live with each other… there’s consequences. I don’t want people to feel scarred from having to contribute in groups… when they didn’t want to…” (EC 106)

“…From the way I operate, as a person; I feel a lot more comfortable not having to go out and push the program all the time…” (EC 65)

“…For people who don’t want to be there, it’s not only a waste of time for them, but they destroy the group for the other people, or they can…” (AC 104)

“I’m guessing that there would be fewer people [in the groups currently], but those who are there are there to work…” (ID 104)

Several residents expressed awareness of different ways of making sense of whether groups should be compulsory:

“…The good thing about now that it’s not compulsory, is that when people go they really want to be there, and it’s so much better for all of us. Whereas before, it’s like opening up to intimate things…and some of the people didn’t want to be there...
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and that was really hard... Then I can also see how a lot of people can come here and really lack motivation and the desire to really want to help themselves, so I think the compulsory thing is good in that way – that people can look at things that they wouldn’t want to look at... the newer residents aren’t’ going to the groups as much now...” (AS 103)

“...You’re not in school. I don’t think participating is so important... it’s silly making people... you don’t have to learn anything if you don’t want...often you shut down when you’re forced to do something... Other than that, it was probably a good idea because it meant you had to do things in a shared basis... you can’t just be there for a free ride – you have to put in some effort... ” (YK 108).

These examples demonstrate the sort of sensemaking that goes on in formulating and maintaining a program. The sense that is made by staff is translated into the structures, culture and expectations of the program. This is taken on board, struggled with, or rejected by service users in various ways at various times. The sort of sense that is made of ‘the community’ itself can be very different according to the lens of the sensemaker – it can be seen as a primary therapeutic tool, as a source of unhealthy dependence, as engendering an overly inward focus which separates people from the wider community, or as a safe yet challenging haven where a person may gradually being to feel a sense of belonging, agency and structure. In the face of residents’ resistance to the program does the team undertake an immediate program evaluation, weather the storm of discontent, redesign the program or use the discontent as an opportunity for dialogue and exploration? (Or all of the above!)

Weick (1995) also raises the intriguing possibility that sometimes when people are ‘lost,’ any map will do, as long as it provides something to go by, which people are able to have some faith in. Sensegivers/leaders, Weick suggests, need to instill a sense of confidence in those they are leading, to get them moving and to believe there may be some value in the journey and the proposed path; this is almost impossible to do if the structures which are in place do not make sense. So if the ‘accuracy’ of the map is not at issue – and indeed one might argue that ‘accuracy’ of any map in relation to human behaviour and growth is problematic - what is? According to Weick, what is necessary is “…something that preserves plausibility and coherence, something that is reasonable and memorable, something that embodies past experience and expectations, something that resonates with other people …something that captures both feeling and thought, something that allows for embellishments to fit

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certain oddities, something that is fun to construct…in other words… a good story” (60-61). These stories, according to Weick, are templates – they “explain…and they energise” – they are plausible (p.61). That sensemaking is “driven by plausibility rather than accuracy” is Weick’s seventh property (p.55); it fits quite well with postmodern thinking around theory as enabling fiction (Rossiter, 1995), as second order story (Daly, 1997) and as a way of knowing forms of truth into being (Curt, 1994).

In their comparative study of several therapeutic communities in the UK, Bloor et al. (1988) put forward a view of the work that goes on in a community that is strikingly similar to the features Weick proposes in his sensemaking framework. Bloor and colleagues observed that the work is one of reality construction, employing the conscious use of a gaze (which is both interpretive and constantly engaged in making sense of things) which is selective in nature and leads to particular forms of intervention – in the therapeutic community generally reality confrontation and conscious structuring of the environment. They consider therapeutic work in communities as “redefinitional work, the transformation of mundane events in the light of some paradigm of therapy” – a form of sensemaking at the very core of practice. In this culture, they suggest, “(e)very…invitation to a resident to describe [i.e. ‘how do you feel about that?’] is also an invitation to construct” (p.188).

One of the most remarkable therapeutic communities I read about was the Quaesta community, providing a truly radical example of a consciously created and highly structured therapeutic community in California (specifically for persons with a diagnosis of schizophrenia) in which the process and power of sensemaking/giving was quite profound. The culture and practices of the community were devised by one individual, named Tamara (herself a recovered – even ‘enlightened’ according to her framework – person who had experienced schizophrenia). According to Wiley’s account (1996), in which she describes the community as a “precarious haven,” Tamara’s belief system around the causes and pathway to recovery for schizophrenia forms the basis of a “culture that structures and limits behavioural options, social contact, emotional response and cognition…,” with how to “see, think, feel and be in the world … deliberately attended to and controlled within the setting” (p.40). Describing Quaesta’s culture as a “reified object,” Wiley suggests that the community came to be seen and experienced by its residents as a “natural world as opposed to a constructed world” of delusion or ‘life out there’ (p.43). Wiley herself is sharply
critical of the community, after the experience of her study of and within it, concluding that the alternative reality “offered in the confines of the community is a rigid structure of meanings that ignores the multiplicity of meanings and necessary ambiguity within a larger outside social space” (p.133), thus leaving community members largely unable, in her opinion, to re-integrate with the wider social community.

Upon entry to the community, Wiley observes, new residents are “pushed and prodded into a new reality” – a culture and meaning system with its own distinctive traditions, including “ways of thinking, feeling and behaving” to which newcomers must adhere and gradually internalise (pp.4-5). The staff, while also sharing in a growth journey, retain powerful positions in the definition of reality and the imposition of quite remarkable “structures” which phase in and out as residents move through a formal four stage program (most residents never it make it to the final stage). A number of “structures” are described as “negative sanctions” in that they create restrictions on where residents can physically be in the house and whom they can communicate with. For example, the “rope structure” (utilised particularly with new residents “to anchor people when they feel chaotic”) is one in which a supervised person is literally tied around the waist with a rope that is tied at the other end to a supervisor, physically connecting them to another to provide maximum support (pp.56-57). Over time in the community setting, Wiley remarks that “a conversion experience occurs” whereby community members “see and speak with the eyes and words of Quae’s definitions of reality” (p.59), for example, speaking in only the language of feelings prescribed by Tamara, whose authority is absolute and overtly stated/presented from a potential resident’s first contact with the centre. The stated aim of the program is to redefine previous dysfunctional meaning systems and the “unacceptable delusional system that contributed to the clients arrival” at the program (p.103).

The point of relating this story is to flesh out, through the use of an extreme example, the powerful nature of the conscious creation of a program or service culture, based on particular ways of making sense of people’s needs and experience, which are then reflected and enacted in the relationships, language, and structures of a program. Wiley, who was quite scathing in her conclusions about the Questa community, observed that the program did not prepare people for re-entering the ‘outside world.’ Indeed, this is an area of controversy even within residential
programs of far less extreme nature. Should the world of the therapeutic community be ‘special’ in its difference from the ‘outside world’ (in order to provide the type of containment and recovery-oriented environment people need), or should it, as much as possible, mirror/resemble that world (in order to prepare people for what they will eventually need to face)? Needless to say, there are different ways of making sense of this dilemma, with some staff and former staff believing the program should be as much like ‘the outside world’ as possible, and others suggesting that a consciously structured environment and program can make possible the formation of internalised structures which will be helpful upon leaving the program. One former resident, who had only recently left the program after a long stay commented on what he perceived to be some of the special qualities of the community that may not always be available elsewhere, “When a resident has done a mistake...they have a cushion – they’re not going to be cornered... like coming down a stair, there’s someone there to take your hand... If you go by yourself you might fall, but if you reach for that hand, you’ve got a chance of being supported not to fall. Life is difficult as it is... society is very strict, it’s very black and white, and we’ve got a big stigma...[The cushion of the program] means that you’re not going to go from one harsh [situation] into another harsh one...” (TI 79).

Wiley’s description of Quaesta portrays a created community with striking dissimilarities to the dominant culture surrounding it. While consciously created environments may at times challenge dominant ideological constructions of reality, generally services funded by the state embody at least some demands of dominant discourse in terms of process and outcome. It is an interesting divergence to look briefly at the way various geographically or ethnically based cultures respond to ‘mental illness,’ as it highlights the constructed and potentially diverse nature of social relations and expectations created within cultural contexts. In an interesting article looking at community based psychiatric disability support services in Sweden, for example, Johnson (1991) highlights how wider social/cultural norms around quality of life, ‘normalcy’ and ‘success’ are reflected in mental health services. A prime example of this would be the almost unquestioned norm in western countries that psychiatric rehabilitation will lead to participation in the paid workforce. Interestingly, Johnson, in describing Sweden as a “mature welfare state” and the United States as a “reluctant welfare state,” observes that while participants in his study wanted jobs, there seemed to be no shame or social disapproval associated with
not having a job in Swedish culture. Thus, he reminds us, the notion of the desired
goal of economic self-sufficiency is value and culture based. Indeed, both workers
and residents commented on the internalisation of cultural values around success, with
one resident describing the shame he felt as a recipient of the disability support
pension.

Marsella and Westermeyer (1993) observe that ‘sickness’ in non-western
cultures is constructed more as a state of “disharmony” resulting from a pattern of
causes, than an “intruding agent” (p.400). The way a particular culture responds to
psychological upheaval, Marsella and Westermeyer suggest, says something about the
way in which that culture conceptualises self and self-in-the-world.

They describe a process called ‘ho’oponoporo’ (which means ‘to make right’)
practised in Hawaii, based on traditional Polynesian values and belief systems, that
focuses on restoring the health of an individual by restoring family harmony and
cultural and community connections. (This may be somewhat similar to Australian
Aboriginal concepts around mental health and well being.) In Hawaiian culture, from
my experience of living on the big island, ‘satisfactory role performance’ is not
judged simply by one’s position in the workforce or marketplace, nor one’s individual
achievements, but is also highly determined by one’s generosity, caring and
commitment to family, extended family, neighbourhood and community. Hence, it
makes sense that the healing of mental disorders, although manifested at an individual
level, is seen to lie to a great extent in reconnection to these important aspects of life.

Winship (1996, 1995) highlights the way in which cultural and political forces
of the day “trickle down” into welfare systems, human services and specific program
settings. He links the ascendancy of a sort of “therapeutic individualism” as a primary
feature of health services that accompanied burgeoning politics of free market
individualism and attacks on egalitarian notions of the collective good generally (e.g.
a relative decline in spending on public health, education and housing, attacks on
trade unionism and a shrinking welfare state). Kennard (1998) also highlights how a
dominant ideology might assume that individuals need to “stick up for their rights in a
world of other self-advancing individuals” and thus need to learn skills and ways of
functioning that reflect independence, rather than interdependence, and certainly
rather than any form of dependence (i.e. on the state). The yardsticks of success used
by workers and clients cannot help but be effected by dominant stories about what it
means to be a person of worth in our society, with psychotic experience and its
aftermath often being the absolute antithesis of dominant Western constructions of worthiness (White, 1995, p.16). Again, it is worth problematising, as an individual worker and as a team, how we may unwittingly be co-opted into dominant ideology and cultural constructions of individual worth.

This chapter has highlighted the powerful role of sensemaking, meaning ascription and the creation of culture in program, service and organisational settings and the participation of workers – more or less consciously – in that process. Critical teams and practitioners who are willing to interrogate or critically reflect on the meaning systems or cultures they are part of may find the space to reconstruct culture in more critical, therapeutic, affirming and anti-oppressive ways. Leonard (1997, p.169) reaffirm the role of critical social work in engaging in “collective resistance” towards disempowering practices and structures, which keep individuals silenced and objectified. He suggests sites of resistance can be established through the development of “alternative forms of collectivist organisation” (p.169), which, in a broad interpretation, could be anywhere from a residential service, to a worker’s office, to a classroom or meeting room, where culture and sense are constantly being made. In all these settings workers are involved in large and small ways in constructing meaning and subject positions, and creating culture and certain ways of making sense of the world. The more consciously and dialogically these processes are engaged with, the more possibilities may arise for critical practice to mirror critical intent. Perhaps cultures can indeed slowly shift, at both micro and macro levels, in response to the conscious and critically reflective sensemaking of workers, in collaboration with service users. While cultures and systems of meaning-making can be more or less enabling for all involved, the capacity of workers or services to actually change the people who use the services, while often expected by funding bodies, is also worthy of problematisation. It is to this question of the role of workers as change agents in the lives of others, and the experience of service users in coming to what might be described as turning points in their recovery journey, that I now turn to in the next chapter.
Chapter 8

Change and turning points

“Staff aren’t there to be the ‘masseur’... they’re there to facilitate the process of self massage or community massage... I imagine it’s probably a constant struggle for the staff, not to be sitting there with the thumbs. It’s about professional skill – to get to the point where you are a pure facilitator and not someone who’s working directly on the knots...” (IR, former resident).

“We must ask ourselves some basic questions – ‘What do we mean when we say we help a person? What counts as help? Who defines what counts as help... these are not scientific or medical questions; they are riddles about life” (Szasz, cited in Farber, 1993, p. xiii).

This chapter explores the role of program staff as change agents in the lives of service users, and problematises the notion that workers can – or should – set themselves up to ‘change’ others. While change may indeed be the goal of many people using mental health services, the impetus, capacity and process by which change occurs may be much more complex than many funding arrangements or social expectations allow for. This chapter also explores what might be described as turning point experiences for residents, when they felt possibilities for change began to occur, often linked to the development of a sense of agency – “practices or actions that have an effect and bring about changes” (Turner, 1992, p. 245). When conversing with research participants, I sometimes asked directly if they had been aware of any turning point experiences during their stay in the program; at other times comments came up more spontaneously. The role of hope in relation to change is also discussed. The chapter begins with a discussion of the concept of recovery, to lay the groundwork for the ensuing discussion of change, growth and turning points. I also explore some of the reasons given by residents and former residents for their coming to the program initially, and present some observations made by staff around why individuals enter the program. As in previous chapters, the words of
participants are interwoven with material from the literature, to shed some light on the change processes that occurred for service users in the program.

**Recovery and hope**

A discourse of recovery in relation to psychiatric upheaval has been largely introduced by the consumer movement (see for example Lovejoy, 1984; Deegan, 1988, 1990; Leibrich, 1998) and embraced by the psychiatric disability support sector. As touched upon in earlier chapters, recovery implies not so much a cure or the obliteration of past events, but as Anthony puts it: “the development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness… a mysterious and subjective process” (1993, p.17). It is not a denial that something has happened, but an affirmation that life can evolve to the point where the catastrophe is no longer the primary focus of one’s life. The recovery paradigm is, as Anthony suggests, a potentially “unifying” one (as contrasted with a more ‘othering’ framework of medical model psychiatric discourse), as most people can relate to experiences in their own lives that, while initially devastating, they have recovered from. Examples would be the death of a loved one, divorce, unexpected severe illness, the trauma of an automobile accident, etc.: people can get better and move on, even though the effects of the trauma may always remain in some form. It is interesting to note that the term ‘recovering,’ although often used in relation to people suffering with alcoholism or various forms of addiction does not seem to be used often in consumer discourse around mental health, perhaps due to its appropriation by twelve step programs that often seem to have a somewhat evangelical bent.

As Anthony (1993) suggests - and as commented upon by participants in this study – the experience of mental illness or psychosis, and subsequent hospitalisation, medication and/or treatment regimes, potential relapses and re-hospitalisations, means that people have to recover not only from the illness experience itself, but also from the trauma, stigma and loss associated with it. The disruption of one’s sense of identity, meaning or purposefulness in life, as well as, potentially, the concrete loss of employment, study, family and friends that often occurs after a breakdown or psychotic episode, can be profound (1993). “Psychological recovery” as distinct from clinical recovery (lessening or absence of symptoms) or social recovery (achieving greater
independence) refers to an individual’s sense of self worth, meaning and purpose (Watkins, 1996, p.188). Psychological recovery need not be dependent on whether or not the person continues to experience some symptoms or requires ongoing medication or support.

In 1988 Deegan wrote a now-classic paper entitled ‘Recovery, the lived experience of rehabilitation,’ in which she suggested that although recovery was vital to the rehabilitation process, it had been overlooked in professional discourse because of its elusive quality that defied a neat fit within scientific paradigms. She described three phases of recovery: denial, despair, and then – a mysterious transition to hope at a point which, in her experience, was difficult to precisely identify, but which she compared to a tiny flame brought to life by two things: people who did not abandon her and “the possibility of being loved” (1988, p.14). While recovery could not be forced, Deegan said, it could be nurtured by an environment that recognised the non-linear nature of the process and the uniqueness of each person’s journey.

The importance of hope to the recovery process, although not strongly iterated in professional literature (again, perhaps of its difficult to quantify nature), has been raised consistently by authors writing about their own or a loved one’s experience (Lovejoy, 1984; Deegan, 1988; Smart, 1994; Gagne, 1996; Orrin, 1996; Drozd & Goldfried, 1996; Leibrich, 1997). Lovejoy, describing her recovery process, states succinctly, “when I believed there was no hope for me, I found no avenues of change” (1984, p.812). The profound experience of losing all hope that anything could change for the better was also raised by Gagne (1996), who describes hope as something felt and communicated not only by service users but by professionals/workers as well. Hope, she says, is not the same as “blind optimism” but nurtures the possibility of change, while acknowledging the deep losses the person may have experienced: a hope that can be facilitated by “anchor[ing] hopefulness into every program and interaction” (p.2). Walsh echoes this proposition that an environment that fosters recovery “must be one in which hope is an essential component of each activity” (1996, p.89). Moorhead (1994, p.307) suggests simply that being hopeful about the lives of clients (as well as their own lives) may be the most important credentials a worker needs.
Along these lines, Russinova (1999) makes the interesting proposal that the competence of workers and organisations be assessed in terms of their capacity to inspire hope; she suggests that practitioners’ ability to inspire and maintain hope in clients is central in “providing the motivational resources necessary for a recovery process to occur” (p.50). She describes hope as an effective antidote to deficit perspectives, and suggests that the hope felt and conveyed by supportive others can facilitate the (re)emergence of a client’s own hope for change or recovery, breaking “the closed circuit of despair that tends to stagnate the person and limit involvement in recovery-promoting activities” (p.54). Awareness of the existence of resources, let alone the capacity to extend oneself towards them, is something easily thwarted by a sense of despair.

Assisting a client to develop both internal and external resources, Russinova suggests, can facilitate recovery as service users begin to feel more hopeful, through a gradual achievement of meaningful interactions and experiences, the recovery process can build. Resonating with Deegan’s view of recovery, she notes that this hope inspiring capacity demands that workers are able to tolerate or even embrace uncertainty and non-linear ‘progress,’ experiences that are no doubt intrinsic to their own lives as well.

This emphasis on hope at the level of inner and interpersonal experience, resembles at a micro level, the sort of ‘critical hope’ suggested by Robert Jensen, an American political critic and professor of journalism, in his writings around radical citizenship at a more macro level (2001). He describes his journey from cynicism to critical hope, which involved a realisation of the depth of the problems being confronted (for him, in relation to unjust political structures) and a “sensible assessment of the situation.” Hope, for him, became “an appropriate response to a task that, while difficult, is imaginable… And I could imagine what activities and actions and ideas it would take to get… there…. In other words, I finally figured out that I should get to work” (p.2). Thus, a growing sense of agency and the possibility of taking small gradual steps towards a more distant goal can make the pain and challenge that often accompanies struggle to achieve change, whether personal or political, survivable. Jensen refers to Chomsky, who clearly articulates two choices in relation to change: we can predict that no change is possible and hence not act, guaranteeing no change will occur, or we can “understand that
change is possible, even in the face of great odds, and act on that assumption, which creates the possibility of progress” (cited in Jensen, 2001, p.3).

It is important in mental health services (and perhaps all human services) to understand how it is that a person may have lost both a sense of hopefulness and a sense of agency; a critical worker will attempt to do this rather than rely on uncritical or unconsciously formulated assumptions around individual deficiency or group stereotypes. Moorhead (1994) very eloquently asserts that when someone has been traumatised by psychiatric upheaval, diagnosis and treatment, it is not surprising if they – even temporarily – lose their capacity for both hope and change-creating action. Deegan (1988) describes how “giving up” can numb the pain of despair, offering a solution to the impossible question of how to go on, while simultaneously creating an inertia that is truly disabling. In order to act, Moorhead observes, people need some sense of the possibility of achieving their goals, as well as the energy, space and support to (re)connect with what their desires, and hence their goals, really are. To facilitate this process, a person who listens to a client’s story and hears what they are saying is crucial (McGuiness & Wadsworth, 1991) to assist the person towards feelings of “freedom and choice and of being responsible” (Hatfield & Lefley, 1993, p.136). Feeling responsible, without having the resources to assume and enact this responsibility, is – as we can no doubt all attest to – not only disempowering but potentially paralysing.

An emphasis on the individual’s internal construction of agency can appear, and be thoughtlessly and uncritically imposed, in ways contradictory to critical approaches that highlight the existence and impact of very real social and material oppression. One of the most challenging aspects of postmodern (and, particularly, poststructural) thinking and critical reflection on practice, is the suggestion that people may be freer than they think, or may be able to reconstruct their self-story in more empowering ways. However, if we look beyond binary oppositional thinking, we may be able to find a critical pathway that acknowledges the power of internal and external barriers to agency. Along these lines, Moreau (1990), a seminal writer in relation to structural theory and social work, asserts that “changing macro structures without, at the same time, changing individuals is considered as meaningless as changing individuals without simultaneously changing social…structures” (p. 58). He highlights that defeatism and self-destruction –
experienced at the internal individual level – ultimately serves to perpetuate oppression; critical workers, in this formulation, need to help people “confront outside, as well as internalised, sources of their oppression” and assist them to find time and a safe space in which to begin to see alternatives to their current situations (p. 61). Writing more recently, Fook describes a postmodern critical approach as one in which the concept of power and agency is re-formulated to acknowledge that “every person, despite her or his social status and location, exercises and has the potential to create some form of power (2002, p. 53). She posits that individuals both create their own narratives and live lives that are shaped by the social and cultural context in which certain groups are marginalised and disempowered. She concludes that it is not so much what type of power (personal or structural) a person has at their disposal, but how the person uses and engages with it, that creates opportunities for that person. She says that each social position a person occupies “carries challenges and opportunities for the exercise of different types of power” (168). While, in some ways, this is a hard pill to swallow for those of us theoretically aligned with structural perspectives (and having had life experiences that reinforce the reality of structural inequalities), it is a perspective that I have gradually come to believe is potentially more liberating than narrow binary oppositional constructions of powerful/powerless or empowered/disempowered. As a woman, I may be disempowered in some settings, however, I also have experiences as a white, educated woman that are full of creative potential. A more fluid construction of agency and power need not reject the usefulness or even necessity of a structural approach; it may help individuals and groups to imagine and move towards a more hopeful and empowered sense of self.

Hope according to Kaplan and Schwartz (1993), can “free the individual from the threat of a tragic, deterministic and suicidal view of life…[offering] a therapeutic alternative to a fixation on impossible choices” (p.162). Leete, writing about her own recovery journey (1989, cited in Hatfield & Lefley, 1993) relates that for many years she waited for someone to ‘fix’ her, but finally realised after continual disappointments with workers, that no one but herself could actually make her better. This realisation, she reflected, for the first time, allowed her to assume responsibility for herself; at this point, she said she reached a turning point from which her recovery began. In the next section
of this chapter I look at some of the reasons given by service users as to why they initially entered the program, as the concept of turning points suggests a shift away from somewhere/something towards something else. This discussion creates a useful beginning point from which to then look at how (or if) service users experienced turning points or change in the program, as well as how staff observed these shifts. The theory-stories of participants continue to be positioned alongside relevant literature.

**Initial reasons for coming to the program**

For many residents, the sense or experience of having no other alternatives was a primary reason for coming to the program. This may, indeed, have been part of all residents’ experience, however, it was expressed more overtly by some as a key motivating factor. “I was in a pretty bad way...at one of the wards at Larundel... I didn’t have very many options at the time...” (AJ) was how one former resident put it. A then-current resident, who had been in the program for some months, stated categorically, “if I wasn’t here, I wouldn’t be anywhere. I wouldn’t have anywhere to live.. before I was living here I was in a refuge and sort of all over the place” (BA). And, for another, “When I came I felt like I had to be here, because I couldn’t be alone...it was the only choice I had...there didn’t seem to be any other alternative except going back to drinking” (AS). Staff also reflected this sense of individuals being in desperate need, observing, “I think the initial [motivator] is just to get out of wherever they are, because they’re in a really hellish spot and they need support” (AC) and “I think often people come here because they just haven’t coped anywhere else” (EC).

Despite feeling as if they had nowhere else to go, and despite the discomfort and/or inappropriateness of where they had been, entering the program, for some, was still very difficult and confronting. When recalling her first impressions after moving in, one former resident said, “I thought, oh god, what am I doing here? ... I remember going to Monday lunch [part of the organised program at that time] and thinking, you know, mum had gone, and it was like the first day at school... I wanted to be there only because life was unbearable, and this looked like a way of making it a little bit more bearable” (NA).
Many participants commented on the need for support as a major reason for moving in; obviously, these comments were made retrospectively, with one person commenting that at the time, her need for support would have been buried “deep down” (AS), out of consciousness at the time. It seemed that for some residents there was an acknowledgment even at that early stage, of a destructive pattern in their life that they needed help to break. One resident, who had been in the program only a few months at the time of her interview, said “I felt very emotionally needy, and, for me, the answer to feeling unloved and needing security was ‘I need a man in my life’” (AK). But, she went on, she also knew, at some level, that relationships in the past had been “disastrous” and she wanted to “overcome the need to be liked and approved of by everyone.” In reflecting on his time in the program some months after leaving, a former resident commented that he had “come to a crossroads” in his life: after having been in and out of hospital a number of times, he knew he had to work on his “psychological wellbeing” so he could “venture forward...to get back to work...something had to be done” (UM). Another resident commented on the need to break the “vicious cycle” of hospitalisation – to have an opportunity of “rehabilitation” and support to “rebuild” her life (AM).

Staff members had a range of ideas about service users’ support needs and their awareness of those needs at the time of entering the program. One staff member commented “for someone to want to go into [the program] some pretty major stuff has gone on for them... The referring process actually demands that there is some desire to change – for their lives to be different. There’s got to be something that people are wanting different in their lives” (RT). Another staff member was a bit more equivocal, saying that “…some people have goals before they get here, but they haven’t got the supportive environment to start achieving them so the supportive environment itself is their number one goal” (EC). For a third staff member who commented on service users’ awareness around support needs upon entering the program, there was more of a sense of a felt but perhaps unarticulatable need: “I think about [the person’s] malady as someone knowing there is something not quite right, and knowing it but not knowing what to do about it...There’s something that’s bothering them...that needs recognising” (EG).

For some, living in or returning to the family home was an option; for others, although they wished to return home, that avenue had been closed, for various reasons.
One former resident commented that at the time she entered the program, returning home was an option – indeed, the only other option she felt she had. However, looking back, she commented that had she done so, “…it would have put a lot of stress on my family…some of the symptoms and things that I did… I was quite happy that they were distanced from it…it gave me the opportunity to be a bit further away from them and [for] them also to recover… I guess what they went through also was traumatic – like the rejection I had for them… I’ve talked to mum about it, and she said that she found the time [without me there] very useful – for recouping, really” (OS).

For most participants, residential community life, despite all its complexities, did seem to provide an opportunity for companionship with other community members. This need for companionship was strongly articulated by a number of participants. One resident talked about how, for the two and one half years before coming to the program he was alone in his apartment: “…what I always had was a feeling of low self esteem… depression…and not being able to cope in social situations… I was locking myself away, and I spent twenty months… sleeping that time away” (DA). For another person – a former resident – sleeping all the time was also a problem, at least from his doctor’s perspective, whose idea it had been for him to enter the program. He recalled how, although he “wasn’t keen to be there…from the very beginning, it only took me about two or three days, and I just seemed to be awake more… It was the people – meeting new people… it was a different place [and] I was just more awake…it was very effective” (RE).

Another former resident was specifically looking for companionship when she moved into the program because she was lonely, “and also perhaps more of a chance to work through some problems like feeling panicky when I was alone” (YK). While she did wind up making friends and enjoying their company, she found the more formal group settings stressful and would often fall asleep in those sessions “out of anxiety.” (This is another instance where the way staff made sense of someone falling asleep could be significant. I was actually a worker in the program at the time this was happening, and never had an inkling it might be due to anxiety.) Several residents commented that it was not just any companionship they were seeking, but the companionship of people who had had similar experiences to them, with whom they could identify. For several former
residents, while they had come to the program hoping to find companionship, they left feeling that had not eventuated; interestingly, these particular residents had come to the program at the wishes of someone else, rather than their own.

Given that many people who experience psychiatric or emotional upheaval lose or experience disruption of significant relationships and/or networks (e.g. friends, family, work, contacts), companionship may be a particularly important need at this time. One staff member put it like this: “Quite a lot of them are in their twenties...asking some pretty big questions about who they are and where they come from and what has happened for them to be here...” (EC). One former resident who had been a very busy, active person, studying at university, commented that after her breakdown, “I was pretty isolated living with mum and dad...and all my friends were off doing their own thing” (GE). The beneficial nature of the companionship experienced in the program, for some, extended into their post-program experience. One former resident described the fear she had felt when exiting the program, that she would “hide away” and withdraw – “go back to my old habits.” However, that fear was allayed when she realised there was “something else I learned at [the program] – that when I did feel like withdrawing, I forced myself to be with other people... I could see that if I just withdrew to my room, my room would become my world and I’d start talking to myself” and spiral downwards (OS).

The need for structure in their lives was a motivating factor for quite a number of residents: as one current resident at the time put it, “I was in and out of hospital.. I’d go home for three months, then I’d go back in for three months... All I wanted to do was break that cycle – to get some structure back in my day – get up at a decent hour, not three o’clock in the afternoon” (AG). A former resident commented, “...structure is very important to me, because I don’t have very much motivation sometimes... so we have to do Monday lunch or shopping...and I find that very useful because I don’t think otherwise I’d do anything... I think I’d just be sitting in front of the television all day...” (BM). Similarly, another former resident spoke about the difficulty she was having at the time she came into the program: “I had incredible problems filling my day, and I still did even a year after living at[the program]. But at least it [the program] provided the
A number of individuals came to the program with an awareness of wanting to use it as stepping stone towards more independent living. One resident commented that she was “here because it’s not the right time for me to go out by myself... To build a foundation so I won’t get sick and lapse into what I lapse into... to make a break from my mother and my sister and my family... to learn to look after myself again... make some friends... re-balance my life, not that it was ever very balanced, to be honest. Just to cope, away from the stress of my family... and I’m glad I’m not in a flat by myself” (AG). This statement seems to sum up the experience of many residents and former residents, who viewed the program as a much-needed transitional space. Another resident commented that when her discharge from hospital was being planned, both her mother and her social worker were very concerned about her moving straight into a flat by herself. They were worried about her “just going straight back to work and just pretending like nothing had happened. And that was what I was planning on doing... [coming here] was really about dealing with having had an illness - that’s what you do when you come here. You don’t just sweep it under the carpet and pretend it didn’t happen.. I knew nothing about mental illness... I hadn’t had any counselling... it was all about starting that. And I found it a good time to do it... a main thing is just building up your confidence again, establishing yourself again” (AM). The vulnerability and fragility that was experienced after leaving hospital was part of why a number of individuals came to the program. They felt the need for a transitional or healing place to be: a resident who was preparing to leave the program after a one-year stay, put it like this: “You don’t realise it at the time, but you are really quite fragile... It’s [being in hospital] like another world... It’s completely different to living in society. [The program] is a really good sort of in-between, sort of stepping stone... getting back into society” (AK).

Just as going straight into independent living after leaving hospital was felt to be unhealthy by quite a number of residents, going back to live with one’s family, as previously mentioned, was not considered a healthy or available option for some. One former resident said, about her coming to the program, that she was “…hoping to get a bit of independence... live my own life, away from the family... I knew that the source of
most of my problems was at home, and that I had to leave home. But by that time, all of my social supports had vanished... I didn’t have anybody that I could move in with. So I knew I needed a transitional thing, between where I was and where I wanted to be…” (MA). The value of the program as a stepping stone - as a place to gradually learn about oneself, and then “gradually come back out again,” as one staff member put it, was important for many residents: the program could be “a vital link between feeling completely disempowered [at hospital or in a toxic environment of some sort]…[The program] is the vital transition, being able to sustain themselves and become who they are... Otherwise people can move out of one toxic situation straight into another” (OR).

Another former resident had also looked upon the program as a transitional situation between where he was and where he wanted to be: “Going back to uni had been a long term goal...and getting myself together and back on track enough to do that” was what he felt he needed when he entered the program (IR). Although getting back into society, getting a job or going back to university were goals for some residents, many also acknowledged the need for rest and recuperation, for example: “…the main thing I needed was to allow myself time to recover...just having time to just 'be,' and learning how to do that...” Indeed, for this particular individual, over-working was part of what led to her “breakdown” (AM). One very experienced staff member also commented on the crucial significance of allowing a person the time and space to identify their own goals: within this process, the role of staff, she observed was to offer “a mechanism of... some self reflective time... to provide them with some way of defining what getting back on track meant to them... and then to challenge the client to get back onto that track” (RT 80). Similarly, another staff person suggested that a lot of the work of staff and residents was around “bridging the motivation gap... they've got their goals – where they'd like to be, and they've got their life, and there’s a huge gap in the middle...” (EC 80).

Given the diverse nature of reasons as to why individuals came to the program, what can be said about their experiences of change – or ‘turning points’ – in the program? Did such points occur, what led to them, and how were they experienced, observed and supported? It is to these questions that I now turn, again positioning the words of participants alongside those from the literature.
Turning points

Similarly to others writing about their own experience of recovery (see, for example, Deegan, 1988; Leete, 1989, cited in Hatfield & Lefley, 1993; Gagne, 1996), Lovejoy (1984) writes about two turning points in her experience of recovery from psychiatric upheaval, both revolving around the generation of hope: the first was when she met and worked with a psychiatrist who believed she could get better; the second was when she moved into a residential program where she was around others who had had similar experiences to herself and were getting better. Hope, she said, gave her courage to change, and to try to trust again. Those professionals who truly helped, in her experience, were those who sought answers with her, rather than for her.

Indeed, when asked what they felt might be a turning point experience for some residents, in terms of moving forward, staff without exception commented that the realisation of being able to act upon the world or recognising some personal responsibility for their situation seemed to be such a point: in other words, the realisation that someone else was not going to do something for or to you to make change happen. One staff member suggested it was something about realising that one did not have to be a victim, and then, working on how to be otherwise. This was described by another staff member as a process in which an individual could “discover their power gradually,” for example, by being supported to resolve conflict with others in the house and to be assertive about their own needs, and challenge objectifying and oppressive discourses. This, she observed, was a gradual process, whereby a person could experience a constructive use of their own power to act upon the world and “to see the good that can come out of it” when they expressed themselves in ways that led to positive (or at least not-devastating) results. At the same time, residents and former residents commented on the need for staff to work alongside residents, by “giving them unconditional positive regard... and not being directive” (RD 78). It was important in this that “staff don’t speak for you, they encourage you to speak for yourself, to figure out what you want from the program, rather than them directing you... They’re sort of there as a partner...” (GE 78).
Along similar lines, a third staff member suggested that, in his experience, turning points often occurred when a person realised that the program was not going to be everything they thought it was; that while the program had a lot to offer, it was up to service users what they got out of it. That realisation, he observed, seemed to coincide with a change in the person’s sense of agency, which was also accompanied by the realisation that the program environment could support them through that process; rather than reacting negatively or punitively to them as previous environments or situations may have done. This experience, he suggested could be pivotal for both worker and service user: if a person engaged in the program from “their own desire to know something,” then the role for the worker and the environment is to try to facilitate this re-engagement. The turning point is the realisation that coming to the program is not in itself going to make them better, but it may help them to discover some of their own power in their lives.

A fourth staff member observed that, for some people, discovering their own belief system was a turning point of sorts, particularly for those who had been struggling with difficulties in relationships with their family of origin or wider social discourses around, for example, the role of women. She referred to an individual who gradually came to question, “Do I really believe, as I was taught, that I’m here to look after people?” Discovering that she was allowed and able to have beliefs and needs of her own was a breakthrough that then allowed other positive and liberating growth to occur.

So, how did the observations of service users resonate with those of staff? Interestingly, residents and former residents’ views appeared strikingly similar, when asked if they were aware of any turning point experiences for themselves in the program. The following experiences were identified:

- a realisation that the program was what she made of it and that she could commit to the program without feeling threatened, allowing herself to be open and vulnerable, rather than hanging onto a “tough role, as protection” (AS 35, 36)
- the program being experienced as a catalyst for opening up, “letting things hang out whether they’re true or not” and learning about trust – that it’s okay to share because self disclosure was met with total acceptance and support from other residents and staff (AG 37)
- a rebuilding of trust in people through having people she knew she could talk to (LC 41)
- realisation of a certain “power of mind” – the capacity to think for oneself, discover one’s own power to act and to do: actually “doing things” developed more confidence than ever before (DA 38)
- figuring out what you yourself want from the program (GE 39)
- making a conscious decision about whether to be there (in the program) or not… whether they’re there because they want to get better or because someone told them to go there (UM 34)
- it was sometimes a matter of feeling sorry for others who she observed, who had been referred to the program and didn’t know what they wanted to get out of it; whereas she knew this for herself and felt almost guilty for “manipulating” things into growthful experiences for herself (RD 46)
- the individual needs to look at where they want to go and how to get there (IR 43)
- despite concerns about becoming dependent on the program or the workers, you “have to be able to turn your fear of dependence to conscious use of support” for your own benefit (RA 42)
- becoming aware that being with others and needing others, after being alone for so long was okay (rather than being fearful of the need for interaction) (AS)
- while the program felt at times “intolerable,” learning how to “use the groups” and rising to the challenge of the program was a crucial turning point – becoming “active in the process instead of resisting it, trying to make everything valuable” to her own growth because she was in a “shit situation” and wanted to get out of it (NA 43)

Indeed, ‘hitting rock bottom’ was mentioned (literally) by a number of residents and former residents as a turning point: having nowhere else to go, not being allowed to go home (or not wanting to go home), feeling trapped, and realising that they had to do something. And, for many, the community experience itself, was a turning point, whether it was (re)discovering a capacity to form friendships, discovering a sense of belonging, or learning to (re)engage with life and its activities rather than sleep the day away. A number of residents commented on the gradual nature of building up to such
experiences. One resident reflected that people needed to have the time and support to build up a sense of “emotional safety in the house” to be able to express themselves and “process the shame” of having had a psychotic episode (AK 38). Another former resident commented that at first, you only showed others the surface, then gradually “you’re showing the whole lot and so is everybody else,” and while the issues got deeper and harder to deal with, the capacity to discuss them “got easier” as greater skills in communication were developed through group experiences and individual work (UM 47). One former resident made the interesting comment that she had felt a desire to “show staff I could change, because they couldn’t see what was going on inside” – she felt she had to make the effort to show staff “the whole story” of herself and her experience (NA 44).

The significance of a sense of safety before being able to explore issues and move through painful processes cannot be underestimated, nor can the courage required in order to engage in this process. As one worker put it, “We all need our defences too... it’s a fine line as to how much of this work can be quite invasive and perhaps destructive... because it is a sort of deconstruction we’re doing here... peeling back layers of defences. We [as workers] are IN it, we’re not standing away from the resident... we’re walking beside them, encouraging them” (OR 80). A former resident put it succinctly when she said, “You have to be quite brave, to look back on your past and the patterns you’ve developed...” (RA 74).

As the Melbourne Consumer Consultant Group (1997) observes, staying alive from one day to the next may be a profound challenge and accomplishment at times, or, as Deegan (1996) observes, simply getting out of bed and washing may be a pivotal achievement when profoundly depressed. Similarly, as a colleague reminded me recently, what inspires hope in one person may not in another; what inspires hope in an individual worker may not in their client (or their work colleagues for that matter). Thus it is important for workers to listen and attend to where the seeds of hope lie in each individual, which may be as unique and diverse as walking in a forest for some, or in the writing lists of possibilities for others, or in a feeling of love extended to or by another.

Numerous writers have observed that the imposition of worker-generated goals is usually doomed to failure (Hatfield & Lefley, 1993; Mosher & Burti, 1994; Hendrickson-
Gracie, 1996), arguing that ‘allowing’ service users to take risks in making their own decisions is crucial to their recovery process and sense of agency. This may be a particularly salient point as organisations increasingly take on board the fears generated by what has been described as a ‘risk society’ (see for example, Lupton, 1999) in which organisational, agency and worker accountability demands less risk and more uniformity around service provision and outcomes. Indeed Strauss (1989) identifies that a consistent problem in psychiatric services is that clients’ stories can be overlooked in the rush to push people towards “passive adaptation” to what workers, services or funding bodies believe is of benefit (Caltagirone & Smargiassi, 1997, p.177). It is interesting to note, following on from this, that Finch and Krantz (1991), in their study of worker burnout in high stress settings, concluded that when workers saw their task as “providing opportunities for member growth” they were less stressed than if they were trying to attain more concrete (often worker or agency imposed) goals of the sort often found in traditional clinical settings (p.24).

At the same time individuals may feel so trapped and ineffectual that to dare to attempt change, or to make decisions again becomes almost impossible. Indeed, ‘allowing’ clients to make their own decisions can be difficult for both workers and clients, particularly if that decision is to not do the things workers feel would be beneficial. Karusu (1992) also observes that even though someone comes to a service for the purpose of being helped, at the same time they may wish to remain unchanged, a basic ambivalence that workers need to be prepared for. Here again it is important for workers to critically reflect on their own lives, and how at times, our own attitudes toward change – whether in a relationship, in our workplace, or in our personal behaviours – is one of fear or resistance. This resistance then becomes a shared human experience rather than a particular feature of clients. One former resident made these insightful comments about the nature of his own change process, and that of others that he had observed:

“It’s hard for me to change, still. It’s something in my nature, and to break through that… I don’t know.” He described experiencing “a clash” between what others (staff, family) wanted him to do and what he felt he wanted… “I was taking advantage, in an ignorant way… of not doing what they were telling me… it returns to me listening,
but not doing…[my problems] are MY cause, I caused it like that…it’s my stubbornness, so that’s why I’m not taking any of the skills which I’m supposed to learn from here…I don’t know…maybe the future tells… It’s like a limit. You know your limit. You know when you’re going to stop. And I know when I’m going to change. I think, if I have a family. That’s [where I’d make] my sacrifice, there…” (TI 85).

Workers may walk a fine line between ‘giving’ clients the power to make their own decisions – a potentially problematic and power saturated construction - while, at the same time, not abandoning them or colluding in the repetition of destructive patterns. One resident commented that there needed to be a balance “between being pushed, or basically them [staff] leaving it up to you” (IV 83). Norton cautions that there is a fine line between “tolerance and neglect” (1992, p.19); there is possibly also a fine line between imposing one’s own view of success and good decision-making, and working in a way that allows service users to develop their own formulations (Greenberg, 1994) and path of recovery. A continual challenge for workers, particularly in intensive settings, may be the potential to unconsciously repeat or collude in destructive patterns with the client – together workers and clients may “reproduce old and well-known patterns and life styles …[which] may stabilise patients [sic] and remove frustration, but by diminishing tension prevents profound change, new development and growth” (Pachaly, 1997, p.37). One worker commented thus: “I look at human beings in a very complex way... in trying to understand what is the core issue that [a] person is dealing with, how can we make sure that we don’t get trapped into repeating that pattern for the person. I think that’s sometimes what the work is – to allow them to see what’s their’s…this is a difficult thing to quantify” (EG1 9).

In order to believe that goal-setting is worthwhile, Moorhead observes, not only do the goals need to be self-generated, but the person must believe that they have the power to make the goals an eventual reality (1994). One staff member made this observation about the gap between wanting something and believing it is actually possible to achieve: “My view of mental illness is...somehow, for various reasons...about the individual not being able to have his or her needs met. There’s some sort of rupture...that prevents the individual from experiencing arousal of a need and then completing that to a point of satisfaction. There is a separation of action and energy that
is almost like the action that the individual does to his environment is different to, or is not congruent with, the energy that the individual has” (OR 95). According to Yalom, what may appear as avoidance or abdication of responsibility may actually be a form of protection from a freedom that may be overwhelming (1980, p.224). Along this line, the same worker observed that much of the program’s work is with people who have, for various reasons displaced “their responsibility, and their part of their situation, onto others...hence the work is around somehow placing that responsibility back onto them...in a very gentle, safe and hopefully constructive way” (OR 95).

As previously mentioned, from a critical social work perspective, workers also need to be mindful not to minimise the impacts of structural oppression and the unequal power relations and institutional arrangements that ensue. Assisting or encouraging someone to ‘assume responsibility’ for themselves, without any structural or critical analysis could potentially compound the oppressive nature of social relations by adding oppression by the worker to the equation. Many women I encountered in the mental health system had experienced sexual abuse and/or assault; many individuals had been traumatised by the oppressive nature of the mental health system and the stigma attached to ‘mental illness’ in our society; others had experienced trauma and discrimination due to their sexual orientation, the stress of living in poverty, or other aspects of their identity that fell outside the social norm. To suggest that these are not real aspects of lived experience and that a person simply needs to assume individual responsibility for their problems and/or needs is highly problematic. Any work aimed at facilitating empowerment must acknowledge and validate the way in which structural components shape personal experience. In the late 1970s, the theory of ‘surplus helplessness’ was put forward by Lerner (building on the work of Friere), in which it was postulated that the actual structural powerlessness experienced by oppressed groups was compounded by additional or surplus powerlessness: a psychological internalisation of worthlessness and impotence that becomes a crippling “script for living” (Barber, 1991, pp.30-31).

How might a postmodern critical perspective assist us to make sense of this issue of personal responsibility for change? From my own experience working in mental health, and my own personal journey, I know that there is wisdom and truth in both a structural perspective and a more psychologically oriented one when it comes to a
recovery process in the wake of psychological distress. The role of critical reflection is useful in uncovering ways in which our own individual discourse or story limits our potential for empowerment, as well as ways in which wider social forces shape our experience. We do not, as workers or human beings, need to abandon one analysis for the other; indeed by becoming clearer, or by assisting another person to become clearer, about the nature of obstacles and barriers to change and greater well-being, the inner morass of hopelessness and inactivity may begin to shift. Critical questioning, validation and deguilting – all features of feminist and anti-oppressive practice – can sit alongside more psychologically or narrative oriented approaches that allow an individual’s story to be felt and articulated within a containing and supportive relationship and environment. (It also needs to be acknowledged that some psychological approaches may sit more comfortably alongside critical approaches than others; and psychological concepts can be used more or less oppressively depending on the consciousness and orientation of the worker.) The next section explores and problematises the role of workers and program settings in the change process, in relation to relevant literature and participants’ experiences and observations.

Workers and program as change agents

Viktor Frankl, a Viennese psychotherapist, developed the idea that when people seek help they may be experiencing an “existential vacuum” or sense of emptiness and meaninglessness (1969, p.ix). His treatment – logotherapy – was a form of “healing through meaning…[that] must be found but cannot be given…” (p.67) (my italics). Yalom (1980) built on Frankl’s work, observing that a “vegetative form of existential sickness” was widespread in Western culture, and was, at its extreme often labelled as clinical depression (p.451). The role of the helping practitioner, he said, was to help the client find new meaning through (re)engagement with life and its activities. He too stressed that no one could do this to or for someone, although they could provide support in the process of (re)engagement with life – a process that began with the engagement of worker and client.

Lacan’s intriguing work on psychosis goes so far as to suggest that psychoses themselves are “the emergence in reality of an enormous meaning that has the appearance
of being nothing at all,” an experience so unintegrated into the person’s lived reality as to cause the disintegration of the person at some levels (1995, p.85). Lacan suggests that the person then becomes a “martyr of the unconscious” – incapable of sharing the meaning of their experience (Benvenuto & Kennedy, 1988). Based on this interpretation, the worker’s role in facilitating change might be to assist the person to share their experience in a way that can be understood by others, as part of their reconnection to the world after the isolating experience of psychosis and its aftermath. Janoff-Bulman and Frantz (1997) observe that a meaningful world is one where you know who you are and where what happens to you makes sense; recovery, then, they propose, occurs when the “terror of a meaningless world dissipates as survivors create meaning and value in their lives” (p.100). (These authors acknowledge that not all those who experience such trauma arrive at a successful resolution, some remain “overwhelmed by the terrors of a dangerous world” (p.100) and this too must be accepted by workers.) Welwood points out that rather than denying these experiences of anxiety, meaninglessness and despair – tempting for both workers and clients – they can be seen as part of an ongoing process: indeed, he suggests, “we can’t move forward unless we can let go of where we’ve already been” (1983, p.153). One staff person shared the following reflection, which resonates strikingly with Welwood’s observations, when I asked him if he saw himself as a change agent:

“It’s funny, I don’t see myself as a change agent... Change comes about through greater awareness, not necessarily through force or intervention. A change is actually quite slow... we’re always in process... I see myself as perhaps facilitating a person’s stay here [in the program], but I can’t change someone. The person, in order to change, needs to be who he or she is – to experience the paranoia or whatever, in order for change to occur. Not necessarily to remove that, or deny that experience” (OR 86).

Along much the same lines, a former resident had this to say: “People have their own time of understanding and learning and progressing, and their own ways of expressing that. ... It’s not whipping a person... it’s nurturing a person, guiding a person, flowing with a person... the philosophy of people knowing themselves, where they’re at, who they are, how they feel. Not necessarily how they SHOULD feel, but maybe need to feel, in order to understand themselves” (TI 82).
resident also highlighted some of the difficulties and losses associated with change that workers may need to be mindful of. “How [much] a person changes depends on how [much] they want to change, what they think is worth the effort – they might be comfortable enough where they are... to change, to break out of the old skin isn’t easy. To do it can cause a relapse. Or cause losing friends, or hurting your family... this may be mend-able later, but it’s a decision you have to make... you’ve got to be strong” (TI 82).

Marris, in his seminal book on loss and change (1974), proposed that after a trauma or significant loss, people may be faced with what he called a “crisis of re-integration”: while they desire to recover and move on, the difficulty of reconstructing a viable sense of meaning that ties together past, present and future may be overwhelming. The effort to reconstruct a viable sense of meaning, according to Marris, similarly to Yalom and Frankl, must be accomplished by the individual themselves. “No one can resolve the crisis of reintegration on behalf of another... [it can only be] reformed, piece by piece, from the intimate fragments of personal experience” (Marris, 1974, p.41). For workers to impose their version of life’s meaning, he goes on, is to deny the person a crucial process, treating them “...as puppets dangling by the threads of their own [the helper’s] conceptions... To be told the meaning of your life by others, in terms which are not yours, implies that your existence does not matter to them, except as it is reflected in their own” (p.155). Again, the words of the former resident quoted above are powerful; he observed that change as a result of external pressure “would not be emotional... it would be a forced thing... it wouldn’t be a natural coming thing... it would be an artificial outcome. And it wouldn’t be what the person who is helped is naturally going to have the answer to – it’s going to be what the other person wants... (pause) It also means that the oneself is the oneself teacher. And the other person is very hard to be in their body, in their understanding, in their way of thinking, even though there are similarities in people.” At this point in the conversation I asked, “So people have to come to a point in themselves, where they feel able to change, and that can’t be put on them by someone else?” He replied, “No, or else it won’t be pure... it’s not the true self answer... it’s not the core, it’s the skin” (TI 83).
The psychiatric disability support sector, based on the principles of psychosocial rehabilitation, has a particular perspective regarding where the power to heal or change resides and the role of the worker in facilitating that process. Two key principles of psychosocial rehabilitation are: a) that staff believe recovery is possible and b) that each individual knows what is best for them in their own recovery (Robson, 1997). Indeed, as Sanford wrote in the 1970s, practitioners need to actively resist assuming a role of change agent – a role that may, unintentionally, keep the client in an inferior, ill position (1977) and place the practitioner in a dangerous and unrealistic position – a fantasy of omnipotence. One experienced staff person made this comment, in relation to what he referred to as “paradoxical intervention”: “In order for change to be facilitated, you need to – you have to – let go of the person changing. Not... because you think that by letting go, the person will change, but actually letting go” (EG 85).

In a strikingly similar vein, Podvoll suggests that it is in the “letting be” – the giving up of “all hopes for results – for a cure, for a healing relationship, for feeling good... for thinking of oneself as a gifted therapist...” that the worker truly is able to work skillfully (1990, p.273). He comments that there is no ‘good’ or ‘bad’ counselling session; worker-client interactions are more like seasons that are constantly changing; in this sense, they mirror the non-linear process of change and recovery (and life) itself. This letting go does not imply giving up or receding from relationship, in fact, quite the opposite. It may allow for a different and potentially more empowering relationship to gradually take form. The development of a strong working relationship can take considerable time and effort (Frankl & Gunderson, 1990; Moorhead, 1994); as one former resident commented, at some points the simple act of responding to a worker, even if you cannot engage in the activities or actions they are suggesting, is something that should be acknowledged. While it may not appear significant to the worker, to the traumatised or recovering individual it may be a tenuous but important attempt at communication. “... It helps having someone there, to talk to... and that’s a start – just talking to someone... If they don’t want to talk, well then there’s nothing you can do... They have to be open to actually saying something. But if they’re open to just talking [a bit], that’s a start, and you should give them praise for just doing that...” (YK 17).
Shainberg (1983) suggests that it is the “being together” that is of central importance. “We do not change or fix,” she says, “but over time get to know the patient [sic] as he actually is and lives… In this way, we facilitate his [sic] getting to know himself more clearly at which times he feels increasingly ready to change” (p.164). Similarly, Moren (1994) challenges the concept of social work as a problem-solving activity and proposes a framework wherein the “fundamental element is to contribute to making visible new possibilities of interpretation in destructive life situations” (p. 280). This shifts the focus from the problems of the client to the relationships that can be developed within the culture of the helping organisation. He suggests that if transformation or change, rather than adjustment, is sought, this can only be facilitated via a personal worker-client relationship.

Welwood elaborates on the nature and significance of the healing or supportive relationship, perhaps somewhat alarmingly in the context of conventional social work practice, describing it as an “intimate encounter that can awaken the heart of both therapist and client” (1983, p.viii). This may, to some social workers, sound both undesirable and unprofessional. Social work literature abounds with stories of dangerous workers that over-identify with their clients, let alone social workers who are open to having their hearts awakened through their work. What might it mean for one’s heart to enter into their professional work: is it an inevitable component of passionate and engaged critical practice or a sign of over-involvement, naivety or boundarylessness? Welwood suggests that as a worker’s “need to be in control relaxes, he can be present with more heart:” the heart, he says, is “that part of ourselves where we can be touched, by the world and other people” (p.ix). Is this something workers would want to do: what would it mean to relinquish control and be present with more heart? Being in control of situations may be an aspect of professionalism workers would be understandably wary of abandoning, however, it is useful to deconstruct this concept to see what assumptions underpin it, and what alternative reconstructions might look like. The need to be in control may rest on assumptions that if things happen which are unpredictable we may not know how to handle them. It may also have something to do with not being manipulated by clients or equating control with a justifiable and benign power of our role, or protecting ourselves from the sometimes very painful world of the other. Each
worker needs to analyse this for him or herself. Would relinquishing the need for control create an openness to sharing power with clients or to being, as Welwood suggests, more fully present, or would it undermine our capacity to work at a professional level, as we conceive it? From a critical and reflective perspective, the usefulness and meaning of opening one’s heart as a worker could be fruitfully explored, like other approaches to practice or ways of being, as potentially contextual and fluid, open to ongoing analysis, and creating various forms of trespass and possibility in specific situations and settings.

Moffatt observes that the relationship between social worker and client is often constructed in a way that serves bureaucratic funding bodies and technicist models of practice as much as the needs of clients; within this construction, “the social worker is expected to help the client progress from worse to better or from chaos to order” (1996, p.49). In one of my interviews with a senior staff person, the following exchange occurred, when I asked if she thought it was possible to expect a program “to achieve a certain amount of change for people?” Her reply was, “As a manager, I had that expectation. Deeply. … Taxpayers’ money was being spent. … But internally, much more problematically, was the fact that I unconsciously carried that [expectation]… because the need was so massive from the clients” (RT). This deep desire to achieve change for people is potentially located in a complex web of layers for workers, ranging from co-option in modernist quests for a particular type of professional validity, to very real requirements of funding bodies, to deeply internalised desires to help.

In human services, helping is often constructed, at its most basic level, as ‘changing’ someone or something in linear and tangible ways. Perhaps even before becoming professionally qualified as social workers we wanted to help people; once professionally qualified and employed, this need may become stronger as others may also be judging our abilities – not the least of which are service users. Shainberg refers to our “lifetime conditioning to accomplish, to get better, to please, to be liked, to be thought of in a certain way…” (1983, p.175). However, the modernist meta-narrative of linear progression from one state (chaos, non-productivity) to another state (order and a particular type of productivity legitimated by dominant discourses) has increasingly been questioned by consumers, progressive workers and critical postmodern perspectives.
Joan Clarke, then Director of Melbourne’s Prahran Mission, in a paper presented to the 1996 Recovery Conference (Melbourne) concluded simply that the most useful role of organisations delivering mental health services was to assist people in becoming “experts in their own recovery” (Clarke, 1996, p.220): quite a different construction of the worker’s and the organisation’s task around change. This is mirrored by Leibrich who, in describing her recovery experience, firmly states, “no one else is an expert on me;” the professional, she says, needs to understand the idea that the healer lies with the person and the job of the professional is “to help them find it.” She concludes, “There is no right theory. There is no right therapy. There are only right people. And the right way to care for people with mental illness is to help them see and say what is right for them” (1998, p.273).

In the process, then, of assisting individuals to find their own healer within, is it possible (or desirable) for some sort of mutual change to occur? Riley (1996) observes that in the construction of social workers as impassive and neutral agents of change, they are seen “almost like a catalyst … that remains untouched or unchanged through the change process that the client has been led through” (p.38). However, as White (1995) suggests, it may be reasonable to assume that any sort of therapeutic or other interaction is a two-way experience; inevitably, he says, “we change each other’s lives, often in ways that are hard to speak of” (p.57). Honest critical reflection on why this should be hard to speak of, if indeed it is, would be useful to critical practice. Is there a sense of unprofessionalism or weakness in acknowledging that our work and interactions with clients changes us? Are we so immersed in the paradigm that it is the service user’s role to change that we are not able to acknowledge or embrace opportunities for change as workers?

White suggests that an awareness of this mutual impact is very important, and the practitioner must find an appropriate way of expressing this openly with a client. He gives examples of ways in which a practitioner may be changed by their interaction with clients: new perspectives on one’s work or life, a greater appreciation of some aspect of one’s life, or some ‘gift’ of new ways of thinking or being. This awareness and acknowledgment, he says, is potentially a mutually sustaining one. Rather than feeling somehow belittled (or unprofessional) by the experience of learning from a client, the
worker is enriched and sustained. What would it mean, what would it feel like, to share this acknowledgment with clients? What might be lost and what might be gained, and for whom? In the process of carrying out this research, in any number of my interviews with participants, there were moments where I felt the most insightful, intriguing and articulate expressions of experience were being shared with me by residents and former residents who were definitely my teachers. Perhaps in the research context (where, as one participant reminded me when I spoke with surprise about all the things I’d been learning that I hadn’t known before – “isn’t that what’s supposed to happen?”), it was easier to acknowledge how much I was learning from participants than in the service delivery context where the onus of change is consistently on clients and where workers are supposed to be the knowers.

Kanter (1985) observes that while his interventions as a worker/therapist were sometimes significant in facilitating change, they often played a very small role in the “larger dramas” of clients’ lives. He suggests that it was the natural evolution of clients, particularly their social interactions, that created a process of positive development, and that his best work was to help prepare clients for more successful “exploitation of these unpredictable occurrences” (p.65) – i.e. the life events through which clients’ ongoing healing journey crystallised. (He observes, in fact, that positive change achieved and experienced by service users sometimes seemed to be the result of reaction against professional interventions.) Field theory suggests that the degree of impact that any one individual or period of experience may have on another’s life is always limited and interacts with a whole range of forces within a person’s field of experience (Long, 1992); no matter how powerful an experience, it is still “but an instant in a lifelong scenario” (Estroff, 1981, p.36). One experienced staff person observed that some individuals might not be able to make beneficial use of a service because their trauma or disturbance had been so great that the relatively minute “drop in the ocean” of the program experience was not great enough to penetrate their experience in a meaningful way (RT 48). Another staff person observed, “…there are so many factors in one’s field that are impacting on that person’s life at any one time, that to take one aspect of that person’s field, and to measure outcome from that is denying everything else that is occurring in that person’s life…” (OR1 8).
The latter staff member’s comments refer to the relative insignificance of the program in relation to the entire experience of the individual. As well as their past, residents also brought their current inner state and relationships into the program with them. For some residents, their inner state at the time of residency seemed to create an insurmountable barrier to participation in the program. One former resident reflected that during this time in the program (which was less than six months) he had been experiencing “a dark identity crisis” – a powerful self-deprecating voice that hung over him constantly. As a result, he reflected, he did not benefit from anything at that point – programmatic or otherwise; he commented that he had neither the “spirit or energy” at that time to re-engage with life. “You can’t,” he said, “conjure commitment out of the air…” (BO 34). Another former resident commented on the debilitating experience of “living in limbo” after a psychotic episode, which was, she said, worse than a crisis, because “you feel like you’re nobody, you have no boundaries, no limits and nothing to relate to” (YK 47). Reflecting on her experience in the program, this same ex-resident felt disappointed that she had not changed some of her negative patterns during her time in the program. She had been asked to leave, and had eventually wound up living, with outreach support, in a comfortable flat, however she found, “I didn’t have the skills that I’d thought I’d have… [I was] still on my own and I still had the same problems I started with… I still haven’t worked out my friendships…[I’m] still attracted to people who use me…” (YK 68).

Staff, residents and former residents offered reflections around the vexed area of motivation and commitment, which often resembles the old riddle around which comes first – the chicken (i.e. motivation) or the egg (i.e. ‘progress’). If a person does not have the motivation or “some level of self reflective capacities,” or some – even small and hardly formulated – desire to alter their life, it is likely they will not, according to one long term staff member, reach a turning point or experience much change during their time in a program (RT 48). Residents and former residents expressed similar views, with one former resident summarising that in order to achieve change or growth within the program, an individual must have a “desire and need for growth within a community” (LC 42). For one former resident, the time he had spent in the program seemed totally useless; he had never gotten used to being there and had felt frightened of the other
residents, particularly when staff were not present. He had not wanted, at any point, to be in the program and had gone there only at the insistence of parents and doctors.

Another former resident, who had experienced what she and staff would describe as a very successful stay, recalled a period of time when she had “needed to stay sick” but then “came out of it” although she did not know how this had happened (RD 46). This need to stay sick may be a form of protection and an expression of the need for asylum or withdrawal or as previously mentioned, an understandable fear of the risk involved in change. Another former resident recalled how she had been incredibly fragile at the beginning of her stay, when “everything felt awful.” Although she acknowledged that she had needed to question how she ran her life, and indeed had some awareness of that even at this awful time, she also felt too vulnerable and unprotected to benefit from being “confronted...or questioned” – what she needed initially, she felt, was more along the lines of comforting, validation and gentle support (NA).

Whilst acknowledging the importance of one’s readiness to engage at some time during their stay within the program, both residents and staff also highlighted that even if someone did not experience a significant turning point, or engage fully with the program, they may still get something useful from it, which may not be immediately recognisable. One former staff member commented that the program, even though not achieving observable concrete change may still be “an important part of the individual’s journey” (ME 48). Similarly, a former long term resident observed that while there was a difference amongst individuals in the program in terms of both their willingness and capability to engage in the program, “some people can still benefit even if they’re not fully ready” (TI 46). He went on to say that this depends on whether the person is uncomfortable enough in their current state to risk making changes. He reflected that he was still unsure when he would be ready to make real changes; something which, he mused would be not only “strange,” but “miraculous” TI 46).

At the same time, workers may not realise the process that is occurring for someone, under the surface of what is being shown. Despite outside appearances to the contrary, some aspect of the person’s community or program experience may be silently and slowly bringing about very subtle shifts. As Bleuler (cited in Kanter, 1985) suggests, in the “active communal relationship” where one is related to with acceptance and
kindness, there is an opportunity to not only begin to accept oneself more fully but also to “experience and discover an inquisitiveness and concern for other people” and therefore achieve some liberation from a “painful absorption in illness” (Podvoll, 1990, p.254). Along these lines, one former resident reflected that while she was often silent in groups, she was still, in her own way, participating. She found that, gradually, especially in art group or cooking, she could help people – she felt she was being useful by giving to others, which in turn – and somewhat to her surprise – helped her (YK 47).

Deegan (1988) writes that she cannot recall the moment when a tiny flame of hope began to flicker, but she sensed that it was “called forth” by the people who did not abandon her, and by the “possibility of being loved” (p.14). One program resident in particular commented on this experience by saying that when she started loving and respecting herself more, she was better able trust and communicate with others. Part of this process for her was a working through of childhood abuse issues which enabled her to better accept herself, and as a consequence, others. She described how she began to feel she was actually lovable and good sometimes, which was a significant shift in her sense of self (AS 36). One resident, who was just about to leave the program after a twelve month stay, also commented on the significance of this nurturing relationship, saying that before coming to the program, “I’d never really had an adult figure in my life who was willing to just sit there and listen... just to be there... and be really supportive and not react to things I’m saying. And being able to express feelings that family or friends might feel uncomfortable with...” (RA 78). And, from another resident, “[my keyworker] has allowed the space to just go into anything, which has been fantastic” (AS 78). One former staff member also commented on the significance of developing a trusting relationship in which service users could authentically engage in whatever process they needed to, in order to move forward: “It’s useful to be in a relationship where you build up trust... so that what is being talked about is genuine, and matters to the resident. That kind of stuff only comes out between two people though having a relationship. And I really believe that’s how people move on. You support someone by knowing what their story is... I intend that what happens in our relationship is that the person realises their own power over their life...” (UR 97).
Narrative theory and therapy suggests that all human beings have stories that enable them to make sense of experience, including dominant stories that create our sense of identity (White, 1995). Indeed the stories we tell ourselves and others (and which are often told back to us) to some extent shape our lives and circumscribe or expand our repertoire of actions and possibilities. The creation of new stories might allow new actions (Dulwich Centre, 1997); workers can acknowledge both the power of dominant stories to restrict understanding and action, and draw out sub-stories that may have gone underground or been displaced by a history of “pain, discouragement, missed opportunities and unfulfilled hopes…” (Podvoll, 1983, p.83). The attentive gaze of a support person may be able to assist the client to discover these stories and explore other ways of living and thinking: this too, is a universal human experience, as we all have had experiences whereby others have assisted us, sometimes very subtly, to acknowledge those creative and resilient parts of our selves that sometimes get buried beneath less empowering self-stories.

This is the liberating nature of what White and Epston describe as “re-storying” (1989, p.7) and Estroff might refer to as (re)engendering a positive sense of “personhood” (1989, p.195). Indeed, encouraging and supporting service users to try out new and potentially liberating responses and actions can be a key role for the worker in providing challenge, along with support (see Hatfield & Lefley, 1993; Orrin, 1996). Both residents and staff, unprompted, identified very similar support roles as important: “It was just the keyworker’s honesty… when I was here at the start I kept talking about wanting to go home, and she actually said she was sick of it. So I took a different course, I sort of decided to talk more about… instead of wanting to go home, WHY I wanted to go home, changing the want to why…” (IV 94).

A flicker of hope, Deegan suggests, must be quickly followed by the willingness to act – the willingness to try and possibly discover that one can do. This may begin in very small ways – “with small triumphs and simple acts of courage” (1988, p.14). Here may be another use of a truly professional and empowering gaze, which can recognise when hope is beginning to flicker and support acts of agency, no matter how small, and recognise their promise. Thus workers are not so much agents of change, but alert witnesses and attentive support persons. Podvoll also comments on the importance of
acknowledging and possibly even arousing service users’ courage to work on difficult and even frightening issues and to be in relationship. “Just as madness forces a confrontation with oneself,” he says, “so does recovery…[demanding that] one may have to face essential realities about oneself over and over again… a coming out, a tentative process in which the patient [sic] begins to peek out from his enclosed world” (1983, pp.207-208). In this process, workers need to ensure that challenges to engage in interactions and personal development are accompanied by a supportive environment where it feels safe to explore and acknowledge moment to moment experiences of fear that often accompany the risk of change. What may initially manifest as a period of inaction and even self-destructiveness before a new direction in life can be contemplated, may be necessary to the recovery process (Podvoll, 1983; Breier & Strauss, 1984).

To conclude this chapter about change and turning points, it seems appropriate to briefly explore what it might be that people are changing ‘to,’ in terms of their identity or experience. A number of authors have written about the process of “becoming an ex-crazy” (Herman, N., 1993, p.23). They question if such a process exists and suggest that if it does exist, it may be considerably hampered by the stigma that accompanies psychiatric labelling, the often-disempowering position of client, and the self-labelling that may occur as a result. There is generally no ‘rite of passage’ from crazy to ex-crazy, which might assist in the construction of the illness experience as something more akin to a state or an aspect of one’s experience, rather than a permanent and complete identity.

Estroff, in her classic study (1989) of identity construction and ‘being crazy’ suggests that “there is not an AFTER with schizophrenia, only a before…” (p.191). She talks about the “narratives of loss” told by participants in her study (people who were involved in the mental health system in the U.S.) as tales of “the new, strange, disturbed and disturbing, not-really-who-they-were-before-but-still-somehow-the-same-person” (p.191). As workers, she says, we can become complicit in the perpetuation of internalised stigma on the part of our clients by failing to recognise, support and acknowledge the persistence of person. This strikes a chord with Podvoll’s suggestion that a key aspect of the role of helpers is to continually try to uncover the person’s history of sanity. Barrett (1988) notes how the “sick person” is “written sick” through case notes etc., with no corresponding writing process (nor any other process, perhaps) whereby the
person is literally or symbolically transformed back to health. Herman (1993) concludes that while “…the ex’s themselves have to create role definitions as they play out their lives…” (p.323), this very personal process can also be acknowledged and facilitated by sensitive others.

Although this quote has already been presented in a previous chapter, it seems fitting to include it here again, as it was a particularly heart-felt observation, which raises the related question of when (if ever) a client becomes an ex-client: “…I always felt I was not as worthy as the professionals in the place. And this idea also, that it didn’t end when you left the community. It carried on through your whole life. I have this feeling that I could meet (name of former 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.’ Because that’s professional information. And this feeling that I’ve done something, or something’s happened to me in my life, 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! That’s precisely the kind of thing that should be prevented... It’s just another form of stigma” (NA 48).

Herman (1993) makes an interesting observation when comparing the process of becoming an ex-crazy to the process of becoming an ex-nun, referring to Helen Ebaugh’s 1984 study. Ebaugh posited, according to Herman, that ‘ex’ roles “represent a unique sociological phenomena, in that definitions of self and societal expectations are shaped and often determined by a previous identity… [W]hat we are seeing in society today is an increasing number of ‘ex’ roles for which there are few well defined normative expectations…” (p.323). As someone who is an ‘ex’ wife and ‘ex’ member of a nuclear family, I can relate this to my own experience very easily, as, no doubt, can many others who have experienced being and becoming an ‘ex.’ Like the experience of recovery, the fear that may accompany change and the power of entrapping or enabling niches in one’s own life, becoming an ‘ex’ may be a shared human experience that we can all critically reflect upon, looking at ways we have struggled with or achieved this transition and how it was shaped by the responses of those around us – from individuals in our social mileau, to the dominant discourses - that impacted on our capacity to embrace and enact new or submerged identities.
(How) do workers acknowledge and work with this identity transformation or integration of the ‘well’ with the ‘sometimes not-well’? What are workers’ attitudes and assumptions around service users’ capacity to change and shift to wellness, at the deep levels of their being? How do workers’ professional views of well being for clients and their capacity to change, resonate with their own narrative of personal change and well being in relation to themselves? In much the same way as I suggested in the earlier chapters of this thesis, that my approach to research and practice has been influenced by my personal journey as well as my professional education and experience, workers’ attitudes to the permeability of the boundary between wellness and illness, and the transition from service user to ex-service user may be shaped by a range of dynamic factors. Workers – and I include myself here - may apply somewhat different ‘rules,’ judgments or perspectives to their own experiences than they/we do to that of service users; this may have to do with the accountability required by professional practice, but it is certainly worth some critical interrogation.

This leaves us with some questions around what marks the client’s departure from craziness/diagnosis, and how do the services and cultures we work in facilitate (or ignore or restrict) this transition? How do we, as workers, validate new and more empowering senses of identity in our clients (and, it may well be added, in our co-workers)? Although similarities in individuals’ experiences of change and turning points have been suggested in this chapter (such as the development of a sense and experience of hopefulness, agency, re-storying, integration of experience and identity, giving and receiving support, taking risks and (re)generating engagement with life), each individual’s experience is unique. Workers, while not actual agents of change, can offer support and challenge mindfully to service users, and engage in critical reflection on their assumptions around change and how these assumptions are manifested in their practice in often unconscious but powerful ways. The preceding exploration of recovery, turning points and change seems to lead quite naturally to a problematisation of the measurement and conceptualisation of outcomes in mental health services; it is to this that the following chapter is devoted.
Chapter 9

Problematising and exploring outcomes

As I said in the opening pages of this thesis, I began my research with an interest in finding out ‘how people went’ after leaving the program. From my experience as a worker, I knew that people came to the program with their own unique history, needs and issues, had varying and often quite intense experiences of and in the program, and left under differing circumstances to move on to a range of diverse situations and living environments. By speaking with former residents and staff, I hoped to get some idea of what people ‘left the program with.’ In mental health literature this is often conceptualised in terms of ‘outcomes.’ However, as participants shared their stories, I began to consider the problematic nature of outcome measurement in mental health, particularly in light of recovery-oriented literature that emphasised the subtle, ongoing, non-linear and highly individual process of a person’s journey along a continuum of well being. As I gradually developed an understanding of critically reflective and critical postmodern approaches to social work, in which taken-for-granted assumptions were opened up for deconstruction and reconstruction, it seemed that the notion of ‘outcomes’ itself could be usefully problematised. If we consider an outcome to be the result or the aftermath of a conclusion of some sort (in this case, leaving the program), what taken-for-granted assumptions underpin attempts at ‘measuring’ these results, and how might different assumptions give rise to different approaches to discovering what has been useful for someone about a particular experience? Given that pressure was beginning to be placed upon community-based mental health services to implement universalised outcome measures, it seemed useful to explore the nature of outcomes and their measurement in light of participants’ narratives and relevant literature.

Critical social work has always considered process equally important to outcome, and in fact sees the two as inseparable; recovery literature – and indeed many of our personal philosophies about life - suggests that individuals are always, to some extent, in process. These views appear somewhat at odds with current policy trends; however, the idea that mental health outcomes can be measured is understandably popular with policy
makers and funding bodies that need to evaluate and rationalise services and resources. And, indeed, gaining a better understanding of service users’ experiences and what programs do well, and could do better, is highly desirable for those providing the service, and is ultimately crucial to service users’ well being and worker accountability. However, outcomes in mental health are not as straightforward as they may seem, and for critical practitioners many questions will be raised: When does an outcome occur? How do we know when and how to ‘measure’ it? When has ‘it’ fully happened? How do we know what factors contribute to what outcomes? How and when do you ‘measure,’ for example, the (re)development of a sense of empowerment or meaningfulness in life (Anthony, 1993)? And, importantly, who defines what a successful outcome is?

The bulk of this chapter comprises an exploration of some of the complexities that mitigate against a simplistic approach to the measurement of mental health outcomes. The chapter concludes with a selection of stories from former program residents, describing some of what they gained or ‘took with them’ when they left the program, as well as reflections from staff on their view of what people might take with them when they leave the program.

**The non-linear, subtle and ongoing nature of recovery**

The question of when an ‘outcome’ actually occurs, seems, at face value, a simplistic one. However, if one examines their own life experience, some of the subtleties of this question become more apparent. In my own life, the outcome of receiving a degree in social work was initially that I qualified for membership of the professional body and could apply for positions that required that qualification (as well as, presumably, having some knowledge that would enable me to fill such a position). But where and when do the outcomes of gaining my BSW ‘end?’ Would there have been outcomes to my study, even if I hadn’t finished the degree? When and how can they be measured? At times, the result of having gained that qualification and the positions I then became entitled to, has been a profound sense of burnout and/or dis-ease at being in positions where what I said or did might unintentionally harm an other; at other times the gaining of my degree has provided a sense of elation and appreciation that I could earn my living in ways that seemed beneficial to other human beings. Currently, as an
academic and PhD candidate, I am still reaping the rewards – as well as the circumscriptions and limitations – of having received that degree, which propelled me along a certain pathway. At times I have wondered what I might have done (perhaps something more ‘creative’ and connected to the earth) had I not gotten that degree. I wondered how the gaining of that degree factored into my divorce – potentially an unexpected outcome. Thus the outcomes of my graduating with a Bachelor of Social Work degree continue to unfold, and completing that same course of study, for others, may have led to entirely different experiences.

The recovery literature, discussed throughout the previous chapters of this thesis, has suggested that recovery – a shared human experience - is a non-linear process of ups and downs, movement and non-movement, reaching out and withdrawal, vulnerability and guardedness: each of these experiences, it can be argued, is neither inherently good nor bad, depending on the context and the meaning ascribed to the experience. As touched upon in a previous chapter, vulnerability is often constructed as a lack of protection against harm but it may also, at times, be a useful openness to being touched in some way that leads to healthy growth and connectedness. Similarly, movement is often constructed as a form of progress, and stillness as a form of passivity or stuck-ness (which, at times it may be); however, in some circumstances or at certain points in one’s life, stillness may be ‘healthier’ than more overt forms of change. Dominant social discourses around success, independence and productivity tend to support narrow definitions of worthiness, which are internalised in subtle and not so subtle ways. At a particular point in time one may be experiencing some sort of progress toward a greater sense and state of well being; this may temporarily, however, be experienced, and perhaps expressed, more as pain or struggle, withdrawal or anger, than as happiness or success. A person may experience what appears to be a relapse or regression to an undesirable state, but out of this may come new awareness and growth that may not have occurred otherwise. Again, in many ways, this is a shared human experience, as we have all had ‘relapses’ in relation to achieving change (whether something as tangible as quitting smoking cigarettes, or something more subtle as making more empowered choices about who we get involved with romantically). At times we have probably all,
unfortunately, ‘needed’ more time, more support, or another dreadful experience to push us along to some new understanding (even if only to ‘fail’ again).

Schimmel, in his review of therapeutic communities published in the Australian & New Zealand Journal of Psychiatry in 1997, observed that the unique environment provided by the therapeutic community allowed for “therapeutic regression” while mitigating against “anti-therapeutic behaviour regress” (1997, p.121). While this is a heavily psychologised statement, it does point, in the context of this discussion, to the notion that what might appear to be regression (or going backwards) may actually be a necessary part of the recovery process, if support and safety can be provided as well. Schimmel suggests that symptom relief – often a hallmark of a successful outcome in mental health services - in itself is not necessarily therapeutic, as deeper “understanding and working through” of emotional conflicts may not have been addressed. While this working through is taking place, it may appear as if someone is not progressing – indeed quite the contrary - but the time required for real change/growth to occur may not be accommodated or recognised by outcome measurements built on expectations of more immediate and concrete results. One experienced staff member reflected that, for him, a successful outcome for residents would be that they re-engaged “with themselves more fully – as subjects. Not as objects of study or objects of my knowledge, or objects of the state saying ‘these are the outcomes for rehabilitation programs’ – which is that someone should have this, this and this. I think that is a BY-PRODUCT. A lot of people DO leave here being able to live more independently, but not necessarily” (EG 78).

Peck (1993, p.17), a psychotherapist, reflects that he sometimes tells his clients not to expect to leave therapy any happier: therapy, he says, “is not about happiness, it’s about power” – the power of greater agency and competency. Along somewhat similar lines, Sanford (1997, p.21) observes “to be healthy…has nothing to do with serenity, and less to do with adjustment.” Indeed, the staff member quoted in the previous paragraph went on to say that being seen as an “expert who has knowledge of a way to live…a way of being able to find happiness…[is] one of the great illusions of what we do – that we can actually help someone be happy” (EG 6).

Gubrium and Buckhold (1982, cited in Silverman, 1989, p.40) also trouble the notion of client/patient progress, suggesting that in itself, it has no essential meaning:
even if it is presented as factual, objective or common sense, it is actually value laden. They also highlight the contextual nature of any assessment of client progress and how it shifts on a day-to-day basis according to the context in which it is being presented – whether in a worker-client discussion, whether the client’s family is being informed of their relation’s progress, or whether progress is being reported to an official funding body. Thus the reporting of progress itself is an interpretive act, where the interpreter and the receivers of the interpretation must be located and contextualised, and where, somewhere in the mix, the client is experiencing their own sense of self.

Returning to paid work is often considered a sign of improvement in Western countries, and while it may appear, on the surface, as a successful outcome, if the person has returned to work too early without adequate self awareness to know when they were becoming stressed or unwell, or without adequate supports, they may not experience the successful outcome that was anticipated. The Melbourne Consumer Consultant Group observes that using one’s employment status as a measure of success is potentially detrimental: jobs can be soul and health destroying, and self esteem and a love for what you are doing can be more important and health-inducing (1997). This is clearly reflected in the following comments, the first from a program resident and the others from staff.

“I’m not going back to work straightaway... I’d like to do something that I feel a bit good about. I feel like I can do this now” (AG 54).

“These [proposed] outcome measures don’t honour that for some people, who have been running away from their issues for most of their lives, and at least since diagnosis, to STOP working or to stop looking for work and address personal issues, can be a huge gain. The most important thing that’s ever happened in this person’s life may be that they’ve stopped keeping themselves so busy that they don’t have time to think, but presumably not working or not looking for work would be seen negatively in the data collector’s eyes...” (ID 75).

“Typical outcome measures have more to do with things that can be quantified and identified very clearly, like you are or not working, or you are or are not preparing for work... there’s no mention of psychological or emotional states” (OR 75).

Writing specifically about factors to be considered in selecting outcome measures for Australian mental health services, Hugo cautions that sometimes staying the same
(i.e. not ‘deteriorating’) is as significant an outcome as positive change (1998). This observation resonates closely with the comments of one experienced staff member: “I think the program can be called successful if a resident says it was worthwhile being here. Or... (pause) ... I don’t really even know that... It’s really hard. I remember [program manager] saying for some people what might be the sum total of what we provide is that they had a stable period in their life, for one or two years...”. She then reflected on a former resident she had worked with for approximately twelve months as keyworker: “I have no idea what she would have gotten out of the program in terms of changes within herself and her life... I know she had a period that was relatively drug free... where she had food all the time, where she had people to talk to, me to talk to... where someone showed her they gave a shit, basically. But I couldn’t begin to say any more about what might have changed in her life... None of what she put down on her IPP [individual program plan] document would have been achieved... But I’m still pretty sure, from discussions I had with her, that she sees [the program] as having been a worthwhile experience, as having been successful... Her circumstances on the whole were okay for a certain period of time... And how do you put that into any measurable outcomes? She generally got into the program, had people to talk to, and learned how to really talk to me about things, in a trusting relationship, but there’s no way I could ever put down on a piece of paper and say ‘x, y and z were achieved’” (ME).

The long-term nature of some psychiatric ill health (as well as the non-linear nature of a recovery process) may also mean that attempting to measure success by the need for ongoing support can be misconceived. Several staff members commented that some residents who went through the program would quite likely need continued support after leaving. Some individuals, observed one former staff member, may need an environment like that offered by the program “forever...[perhaps due to] the degree of trauma and internal damage, [they’re] not able to develop their own internal structure and therefore structure their lives post leaving the service. They need to be moving on into another environment which provides some degree of containment” (EG). Another worker commented that while “there are people who will probably have an outreach worker, always,” there were others who, unless something went very wrong in their life,
may never be involved in the psychiatric system again, while others may be at university or in paid employment but still be on medication.

Even if an individual leaves a therapeutic environment or support relationship “more competent,” Peck cautions, “there is a kind of vacuum of competence in the world…so that as soon as a person becomes more competent, life or God will find her greater problems to work on…” (1993, pp.17-18). Individuals leaving a program will be presented with new challenges and new environments, which may test the durability or strength of changes that may have occurred whilst in the program environment. While some outcomes seem relatively clear (for example, improved relationships with parents) they may also be temporary, as one staff member observed: “You can never know how long lasting they are. And that’s the same for all of us. And other outcomes may not be in evidence for maybe two or three years... something that somebody’s learned by being here that just suddenly comes to fruition...one’s sense of self confidence, ability to make one’s own decisions, and recognition that ‘I am the most powerful person in my life,’ which is a totally new concept to a lot of people when they come here…” (ID 79).

Drozd and Goldfield (1996) propose four principles of therapeutic change, that reflect quite subtle but potentially profound shifts: 1) the renewal of the client’s sense of hope, 2) development of a warm and supportive worker-client relationship, 3) development of greater awareness of self and others, and 4) engagement in developmental experiences. While these goals may be difficult to measure quantitatively, qualitative exploration may reflect some of these more subtle and personal changes or outcomes. Quite strikingly, Drozd & Goldfield’s principles of therapeutic change were mirrored by residents’ and former residents’ comments in relation to what they had achieved in the program, suggesting they are of significant importance, despite their somewhat elusive nature.

One resident, who had been in the program for over one year at the time of her second interview with me reflected that before coming to the program, she had never really “addressed” her feelings – she had never “sat down with somebody” and worked through what was going on for herself emotionally. Another resident commented that building up emotional stability to take with her when she left – “slowly rebuilding yourself” – was something she thought had occurred for her during her time in the
program; rebuilding herself meant learning to deal more productively with stressful situations and “how I deal with my emotions” as well as learning to “be honest” with herself. Not only had this occurred for her during her time in the program, but she felt the changes/growth would be long lasting: “now I can work through emotional issues on my own – I have more tools to do it.” A former resident echoed this, saying that the program “builds skilful ways of dealing with things, that do transfer out [once you leave]... rather than skills in a sheltered workshop type sense... There's no question there's a transfer.” For him, developing the “inner resources to get back on track” to go to uni had been a primary goal which was met and superseded. For another resident, an important part of re-building her life and her sense of self was around “starting to actually believe that I’m lovable, and that I’m a good person sometimes... and [because of this] there’s been an incredible change to the quality of my life.”

The theme of rediscovering one’s sense of self esteem was highlighted by another resident interviewed shortly after moving out, who was asked if the things he’d learned at the program would continue to be useful now that he had left. His reply was, “Yeah, the self confidence, the self esteem... knowing that’s there, somewhere – that I just have to let it come... I feel that I learned at [the program] that you’re still the same person, it’s just blocked up. It’s like you’ve put an eggshell over your whole body, and you’ve got to crack the eggshell and come out again.” In this process, he went on, the environment is crucial: “When I was at home with mum, I was in a deep shell...and I didn’t really feel the need to find anything, because mum was there... Well, mum's not going to be here all the time... I’m still in a bit of it [the eggshell] but I reckon it’s definitely cracked.” This engagement in an ongoing process of growth was also commented upon by a staff member, who stated that an outcome she would consider favourable was that the program would serve as a “door opening to continued emotional growth.” Reflecting on what he had observed during his time in the program, another former resident highlighted that when someone left the program, they were still in process – “You may not be fully well... but you might be recovering in a way that you’re achieving something...you’re one step ahead.”

Another resident specifically rang me to request a second interview, as she had had some additional realisations, after the first interview, about her learning in the
program: “I actually gained thinking skills, the ability to think things through... Like before, I’d suppress all my thoughts because I thought, ‘oh shit, this isn’t right’... [Now] I’m happier – I can work through things and things get me down I can still think about them, and not be scared that they’ll hurt me, or hurt somebody else... There’s been a shift, and I think [the program] has been a catalyst for it” (AG). This capacity – and giving oneself permission – to think things through was also commented upon by staff, in considering what residents might achieve in the program. One staff member put it this way: “People come into the program because they have gone off the track in some way...whatever getting back on track meant to a person, that’s what [the program] tried to do... to provide them with some way of defining what getting back on track meant to them...to try and provide them with a capacity to self determine what that meant...from time when nothing was happening...through to some really peak moments of direct challenge” (RT).

One resident, who felt her year-long stay had been very successful commented that the program had provided an opportunity for her to reflect on the lifestyle she had been leading at the time of getting sick and her ways of coping and “denying stress...at the time I didn’t really understand why I’d become unwell, but now, looking back on it, it was almost inevitable... I think for a lot of the time I was sort of in denial... The day I had a psychotic episode I was really off the planet... it’s so hard to admit that... denial was basically my coping mechanism and my keyworker picked that up almost straightaway.” Through her keywork sessions, and through feedback from fellow residents, she said she had learned to slow down and attend to her needs, rather than denying them. Another resident commented that, for her, learning about boundaries and how to keep her own space safe, was important: “learning to identify what I need...to get in contact with how I really feel.” Other residents also commented that developing greater insight into their illness experience and how to recognise the signs of becoming unwell and needing help was important. Learning to identify needs, healthy coping mechanisms, being in touch with one’s emotions, trusting one’s sense of self and learning to think things through are all subtle ‘outcomes’ experienced by individuals in the program but considered highly worthwhile and vital to their experience of recovery.
One former resident provided an evocative metaphor for the process of working on oneself that could occur in the program – a process that he felt had been crucial to his successful experience. He compared the process of [the program] to a sort of “psycho-massage... You get these nasty knotted bits, where the muscles have all tensed up and you sort of get the thumb in there and start tweaking them out...” even though it’s painful or “less than comfortable at times.” When asked to say more about what the nasty knotted bits might be, he suggested “recurring patterns of behaviours” as one way of characterising them. Indeed, another resident who had been in the program for nearly one year, said that the best outcome of the program “for me...[would be] being at one with my experiences... It’s sort of like if someone breaks their cycle... it doesn’t matter what they go on to, but they’ve broken this old pattern of behaviour which they came here to break.”

For some people – perhaps for all, more or less consciously – the program also provided a time and a place for ‘time out’ – perhaps the special kind of rest spoken of by Podvoll (1990). Not a rest of doing nothing, but a rest that allowed one, gradually, to do what they needed to do. One former resident reflected on his two years in the program as a “sanctuary” that provided a time of “rest... away from the stresses...to actually look at yourself...a cushioning...” When first coming to the program, “a lot of the things I had to work on were probably clear to me, and had been for quite some time, it’s just that there were always other priorities...” For him, the program offered “asylum, in a true sense of the word.” Another metaphor was used by a staff member along this line, to describe the program as an “insulator” to the person’s wider environment, giving them needed relief. Another former resident, reflecting on his time in the program which he had left several years previously, commented that mainly the program had allowed him “the space to find out a lot about myself, and why I did certain things in certain situations... I don’t think I’d be here [in full-time work] otherwise... I can’t see anything else that would have done the same...it’s a space where you can reflect and work things out...away from society...where I could slowly ease back into work.” Another former resident, who had found some things about the program difficult or irritating, suggested that “at least it was somewhere on the way.. with nice people around...and where issues were brought up that you could contemplate...[so] I decided to make my own way, I had that safety and
Another former resident described it as a “time to plan,” without rushing into decisions that had in the past turned out to be ill considered.

One staff member, candidly, had this to say: “I don’t really know what psychiatric rehabilitation REALLY is about… sometimes I think this place is really about a two year break for people. There is a potential that all this place could offer is a safe place for people to take time out, to be contained, to have structure in their life. I think there is a lot more though… that it is formative as well… I think [people] do internalise something of this place – that they leave perhaps knowing that a structure helps them, that a supportive relationship and friendships are nurturing…that there are certain types of people that are toxic for them… I believe there are very qualitative changes that occur in people’s lives which are very difficult to measure… With the psyche and with the mind, how do you gauge [rehabilitation]…and who’s asking the questions?” (OR).

Mohr observes that we need to know how what we do as workers is experienced by those who are on the receiving end of services, moving beyond narrow conceptualisations and correlations and “other indicators that tell us nothing about the human beings” involved (1997, p.285). Pardeck et al. suggest that it is the client him or herself who should be consulted in regard to their progress (1994). Self-reports around outcomes have, however, been critiqued on two basic premises. Firstly, based on the psychoanalytic concept of the unconscious, it is argued that individuals may be unaware of some of their most significant feelings and thus not capable of evaluating themselves accurately. Secondly, responses of clients may be biased, tending to either present oneself in a more favourable light than what they actually feel to be true, and/or attempting to please workers by presenting the service favourably. However, in relation to both points, it can also be argued, as Eisen et al. (1991, p.216) suggest, that any informant “brings his or her own bias to the assessment situation,” including workers, researchers and professionals from all disciplines (even those who consider their approach objective). Indeed, professionals are undoubtedly biased by their own social positions, their theoretical frameworks and their investment in the client and their progress. One of the main advantages of self-reports, Eisen et al. (1991) suggest, is that individuals actually do know more about themselves than anyone else, and that they also have the ability to use this self-knowledge to predict how they might fare in the future. This resonates with
consumer and recovery literature, as well as critical social work practice, by positioning the service user as someone who brings their own unique expertise to the collaborative process with the worker. It is interesting to note that in a study of quality of care in a mental health program in the UK, the quantitative measure used to gain worker’s evaluations generated a very different picture than that presented by the clients’ views (Forrest, 1994). Forrest concluded that had only the quantitative findings been used to form judgments about client outcomes, the results would have seriously misrepresented the clients’ own experience of care and support in the program. Prior (1989) suggests that any measurement scale that constructs a de-contextualised, problematic individual who is assessed solely in terms of their behaviour without acknowledging their social conditions, and that sorts individual behaviour into “constructive and unconstructive, useful and useless, dependent and productive categories” needs to be problematised. Conceptualising evaluative research as objective and value-free, Prior suggests, is “sociologically naïve.” (p.144).

In a very interesting and relevant American article, looking specifically at outcome measurement in the non-profit sector, Plantz, Greenway and Hendricks (1997) query the type of “if-then” relationships that most measurements of outcome (and service effectiveness) are based upon: i.e. the notion that if a person attends a service, then they will become better, and positive change can be directly attributable to the service. They suggest that other influences – both past and present – may have just as great an influence on outcome as anything that goes on in the service, and that outcome measurements typically do not prove the program caused the outcomes, or what to do to improve the outcomes (see also Greenway, 1996). Almond (1974) observed that good outcomes (which he associated with people becoming less “crippled” by emotional problems) often seemed to be at least partially linked to personal or social backgrounds that enhanced their capacity to engage with the program. He concluded that it was impossible to say whether the frequent good outcomes on follow-up for the group that he called ‘pre-converts’ was attributable to “Treatment [sic] rather than to intrinsic strengths” (p. 96). Not only were the ‘pre-converts’ generally associated with good outcomes, but also those he referred to as the ‘unit converts’ – young adults who arrived “in a considerable state of subjective upset,” and gradually moved past constructing the program as a threat, to
seeing it as potentially responsive to them (often including confrontation and conflict). Indeed, this was borne out by residents’ stories described in the previous chapter on change and turning points.

One very experienced worker put it this way: “For some residents the track doesn’t change a lot, from entrance to exit. And I can think of some for whom there’s a profound change of rails... There are people who were not able to make use of what was on offer at [the program] for various reasons... the degree of trauma was too great. We were too small a feature in their lives. The disturbance could have been so great that the drop in the ocean of experience we offered was not enough... For others this approach [at the program] was not right for them – this service delivery style was working on the principle that someone had a desire to alter their life... it’s not a service for people who are oblivious to what’s going on around them...without the desire to make an effort, it’s a hopeless scenario... People come through in a great deal of denial...taking lots of drugs, having had maybe one or two psychotic episodes...they just had to deny the experience...they needed more psychotic episodes and more ghastly experiences before they were able to move into a service like [this]” (RT 72).

The issue of the longevity or durability of outcomes or positive change, has been explored by Moos (1996), who has done some interesting research suggesting that outcome studies conducted at a specified time after a person has left a program and moved on to a new environment, may indeed be measuring the impact of the person’s current environment rather than the impact of the interventive program they have left. That is, that the power of the person’s new environment might be equally strong, or stronger, than the program environment they have left, and quite possibly less supportive. This leads him to recommend that an important area of research is an exploration of the aspects of any therapeutic environment and/or intervention that are powerful and potent enough to stay with people after they leave, and what it is about individuals that make them ripe for change (Moos’ terminology) at a given point. Almond, in the 1970s, stated quite categorically that it was “the process, not the specifics that are the essence of...healing community” (1974, p.xiii), and indeed, that is what many former residents expressed. In his study of nearly sixty individuals post leaving a therapeutic community setting, Almond found that leaving the program was reported by most as a “jarring
change,” when they again encountered the “normative assumptions” of other situations and environments. What happens for them then, in the face of this jarring return, he says, is “very much a function of the individual life history: is the individual past the worst phase of a life crisis? Are there ways for him [sic] to continue dealing with the problems that were clarified and worked on in the [therapeutic community environment]?” (1974, p.150).

Barham and Hayward (1991, p.1) also point to the difficulties experienced by individuals who tried to live in a more integrated way in the wider community, where they continued to experience “otherness,” exclusion and stigmatisation despite their attempts to “re-establish their personhood” (p.3). Along these lines, a speaker at a recovery conference I attended some years ago made the memorable statement that while the doors of the asylums had opened as a result of deinstitutionalisation, the doors of the community had remained closed, thus being able to meet one’s needs was strongly mediated by structural and material exclusion not accounted for in narrow and individualistic conceptions of outcome. Whilst workers in the program are primarily involved in work with individuals and the therapeutic community itself, the program was embedded in a sector that continually challenged, lobbied and provided alternative consumer and program level viewpoints to mental health policy makers, based on principles of empowerment and recovery-oriented approaches to practice. At one point during my time as a worker, a consumer-run support and information centre was opened in one of the downstairs rooms of the building, supported by the organisation, where a number of program participants were involved.

Funding bodies and policy makers, Plantz et al. (1997) suggest, may actually impede successful work in programs, by imposing outcome measures that do not align with agency efforts and that do not recognise the subtleties of human experience. Done badly, they conclude, linking outcomes to funding can penalise programs with developmental and more subtle (and less easily measured) outcomes. Nolan-Forman (1997) suggests that incentives established by funding arrangements can not only lead to a narrowing of desirable outcomes, but also creaming of ‘easier’ clients and a short term focus, both in terms of a ‘change’ process and the building of relationships. This, he says, “is no mere trivial side issue in a field where intangibles can be crucial,
outcomes…notoriously difficult to measure, [and] where real changes may only occur over relatively long periods” (p.14). Robson, writing about outcome measures in Victorian psychiatric disability support services, echoes these concerns, and observes that some outcome measures may unfortunately measure “the things which our services do not actually do best, nor the ways we do them…” (1998b, p.22). There is a danger, she suggests, that government bodies will increasingly “purchase outcomes rather than principles.” An intriguing question raised by Plantz et al. has to do with what can actually be expected from psychiatric disability support services: they pose the query, would a 20% ‘success rate’ in psychiatric disability support services be an amazing success, or a dismal failure? (1997). Harding and Strauss suggest that the complexities and dynamic qualities involved in relation to mental well-being, do not lend themselves easily to conceptualisations of outcome as a “definitive status, when, in fact, it reflects only a fleeting moment of time…and needs to be looked at from the standpoint of patterns and trends rather than cross-sectional points… across contexts and across individual components of a developing person” (1985, p.348).

In response to the question of how an outsider might evaluate the success rate in his therapeutic community program, Podvoll observed that before coming to the program, none of the current residents had lasted more than six months in other settings, but since coming to the house everyone “smiles more easily, is more interested in their lives, and is much more judicious about the use of alcohol and drugs. They have more friends, and they have learned something about community. They have come a long way from early days of resenting each other, to being more considerate, kinder people, with restored and more readily accessible sense of humour” (1990, p.314). These may indeed be difficult things to measure, and perhaps difficult to conceptualise as outcomes or progress by someone who has never, as Podvoll puts it, “witnessed someone in the gradual and painstaking recovery from psychosis” (p.315).

One staff member reflected that, “Change is slow… two years is very short. Field theory suggests that there are so many factors in one’s field impacting on a person’s life at any time, that to take one aspect of the person’s field and measure outcomes from that is quite a restrictive view… It doesn’t take into account other truths... even if we were to try and measure outcomes within the field of [the program] we’d be forgetting and
missing out on what else is occurring in the person’s life – family, friends, other interests, the state of the economy – we could even go that far. [The program] is a significant part of the field for a person who comes here... it’s intensive... and so –at least that part of the field is hopefully about safety, trust, learning to reflect on life and relationships” (OR 71). Similarly, Bertolote suggests that any approach to quality assurance in mental health programs, must acknowledge the complex processes that are part of human existence: he suggests that whether an individual experiences clinical symptoms, does well in work or study or has healthy relationships is determined by many cultural, socio-economic and interpersonal factors, as well as any programmatic intervention (1993). Developmental changes as a result of maturation, or simply the “natural course” of the person’s struggle with varying states of wellness, can also affect what is perceived as progress or lack thereof (Blotcky et al., 1984).

It is also important to acknowledge that the formal aspects of a residential service are one thing, but there are also informal aspects of living in such a program or community that may also have a significant impact. Patton (1980, p.147) observes that a “major part of a program’s impact may take place on the periphery of structured activity.” How can the things that take place ‘on the periphery’ of the program – the informal, unplanned, unstructured activity and interaction – be identified, articulated and ‘measured’? The therapeutic community provides the opportunity for containment, exploration of and reflection on these peripheral, but potentially crucial, moments of impact or change. As one experienced staff person commented, “You can’t trace or compartmentalise service effectiveness to specific parts of the program – it’s the totality of the experience that one engages in... a person may hate four things about the program and like seven, that doesn’t mean that engaging in the ones you hate isn’t going to be part of the potentially beneficial nature of your experience” (EG 6). Indeed, many former residents observed, in retrospect, that one aspect of the program they had disliked at the time – getting up by nine in the morning – was actually one of them most beneficial and long-lasting results of their stay.

Residents and former residents did comment on some specific aspects of the program that they had found beneficial, some of which might on the surface appear to be peripheral to the main therapeutic components of the program. They were, however, of
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significance to residents, to the point that they raised them, unsolicited. Some of the
activities mentioned achieved more than what might seem intrinsic to the activity itself,
having particular and significant meaning for the individual. Cooking, cleaning,
gardening and going on outings were all considered useful, not only in order to move on
to more independent living, but, as one resident, put it, they were also experienced as
“therapeutic... Practical stuff helps you ease a lot of tension... Some people get restless
because they have too much time to think... I used to feel really upset sometimes, and
then I’d mow the lawn, and after an hour, something just comes in and I’d feel better for
days... It’s satisfying too, to make something look really neat.” He went on to describe
how he had planted a tree in the garden the previous year and how it still provided him
with a sense of inner well being: “You’re giving something a chance to live... I often look
at the tree now and I feel like I’ve achieved something... I’m starting to appreciate small
things... like making a fruit salad or whatever....” The “grounding nature” of doing
routine tasks such as cooking, gardening and shopping was perceived by many residents
as beneficial, particularly at a time when they were attempting to get back on track after
experiences of hospitalisation, isolation and inactivity.

Several other residents commented on the therapeutic nature of gardening in
particular; one former resident, looking back on his time in the program commented that
“any group therapy outside is beneficial... Everyone is doing little things and it all adds
up”; while he found it difficult to participate at the time, the compulsory nature of the
gardening group was appreciated in retrospect: “It was something I had to do, even if I
didn’t have the energy to do much.” The healing nature of “the earth, the life cycle, the
birds” was spoken about by another resident as particularly useful in his recovery
process. If workers or researchers reflect on their own experiences, these are not simply
activities that are ‘therapeutic’ or ‘empowering’ for service users; they are part of what
probably keeps us all ‘sane.’ Another important part of the program for many residents
and former residents was having opportunities to simply go places, be creative and
participate in pleasurable activities. As a worker I had not fully appreciated the healing
nature of these activities, although in my own life I was aware of their importance.
Again, this highlights the potential gap between a worker’s awareness of what may be
experienced in their own personal life as an important component of well being, and the
professional construction of what service users’ well being requires. It also highlights the significance of both access to resources (for example, money to purchase gardening materials; money and transport and equipment to go camping, etc.) and self confidence, support and energy to believe it’s possible for oneself to do these things. ‘Belonging’ to an already-stigmatised group, this may be doubly difficult at certain times.

In relation to both the camps and the gardening that people enjoyed, it is useful to look at what Roszak (n.d.) has labelled “eco-psychology” (although on another level, this can be problematised as the application of professional/academic jargon to what can be construed much more simply as “being outdoors” or “connecting with nature”). Roszak, however, engages in some useful theoretical explications of what is often missed in psychological interpretation of human need and experience: that is, the “assumption that you can treat the psyche in isolation from the natural environment” (p.1). This, he suggests, is a severely depleted way of understanding the human mind. He draws attention to the way in which older (formerly called ‘primitive’) societies construed both madness and well being as connected to human relationship with the natural world; at the same time, he suggests that Westerners cannot simply adopt other cultures’ constructions, but must work out their own. This, he says, “is as much a job of the ecologist as it is of the therapist” (p.2). The psychiatrists and psychologists who have constructed modern psychological theory (often drawing on Freudian theory), he observes, have generally themselves been embedded in urban culture and practice, so the madness of urban life has not been taken into account. Eco-psychology goes further into the unconscious of human beings to reveal the deep connection of humankind to the non-human natural world. Within this context, it is hardly surprising that connection with plants, earth and animals is deeply healing, yet often disregarded by social work and other human service practitioners.

Senior & Townsend (2005) also discuss the connection between nature and well being: isolation from non-human animals and plants, they suggest, creates detrimental effects on humans. They refer to research that suggests “too much artificial stimulation and an existence spent in purely human environments may cause exhaustion, or produce a loss of vitality and health” (p.3). They observe Western society currently is unique historically in the disconnection of human beings from the natural world of plants and
animals, and that the implications of this are only starting to be seen. They refer to the work of Lewis (1990) and Kuo (2001), who propose that access to “green nature” can reduce crime, improve psychological well being, reduce stress and promote healing in psychiatric patients [sic], as well as improve one’s sense of connectedness to community (Senior & Townsend, 2005, p.4). They also make the salient point that people may need encouragement to believe or acknowledge that simple activities such as being outdoors can have an impact on their well being: this observation is of particular significance to support workers.

‘Leisure’ activities in general can mistakenly be constructed as peripheral or as time out from the ‘real’ therapeutic activities of a service or program; however they may be just as significant as anything else that occurs or is experienced, in relation to holistic well being. The bodywork component of the program generally occurred on a rotating basis, one day per week, throughout the yearly program structure. These ranged from a term of shiatsu massage (with residents and staff receiving shiatsu treatment), yoga, swimming, tai chi, Reiki, and other such opportunities. Not only did residents express that these were very relaxing and health inducing, but they also provided exposure to various ways of gaining and maintaining wellness that they had not previously considered or had an opportunity to engage in. Again, the cost factor may prevent people who are often living below the poverty line on government benefits from participating in these health-inducing activities. Stigmatising social attitudes toward ‘welfare recipients’ also create prevailing views or dominant discourses about the deservedness of those who are unemployed engaging in such activities; social workers and other professionals need to engage in critical reflections around their own embeddedness in such restrictive and disempowering views.

One resident described shiatsu and yoga as “a good pattern to get into,” another commented on the importance of balancing ‘head stuff’ which was often the grist of the therapeutic process with ‘body stuff’, reflecting that the mind and emotions are, after all, contained within the body. Discovering that it was okay, indeed valuable, to “indulge yourself” was important learning for some, and being “exposed” to activities such as yoga seemed to activate a potential to pursue such activities independently, which was seen by many residents as a potentially vital component in their ongoing process of
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recovery and well-being when they left the program. One resident, who had been in the program for about eighteen months and was contemplating her exit put it like this: “When I walk away [from the program] ... I’ll carry it with me and I’ll continue it outside – I’ll find a Gestalt group outside and I’ll find a psychologist outside... and I want to learn music... and go bushwalking... simple things.”

The opportunity to work with art materials – clay, paints, crayons, etc. – was a very beneficial experience for some residents (and staff members, such as myself, who also participated in these sessions, often drawing or painting for the first time in many years), leading to positive ‘outcomes,’ even those for whom other aspects of the program seemed less satisfactory. One former resident, who had found the talk-based and support groups particularly stressful, commented that, for her, art group had been the best thing, for a number of reasons: “It was good to see people progressing... Doing art made me feel much better... If you start drawing you end up with something that is very telling of your subconscious” (YK). Another resident also commented on the therapeutic nature of working with art materials, as a form of expression: “…to get in touch with your understanding and thoughts...how much you’re expressing on paper – what you want people to know, what you don’t want them to know... It’s good therapy...you’re trying to put thoughts onto paper, or your heart, or both... going inside yourself and trying to put it into the open” (TI).

Camps were also described as valuable, again, not only for immediate enjoyment but also to (re)acquaint individuals with the possibility of continuing this form of enjoyment after leaving the program. The benefits of being in a “new environment,” “relaxing,” “being in nature, being with others for motivation to get out and do things” were described. While camps were generally held over a number of days, away from the program, outings were held on a weekly or fortnightly basis. Outings were generally decided upon by the community, and ranged from gong to the movies, to ten-pin bowling, to bushwalks. For some residents and former residents, outings seemed to be almost a re-introduction to the world and the capacity to feel safe and enjoy new surroundings. “You look out the window [of the van] and you see trees, people, cars, buildings...maybe the country or a beach. It was very calming. A lot of the places we went, there was just a nice feeling to them...”. A former resident, looking back on his
experience in the program, talked about how the outings were, for him, often the most beneficial of group activities: “When we left the room and we’d go somewhere...[People] would talk in the cars and it would be very relaxed...good for the group... Like one day we just went somewhere and we just played machines. Now, you’d think to yourself, ‘well there’s going to be no good in doing this’... And everyone turns up, and I didn’t play the machines, I just watched... Everyone was playing machines and having a good time... talking to each other and getting together... The interaction between the people... I see that as a plus...there’s a little family element there somewhere, you know...” (RE). This memory was still extremely vivid several years after leaving the program.

**Program staff and resident views on the measurement of outcomes**

When I asked program staff to share their views around outcome measurements in services such as theirs, workers were very clear and thoughtful in describing some of the tensions involved. One experienced former manager put it this way: “I’ll take the liberty of saying that we aren’t in such a primitive state that we don’t know about other ways of researching peoples’ experience...[although more qualitative ways are] very time intensive... So I’m quite cynical about measuring outcomes. I don’t apply measurement in any way to my own life and my own growth. I don’t know why, other than for political and economical reasons, we need to do that. But the real world is such that we get forced into finding ways of negotiating that territory” (RT 4). Again, it is interesting to note the comment that compares the worker’s attitude to her own life with that of service users, the most notable difference being, as she points out, that in one instance the individual’s life is acknowledged to be in process, while in the other, the ‘public’ nature of their personal experience (that is, taxpayers’ money being spent to deliver a service) allows a different construction.

Another experienced worker questioned the normative assumptions upon which conventionally defined outcome measurements were constructed: “Increasingly the role of institutions [like this one] is about playing social role adaptation and while there are certainly aspects of this that are important – like hygiene, I’m not so sure about whether that is what the work is with clients. When you’re process oriented...or insight oriented, what my hope is, is that someone can get into contact with what they want. It’s not just
about adapting, because the question about adaptation is always about – adapting to whom? Adapting to what? Who says this? Is it me [the client] who says this? In a sense, they [the residents] have a sense of being asked to conform...I think every society, throughout history, needs to have a group who is somehow on the outer...” (EG 6).

This same worker went on to observe that “policy and what you’re funded for are sometimes at odds with what is actually therapeutic... I’m unapologetic, I look at humans in a very complex way... It [measuring outcomes] continues to be the dilemma of a service like this...we’re much more process oriented and perhaps insight oriented...” (EG 6).

This valuing of uncertainty and complexity suggests a view of professionalism somewhat at odds with modernist assumptions that construct expertise in terms of certainty, predictability and the attainment of quantifiably measurable outcomes. However, from a critical postmodern perspective, lack of certainty has many potential constructions and effects. In the sense being spoken about in the quote above, a sense of uncertainty is around not wishing to make premature or universalised judgments or assumptions, and being open to ongoing learning and enquiry. It can certainly be argued that a well-functioning therapeutic community or, arguably any service that seriously attempts to help people, needs to continuously and consciously engage in critical reflection or interrogation around the effects of certainty (or uncertainty) on their practice. One staff member commented that “the way of working” espoused and encouraged by the program’s parent organisation was what had drawn him to the job; indeed that the type of staff person who the organisation sought involved a “selection process for new staff [that] siphoned off people who think they know everything about the work... What the organisation is looking for is those who hesitate slightly... who reflect a lot on their own process in the work.” Another staff member commented on the life-changing aspects of her work in the program: “This work has enriched my life, that’s for sure... It’s changed me.” A former staff member who had only recently begun work with another organisation reflected, “Having now changed jobs, its more obvious. I realised how much I’d learned [working at the program], about who I was and about my working style... in nine months, after a four year course” (UR). And, indeed, the nature of the work itself, as expressed by one former staff member with long association with
the program, was considered challenging at a deep level for all those who engage with it, staff or residents. “I have never seen anyone, no staff who has come to [the program] and worked there, without having to be thrown back onto their own psychological foundations, so to speak… I don’t care how you run the program, it’s only a deluded program that could not find that hard… if you’re going to be trying to really get clear about people’s lives, then in that environment its going to be hard. If the program is trying to be REAL it will be hard… I could create fantasies of models, which are less about trying to actually help people change, and more just nurturing a status quo and being nice to people... Then you could be, I think, protected from how difficult the work is for a person as a worker” (RT). Acknowledging the difficult nature of the program – and perhaps any service which functions to empower or ‘heal’ (for lack of a better word) – is, again, not necessarily a sign of professional weakness, but, from a critical perspective, an indicator of genuine willingness to engage with deconstruction and reconstruction of practice.

The difficult nature of the work also revolved around the use of what is often called professional discretion, which can be a form of risk-taking on the part of the worker, but which also contributes to the effectiveness of a service. Risk-taking may not fit neatly within discourses of quality control and outcome measurement, but may be intrinsic to the recovery process. One experienced staff person put it this way: “[It’s]...about knowing when to call clinical services and when to allow a person to sit with their experience and give them a lot of support...[To know] when its appropriate to take what might appear to be a risk, when someone is saying, as they have for the past five years, ‘I’m suicidal’... Times when my heart has been in my mouth that I haven’t called the CAT team, and I’m worried at wakeful hours, at two in the morning, whether they’d be alive when I got there the next day... And they have been. And they are now living very fulfilling lives... But making those decisions... is all part of whether we’re effective, and they’re very difficult” (ID 1).

Participants also commented upon the inherent difficulties of assuming that one-size fits all, so to speak, in meeting the needs of diverse individuals seeking assistance. One very experienced staff person observed, “Staff can fall into a trap sometimes of [feeling they are] able to offer something to everybody who...wants to come in...
are people we can’t help... It’s a particular service and offers a particular thing to people who want to engage in it” (EG 1). This view was echoed by a former resident who commented that the program, in her view, tried to be too many things to too many people who had very different needs and capabilities (NA 1). The program, commented another former resident, was not for high dependency people, but “for an individual who has the desire and need for growth within a community... a lot of [being there] is about working the program... it’s not just a hotel” (MA 2). Another highly experienced former staff member summed it up by saying, “This is a service where those mechanisms [of support and timely challenge] were appropriate for some people. It was definitely not a service for everyone, and NEVER did it wish to be” (RT 3).

There are also difficult decisions to be made around “assessing the people with whom we can work...[for example] how effective is the interview process prior to intake...With too much chaos in the house, no one can make any changes... you have to look at intake procedures...and the dynamic you’re setting up in the house... A service has to know what its capacity is – knowing who we can work with and who we can’t” (OR). This is not a straightforward task, as several former residents observed, commenting that “It’s hard to work out beforehand which people are going to need more support...they might seem ready [for the program], but then the stress of transition might really upset them (IR 2). “I don’t think you can actually look at a person and say, ‘yes, you’re the sort of person who’ll do fine [in the program]’” (UM 3).

Along this line, participants also cautioned that what might not seem significant to an outside observer, could be for a given individual service user, whose goals might be quite diverse. “To the healthy observer, what [the program] has to offer can be quite subtle – like for me, getting on public transport” (MA 2).

“For me, it’s about quality of life... my quality of life was just not very good...When I left [the program] it was much improved... being more relaxed...not having so much anxiety. Having better self-esteem, better direction in my life... and having some new friends. But they’re the things that I feel get sometimes pushed aside, for bigger, more important issues – jargon-y type stuff” (NA 3). Another former resident reflected, “If someone wants to stay on medication but be able to live apart from their parents, that’s just as good a goal as wanting to stay off medication and remove
them selves from the medical system. ...I can also see that its important that while the ultimate goal may not have been met, there may have been a lot of worthwhile milestones met...” (IR 2).

Another former resident suggested that even looking at goals could be premature for some individuals, and for others unique to themselves: “…I don’t know if that’s workable, given that a lot of people come in without goals, and don’t want to be there. [Goals, for some people] might be being able to go to a cafe on their own...and for others it’s a fulltime job... You have to keep it that broad...everyone has their own background and their own values...we’re all different in what we want...” (RD 3).

The relative and individual nature of what might be achieved in the program was reflected upon often by program participants, one of whom, quite new to the program, observed that the program worked to “as fully as possible, prepare people for a return to involvement in the so-called outside world, to the greatest potential of each individual” (RI).

A relatively new staff member reflected, “I’m prone to expecting...people to come out saying, ‘I’m going to uni...I’m going to be an astronaut’...but sometimes it’s [a successful outcome] that people stay out of hospital or can say ‘I need some support.’” For some residents, going on to university and employment did occur: several former residents commented upon they had in fact exceeded their more concrete goals, for example, learning “things about myself I’d never expected to learn,” and “meeting all my goals and surpassing them.” It is probably worth noting that these were individuals who had stayed in the program for at least twelve months, and who had, despite some initial difficulties or even ongoing frustrations with certain aspects of the program, engaged fully in the opportunities.

One staff person put it this way: “I think we’ve been effective if we’ve been able to increase people’s independent and living standards to a level where they feel they can manage themselves okay... University and jobs is all politically great... it’s what politicians want to hear, it’s what Western society values, but I don’t think that’s for everybody... I don’t see why someone should be considered to be not a successful participant just because they haven’t got a job... If they’re happier and more stable and
more independent, that’s fantastic, not that we’re imposing our success labels on them about what they should be able to do” (EC 5).

Robson suggests that a more relevant picture of service users’ experiences in the psychiatric disability support sector would arise from a “genuine desire to understand better what it is we do and where we have made a difference” (1998, p. 19). As previously mentioned, in 1992 the psychiatric disability support sector adopted the principles of psychosocial rehabilitation as the theoretical underpinnings for their services, providing a more solid identity for the sector (see Appendix B). In 1997 VICSERV (the sector’s peak body) convened a meeting to review these principles and to discuss how services enacted them. The meeting came up with eight draft principles that they felt encapsulated their practice ideals:

- staff believe recovery is possible and that each individual knows what is best for them in their recovery
- staff work collaboratively, alongside consumers
- staff do not impose their expectations, but respond to individual need
- service users can choose to be involved in decision making at all levels
- services generate a hope filled environment
- services provide a relevant range of programs
- services work with local communities to challenge systems of discrimination
- services are accountable to their consumers, the local community and to the purchaser for achieving the above (Robson, 1997)

While Robson still utilises the word ‘outcomes,’ she proposes alternative process-oriented constructions that acknowledge the non-linear nature of recovery and that reflect the guiding principles of psychosocial rehabilitation outlined above. Rather than simply looking at independent living, vocational status, social network, engagement with services, community linkages and skills acquisition – all of which are complex factors – she proposes a set of constructs based on goals of empowerment and collaboration, such as that the consumer determines their own goals and asserts their needs and wishes; that the living situation of the consumer is one they have freely chosen and are free to leave; that client support is offered when and how they need it; that the consumer trusts their support worker and that staff-consumer contacts are generally positive; that the consumer
is less reliant on unwanted clinical intervention; and that the consumer is able to choose when and how much support they need. Also included in Robson’s conceptualisation is that the community’s knowledge of psychiatric disability increases and that the consumer increases the decisions they make about service received. In a sense, these represent a form of ‘outcomes’ in that they are achievements, but they are based on a different set of goals which are much more collaborative by their very definition, and are very much process oriented. They also contain fewer normative assumptions based on limited conceptions around success and well being, and acknowledge the crucial significance of the development of greater power of choice and agency in the individual’s own life. In the following chapter, I return to the voices of participants, describing their experience of leaving the program; at the same time, I attempt to round off this thesis with some sort of a summary of the journey.
Chapter 10

Leaving the program; leaving the thesis

“The goal of leaving presents one more paradox in the therapeutic community process - the paradox of finding a home in order to leave it” (Jansen, 1980, p.44).

Just as coming to the program and experiences within the program meant different things to different people and served different purposes, the experience of leaving the program was an individual one as well. It was a time, for many, of mixed feelings: as one former resident put it, looking back, a combination of relief and loss. Some residents found leaving the program difficult and even frightening, but at the same time, felt it was the right thing to do. Reflections on the experience of leaving seem an appropriate way to conclude this chapter, which begins with participants’ words on leaving the program, and concludes with some reflections on my experience of finishing this thesis.

For the staff team, leaving (or ‘exiting’) the program was viewed as an important step; the process and act of leave-taking was recognised as a consequential one with unique meaning for each person. Staff, and indeed the program structure itself, framed exiting as an important event to be engaged with thoughtfully, offering opportunities to reflect upon, repeat or to change previous patterns of leave-taking, which may have been more or less ‘healthy’ for individuals at various times. This way of making sense of the exiting process as something serious and meaningful was transmitted to residents, who were asked to engage in a particular way of leaving that involved discussion of their decision with their keyworker, announcing to the community that they were going into exiting mode, and negotiating with the community the ways in which their participation would decline as their outside interests expanded. There was also, during my time as a worker in the program (although the various steps of the process seem to have gotten lost in the fairly dramatic changeover of staff that later occurred), a special meeting with the exiting resident, their keyworker and the program manager. During this session, the individual’s stay in the program was reviewed and reflected upon, with the aim of
affirming growth and strengths and acknowledging and exploring past, present and future challenges. Community members also had a ‘formal’ opportunity in a special segment of a community meeting to both commemorate the person’s departure and provide feedback about how they had experienced that person during their stay.

The significance of leaving was described in this way by a former staff member: “A lot of people who come through [the program] have experienced a lot of change in their life...very often sudden changes and unplanned and painful changes... Again, [the exiting process] is the modelling – the education – of how change can happen and how you can prepare yourself for change” (ME). Thus leaving the program in a planned and conscious way could provide a new way of leaving that could give the individual different messages about the ‘way they do things’ – a way in which they may feel pain but also not-pain, loss of connection but also the possibility of maintaining relationships: bridges could be crossed without burning them, even though burning them might also sometimes be a good option. As one staff member put it, “The way someone leaves is very important – for ALL of us, for many situations.” Indeed, our own experiences of leaving significant places, spaces and relationships, in hindsight, offer much food for thought.

For many people, one staff member commented, the program “needs to have the capacity...to be the home that they never successfully left... [to experience leaving, but] not having to sever all ties and never return... I’ve seen it be a major milestone in a person’s life, that at last, at whatever age, they’re able to leave home. There may be huge unfinished business around that” (RT). Someone ‘finishing well’ could also be seen by other residents as a way they might leave in future, and also, in the present moment, allowing them to process and articulate their response to the loss of this person, to themselves personally and to the community as a whole. It may also be part of the process of becoming an ‘ex,’ in ways that integrate some of the complexities and ambiguities of constantly evolving identities.

When and how to leave the program, or, potentially, any support service, can be conceptualised as part of the battle many service users engage in “with their independence and dependence along the way.” Far from being constructed as a negative, this struggle and this way of making sense of it, according to an experienced former staff
person, is “actually a desirable scenario – that people want to leave and resolve to stay, and want to leave and resolve to stay... That’s far more encouraging to me than the person who’s so dependent on the place that they’re terrified to leave.” The important thing, she went on, is that the person feels safe and capable to articulate their ambivalence and that, “because of the underlying safety in the environment, by containment, they’ve resolved that now IS the time to go... or now is not the time to go” (RT). Indeed, as another staff member commented, sometimes a person – and this includes all of us – needs to be able to denigrate something they’ve outgrown in order to leave it.

The transmission of sense around leaving the program and the community is evident in a number of comments made by residents. One resident, who had felt quite ambivalent to program processes at various times, discussed how her attitude towards the process of leaving the program had changed. “Before... I just wanted to get out of here my own way, on my own terms. And I discovered, in a major way, you can’t just do that... There’s a process... You can’t just pack up and leave...” (RAM). She commented that now she felt very committed to the “exiting group” that focused on exploring exiting individuals’ needs, concerns and issues. The re-formed exit group that developed during the time I was doing my interviews also provided an opportunity for residents who had recently left to return and, as one former resident put it “tell their story.” She spoke about how she had shared with the group why she came to the program, what she had liked and not liked about it, and what she planned for the future. Going back to the group and telling her story, she said, was a good experience – “to look back and reflect on my time” (BAM).

Another resident said she had “nearly died” when she learned how long the exiting was (for some, up to six months). In the past, her moves, she commented, had always been “really, really quick,” sometimes shifting accommodation several times in one month. Having observed some people in the program going through the exiting process, she commented that she now thought it seemed less stressful to take some time leaving – “it’s a big thing, leaving... You’ve built up bonds... made a commitment...[taking some time means that] maybe it’s not another thing you’re grieving about... it softens it a bit” (AM). Several residents also commented on how leaving was
also softened by being able to see their keyworker for four outreach visits after leaving the program. For some, although they would have liked this to continue over an extended period of time, there was also a recognition that in some ways the longer it went on, the more difficult it would be when it ended.

Some staff expressed concern that too intensive an in-house program could ultimately further isolate residents by demanding, as one new staff member put it, they “relinquish their life outside the community” for a period of their first six months in the program. After this period, she feared, it might be “too late” if residents had “disconnected from the outside world.” Several former community members commented on how their keyworker had strongly encouraged them and tried to support them to become more involved in outside activities as part of their exiting process, but, as one former resident said, she “had trouble with that,” and, as another former resident commented, this was not only very difficult but something he did not really want to do.

One resident who was about to leave after one year in the program observed the importance of the exiting process in building up a social network, “because it’s very easy for [the program] to become your whole life.” One resident, who had been in the program several months at that time, commented that when he left the program he wanted to get a job, as he had always felt “guilty” about being on social security benefits, but was also “terrified of not being able to keep it [a job].” Another resident, who had been in the program about eighteen months at that time, also wanted to go back to work, but when he had gone to the Commonwealth Rehabilitation Service had been disappointed to find that they felt he was not yet ready for employment.

Leaving the structure and containment of the program, even for residents who had worked very hard and organised themselves well for departure, was sometimes more difficult than it appeared on the surface. One former resident said that she had felt she was just starting to “get it together” when she was leaving, and that the hole left by leaving the program was a significant one for her at that time. She had “finally managed to almost hit a point where I was comfortable, and all that just went out the window when I moved out… I didn’t have those relationships with staff anymore and I lost all that ground I’d made… I’m hopeless at forming relationships!” The termination of relationships with staff she experienced as a “false cut-off” - a chop – “and that horrified
me.” However, she said, “You’ve also got your pride, and you don’t want to go back if they’re saying ‘You’re on your own now.’... Literally, ‘We won’t see you again.’ It suddenly became a whole new ballgame, and you’ve just spent two years getting used to the last ballgame... It’s another thing that doesn’t feel real – the cut-off... Like ‘Remember our professional relationship? Remember that contract we signed at the beginning? Well, here’s your signature – off you go!’ And I was as keen as anyone to get out of there” (NNA).

There are a number of issues here that have been discussed in other chapters: namely, the potentially confusing, challenging or confronting nature of the ‘professional’ relationship, and assumptions of workers around what is empowering for service users. It is also, perhaps, a commentary on how the culture of a service becomes internalised: while people need to engage with the culture to some extent in order for it to be therapeutic, this connectedness needs gradually to shift. One former resident put it simply, when commenting on the difficulties he experienced leaving: “It was hard. I get entrenched in places.” At the same time, he had wanted to leave after a long stay in the program and was doing well in his shared flat. Another former resident recalled how having people around had become important to him during his time in the program. Although he had come to the program from quite an isolated existence, living in a household with up to fourteen other people had, despite its challenges, also provided on-tap company nearly all the time. Another resident also commented on his mixed feelings when leaving the program: “It was sad... it was emotional.” There were many things he missed: “the building, the furniture, the garden, the music, the pets, and especially the people.” So part of the challenge, then, is to acknowledge and ‘work through’ feelings of loss (and their myriad and individual manifestations and expressions) even when moving on was necessary and desired. This may be something that workers are not adequately conscious of, in relation to individuals disconnecting from their service and from their relationship. However, we all know, from our own experience, that detaching, even from people and places that we know we need to leave, can be very painful, depending on the place they have occupied in our meaning system.

The emotional nature of leaving the program, for many residents, could not be denied or underestimated: for some there was an attendant fear of, as one staff member
observed, “the safety net disappearing.” Current residents, contemplating what it might be like leaving in future, expressed worry about “filling the gap,” losing their keyworker, getting sick again, being alone and very real concerns about having adequate finances to live more independently. Another staff member observed how, for some residents, prior to entering the program their experiences of “floating in the system, whether they’ve been homeless or in and out of hospital or just never found something to anchor them” had been turned around in the program, where “they have worked through the program and developed friends. It’s incredibly difficult for them to come to terms with leaving. We had someone in the program and he said on his exiting that it was the first time he’d ever made real friends. I think that’s an incredible thing.”

Several former residents, who had not felt they had learned anything useful in the program, and whose period of time in the program varied from several months to over one year, commented that they had been happy to leave. One former resident put it like this: “I went from something that was draining and irritating, to something that was nice...something that was easier to handle and more familiar” – he had gone back to live with his mother. Another former resident was also happy to leave and move back home with her parents: “I was happy to get out of the place... [although] I still miss some of the people.” Another former resident still felt confused and somewhat frustrated about why she had been asked to leave the program, commenting that she felt the program was meant to be there for people with an illness, but felt that she had been asked to leave because of her illness. She said, “I can see maybe people were scared of me... or they didn’t know how to cope with me. But no one, residents or staff, actually told me why I wasn’t allowed to continue... I was upset because I tried to give it a go and it didn’t work.” Like some of the other residents who left the program not feeling they achieved what they wanted, she had returned to live with her parents.

Despite experiencing fears, difficulties and mixed emotions, former residents who seemed to have had a productive stay reported that leaving the program seemed to be a natural step forward at a particular point in time. (Of these residents, the shortest length of stay was one year, the longest upward of two years.) One resident who had been in the program for about six months at the time of interview commented very succinctly about how he viewed exiting, and the transitional nature of the program: “My whole point in
coming here is to have an exit… the whole concept of exiting is there from the beginning.” Another person who had recently left the program, talked about how “moving on” had come to seem inevitable – she had, she commented, “grown out of” the community emphasis and was ready to reach out for her own space… “toward the end, I’d had enough and I didn’t want to be there anymore… I felt happy to be going [but also] quite sad at the same time.” This resonates with the observation made by an experienced staff member, and quoted at length elsewhere in this thesis, about the healthy struggle and ambivalence around wanting to leave the program and wanting to stay, which eventually results in a decision to go. Another former resident who had returned to fulltime work, had continued to find the support useful, but community life increasingly difficult. After being at work all day, coming back and finding “there was someone who’d been using a razor [to self harm] or doing a huge mess… was quite confronting, [going] from, I suppose, ‘normality’ to people who weren’t well… It was frustrating… I suppose it made me want to get out of the place sooner… It’s sort of like graduating, too – ‘I’m free,’ sort of… I did my time…worked hard.”

Finally, one former resident commented on the hopefulness she had felt when she left the program and how her connection with the program still continued to impact on her life and sense of self: “I felt quite good about leaving… I wasn’t really upset, I felt quite hopeful – I didn’t’ feel so attached to the place that I couldn’t leave… I had my study, my painting… I guess I just saw it as the next step… But it’s also nice that once I left, to be able to go and visit people still… When I’m at a loss of what to do, I’ll go to [the program]… I lost a lot of confidence when I got sick…but I found there are certain people there who… boost self esteem… and I’m seeing how useful it is, and how you can get love from other people…they ask how you’re feeling and you can be honest.”

Just as leaving the program created a range of mixed feelings for the individuals I spoke with, abandoning this project creates mixed feelings for me. Its production has certainly been a long process, during which many things in my life have changed, including my understanding of social work and criticality. Over the past eight years, the original research question, “How does living in a residential psychiatric disability support service impact on an individual’s life?” remained central to the thesis, but expanded to
include problematisation of the role of social workers/support workers, and what might be called a postmodern critical exploration of practice assumptions based on material raised in interviews. This exploration came to include the professional gaze, worker power and authority, vulnerability and boundaries, as well as the community as a recovery-oriented environment, sensemaking and the creation of culture, change and turning points, and conceptualisations of outcomes in mental health. My approach, which I described primarily as naturalistic, allowed for a strong reliance on participants’ narratives to describe their experiences in the program and their insights on a range of issues around mental health and ‘illness’ and the role of support in relation to an individual’s journey. Their theory-stories were placed alongside literature I considered relevant or insightful, much of it based in recovery-oriented or empowerment (non-medical model) perspectives. Particularly in the earlier chapters, but to some extent throughout the thesis, I attempted to convey my own struggles with authorship, the researcher’s role and relationships with participants, and acknowledgment of my own standpoint. As I wrote, it also became increasingly obvious to me that many of the struggles, challenges and experiences of ‘residents’ mirrored my own, in relation to such things as fear of change, the achievement of holistic well being, the ongoing nature of recovery from loss, and the creation of (dis)empowering self stories, as well as grappling with material realities.

To some extent, various chapters of this thesis could stand alone, however taken together they suggest that it is important for critical social/support workers to engage in interrogation of, or critical reflection on, their practice and the assumptions that guide it, and consider the possibilities for trespass and emancipation in their interpretations and (inter)actions. My supervisor, sagely and distressingly, on a number of occasions, asked me to try to pin down, my ‘small-“t”’ thesis, and to consolidate it into a sentence. I tried, somewhat defensively, to suggest that I am not an argumentative person, thus a ‘small-“t”’ thesis, if it was an argument, was not the way I did things: I preferred to present a range of possibilities which the reader (if there was one) could consider. At the same time, I recognised the wisdom in his request, so here is the latest version: Social work (and academic/research) practice is a form of power that carries possibilities for trespass and emancipation; critical social work practice requires a brave, dynamic and honest
willingness to deconstruct and reconstruct practice in this light, in order to respond to the
diverse ‘truths’ of human experience. Although this ‘small ‘t’’ thesis seems somewhat
removed from my original research question, it is actually intrinsic to an exploration of
the original question. How can you look at the experiences of service users without
looking at the meaning systems and interactions of workers? Like the bobbin and the
needle threads on a sewing machine, you can’t have one without the other (if you want to
sew a seam, that is): worker and client interact and create each other, even if that creation
is contextual, temporary and power laden. Reflexivity – putting oneself in the picture –
can be missing from many ways of constructing the world; the oppressive consequences
of constructing out-there-ness (or ‘othering’) can be seen across many facets of human
experience, from the construction of a psychiatric patient within the medical model, to
the construction of asylum seekers as burdens to society or less than human. This is
something critical social workers can count amongst their greatest skills and
contributions to society – the capacity for critical interrogation of their own practice.

As my eldest daughter once said about social workers, “If you’re going to be out
there f***ing around with people’s lives, you should have some idea what you’re
doing.” This sentiment resonates well with some of the ideas presented in this thesis:
basically that all ways of knowing and intervening create trespass of some sort, thus the
onus is on each of us to critically reflect upon what assumptions, values, and theories
inform our interpretations and responses, and how are these experienced by others. The
way we conceptualise practice in human services will be based on a range of factors,
including the ethos and primary task of our employing organisation, wider social
discourses that shape our sense of reality, our specific professional discipline and
education, the theoretical orientations we espouse, and who we are as human beings. Our
views of professionalism, our use of professional power and authority, the boundaries we
create and enact, the meanings we attach to experiences, and the sorts of environments
we are involved in creating and maintaining, all stem from the complex array of
knowledge and meaning-making we engage in, more or less consciously. The task then,
is to have the courage and willingness to critically reflect on our constructions of reality
and their consequences in the world of human interaction, in which the line between
worker and client is both real and not real.
Returning to the quote at the beginning of this chapter, which refers to the paradoxical nature of finding a home in order to leave it, this is also descriptive of the experience of writing a PhD thesis. In some senses, and not unlike a therapeutic community, the ‘home’ provided by engagement with this thesis has variously been challenging, confronting, infuriating, and rewarding. It is definitely time for me to leave this home, with mixed emotions. When I started this project, I had three children at home; now I have none. When I started this project, I described myself as a social worker or support worker; now I describe myself sometimes as a social worker, sometimes as a teacher, sometimes as an academic, other times as an old hippy. During the writing of this thesis, a close family member who suffered from various forms of depression and substance dependence died of an overdose; one of the persons who generously provided insightful and considered comments as a former resident for this project has died; others have married and had children; others have completed university degrees; many others I have not been in contact with or received news of for a number of years. I wonder how they are going and what they would say to me now.

As I was finishing typing this final chapter, I had a phone call from one of the former staff persons – also a friend who I had lost contact with - who had participated in this research project. While she had not heard my voice for several years, I had, only that day, been engaged with her words, frozen in textual time, from an interview we had done some five years previously. Her words were totally alive in my thinking and under the touch of my fingers on the keyboard. It makes me wonder now, if anything really ends, or if it just continues in more or less conscious ways, remaining part of a continuing process of inevitable change and movement. This thesis is dedicated to my three children who supported me unconditionally through my own process of research, and the participants who courageously and sensitively welcomed me in the sharing of their stories. I now return to the quote presented in Chapter Two: “We would argue that one of the most important questions to be asked about a text is what conduct it warrants” (Curt 1994: 192); if this thesis resonates with experiences of the reader, if it provides any new insights or creates critical engagement in ways – however small – that contribute to the generation of wisdom, compassion and emancipation, that is a good thing.
APPENDICES
APPENDIX A

Example of PROGRAM TIMETABLE

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>9:00 am Morning get-together and weekly planning meeting</th>
<th>10:00-11:30 Cleaning groups</th>
<th>12:30 pm Monday lunch</th>
<th>2:00-3:30 Gardening group alternating with cooking group</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUESDAY</td>
<td>9:00 Morning get-together</td>
<td>10:00-12:00 Art Group</td>
<td>2:00-3:00 Women’s group/ men’s group</td>
<td></td>
</tr>
<tr>
<td>WEDNESDAY</td>
<td>9:00 Morning get-together</td>
<td>10:00 Shopping</td>
<td>3:00-4:30 Exiting group</td>
<td>6:30 Community meal</td>
</tr>
<tr>
<td>THURSDAY</td>
<td>9:00 Morning get-together</td>
<td>11:00-12:00 Community meeting</td>
<td>12:00 BBQ</td>
<td>2:00-3:00 Support groups</td>
</tr>
<tr>
<td>FRIDAY</td>
<td>9:30 Friday breakfast combined with morning get-together</td>
<td>10:30-12:30 Bodywork (shiatsu, yoga, tai chi, reiki, etc)</td>
<td>Afternoon outing</td>
<td></td>
</tr>
</tbody>
</table>

The program ran on a basis of ‘cycles’ which changed four times each year. Between each cycle (somewhat like a semester or term) there was a break of one to two weeks during which there was no set program. During this time, some residents went on a camp organised by the program (at the organisation’s holiday house at Apollo Bay). The body work component of the program changed from cycle to cycle.

(Please refer to following pages for explanations of the various groups and meetings.)
EXPLANATION OF WEEKLY PROGRAM TIMETABLE

Get-together: This informal meeting took place every morning; attendance by all residents was expected, unless negotiated in advance. The purpose of the gathering was to encourage individuals to get out of bed (many had identified the problem of staying in bed all day and were looking to the program structure to assist them in breaking this habit), as well as to discuss what was happening that day and anything that had come up for people. In this latter category, residents might, for example identify problems in the house (from plumbing to interpersonal conflict), and staff might inform residents of their movements through the week. It was also a time when residents could request to be absented from participation in various program activities, due to a clash with other appointments, etc.

Weekly planning meeting: This occurred as part of the Monday get-together. At this meeting residents decided who was going to be responsible for essential activities such as grocery, meat and vegetable shopping, preparing the Monday lunch and the Thursday community meal and the community breakfast on Friday. Areas of the house to be cleaned by each cleaning group (see below) were also identified. It was expected that these jobs would rotate equitably amongst the residents.

This was also when individual residents and their key-worker scheduled their weekly ‘IPP’ appointment (one-to-one session that occurred in a range of settings, according to individual preference and need, for example sitting together in the garden or in a quiet room in the house and talking, going out for a walk or coffee, or supporting a client to do something in the wider community setting).

Cleaning groups: These groups were compulsory in the ‘old’ program. Each staff member worked with a set group of residents on cleaning various parts of the house. (For example, one group would take the kitchen and lounge area; another group the bathrooms and toilets; and another group the community meeting rooms.) Bedrooms were the responsibility of each individual. (All residents had single bedrooms.)

Monday lunch: This was a special group lunch to start the week: residents were encouraged to attend. Two residents were responsible for getting the money from petty cash to purchase bread rolls, meats, cheeses, dips, etc. and setting them out.

Gardening group: Attendance by everyone was expected at this group (facilitated by a staff member), which was held every second week. The group met to decide what needed to be done, and who was going to do the various tasks, which included mowing, weeding, developing a vegetable garden (if there was interest) and general tidying up.

Cooking group: This group was optional, although individuals were encouraged to attend. This group was sometimes facilitated by a staff member, and sometimes facilitated by an outside nutritionist. Often a meal would be prepared for that night’s dinner. Each night dinner was cooked by a pair of residents, as negotiated in the Monday planning meeting.
Art group: This group was optional, although residents were encouraged to attend if they did not have anything else to do. The art group was usually held at a nearby community art space, facilitated by a staff member with a degree in visual arts. The group might concentrate on ceramics/pottery, or painting, or, in preparation for a one-off celebratory event, creation of a large paper-mache sculpture with a visiting artist. Staff also participated.

Women’s group/men’s group: Attendance was expected at these groups, generally co-facilitated by staff members. At the beginning of each cycle, the group met to brainstorm ideas for the group. Some sessions were facilitated by residents, others by outside people who were invited, and others by the staff persons. Examples of sessions occurring in the women’s group included a session on body image facilitated by a resident, an information session on sexual health facilitated by an outside worker in that area, an informal op-shopping and coffee outing, and discussion sessions on gender-related issues in the house.

Shopping: Grocery, meat/fish and vegetable shopping was done on a weekly basis, with a set budget for each type of food. This task rotated amongst residents, with staff driving to the shops in the community van. Part of this task was to manage the budget allocated.

Exiting group: This group was for residents who were considering leaving the program, or who were in the process of leaving the program. ‘Exiting’ was a serious undertaking, accompanied (ideally) by a thoughtful process of discussing their plans with their key-worker and developing a strategy for moving on successfully, announcing their intentions to the community at a community meeting (and getting feedback from others), and gradually disengaging from the program by becoming more active outside the program. Exiting also included a review with the key-worker and the program manager of their achievements whilst in the program. The exiting group was made up of residents engaged in this process, and sometimes also former residents who came back to talk about their experiences.

Community meal: This was a group dinner that all residents were encouraged to attend, prepared by two residents, and open to former residents who wanted to keep in contact with the program and the community. Two staff generally stayed late to participate.

Community meeting: This was a very important meeting that all residents and staff were expected to attend. Staff would have an ‘agenda’ (not printed) of issues they wished to raise, and residents were encouraged to identify issues they wished to discuss. Examples of what was discussed at these meetings ranged from where (or if) the smoking areas in the house should be; addressing conflict around whether everyone was pulling their weight; six week, one year and exiting reviews (see below); discussions around household issues such as alcohol consumption, cleanliness, noise; planning for camps; lack of participation etc. These meetings were co-facilitated by two staff persons on a rotating basis. Staff met before and after this meeting. The process of the meeting was
considered as important as the content and ‘outcomes,’ in that staff were attentive to
group dynamics, individual participation, etc.

**BBQ:** This was an outdoor (weather permitting) group lunch prepared by two residents
and often a staff member, to which former residents were also invited.

**Support groups:** There were two support groups: one for new residents and one for
residents who had been in the program longer. Each group was co-facilitated by two staff
members. As new residents came into the program, older residents progressed into the
second group. The group for new residents focused on settling-in issues, exploration of
what had brought people into the program, and at times, included activities and/or
exercises on such things as self-esteem, family relationships, etc. The second group
focused on some similar issues, as well as conflict in the house, individual issues that
group members wanted to share, and exiting. As in the community meeting, the process
and dynamics of the group were considered significant.

**Friday breakfast:** A special breakfast (pancakes, waffles, croissants, fruit salads, etc)
prepared by two people – sometimes residents, sometimes staff, combined with morning
get-together. Often the afternoon outing would be planned.

**Bodywork:** Residents and staff would brainstorm, at the end of each cycle, what they
wanted to do in the next cycle. Outside therapists or practitioners would be invited (e.g.
yoga teacher, tai chi teacher). Participation was optional but encouraged. Staff also
participated.

**Afternoon outing:** This could be anything from going to a movie, to going on a drive to
the Dandenongs, to going bowling or to the beach, based on residents’ choice. Two to
three staff participated. Costs were often subsidised by the program.
OTHER ASPECTS OF THE PROGRAM

Entry to the program/interview process: Potential residents could self refer, or were sometimes referred by family members or professionals. Residents needed to come from the particular geographic area specified by funding arrangements. Residents needed to have a psychiatric diagnosis and be aged between 21-40. Staff attempted to keep a reasonable gender balance. Residents were voluntary, although some certainly felt there was nowhere else they could go.

Prospective residents, often accompanied by a support person, participated in an interview with the program manager and a staff member to explore the possibility of entering the program. If the resident was keen, and it seemed their needs could be met in the program, they were invited to spend a day in the program (usually a Tuesday). After this, the community was consulted as to their opinion, and staff made a final decision. Sometimes a new resident commenced on a ‘part-time’ basis, if it was felt that would be a more gradual and successful process.

(If the program was at full capacity – 14 residents – prospective residents were put on a waiting list until there was a vacancy. The program usually ran at full occupancy.)

Six-week review: After a resident had been in the program for six weeks, their residency was reviewed at a community meeting. Other residents and staff gave feedback, from their perspective, as to how they’d observed the person to be settling in, and the resident had an opportunity to talk about how they had found their stay so far.

One year review: When a resident had been in the program for twelve months, there was a review of their residency at a community meeting. This was an opportunity for the individual to reflect on their stay, where they were and where they felt they were heading. It was also an opportunity to receive feedback from others.

Birthdays, Christmases, Organisational events: Birthdays were always celebrated, often at community meeting or lunchtime. Christmas was marked by some festivities as decided by the community. Occasionally organisational events, such as the Annual General Meeting, or program events, such as the 20-year anniversary of the program, were attended as a group, with residents participating as they desired.

After hours support: Staff members rotated carrying a ‘beeper’ on weekends and after-hours, so that residents could ring if they needed support. This was eventually phased out, after a process of putting in place other supports (such as ‘triage’ at the local hospital) for residents experiencing distress. Staff generally were at the program from 9:00-5:00 weekdays. Weekends were unstaffed.

Staffing: The program was generally staffed by three support workers and a program manager (qualifications ranging from Occupational Therapist, to Psychologist in training, to Social Worker or Art Therapist).
Physical set-up of the house: The house was a Victorian terrace house in a well-to-do suburb of Melbourne, well serviced by public transport and with a variety of shops and cafes within easy walking distance. Staff had an office space (initially upstairs, but eventually moved downstairs) with an open door policy unless engaged in a meeting. Also downstairs was a large community meeting room that also housed a billiards table, large kitchen and dining room, and the ‘piano’ room which was also used for one-to-one counselling sessions. Residents’ bedrooms were located upstairs, along with a smaller kitchen, lounge room and ‘smoking room.’ Toilets and showers were upstairs. The gardens were quite large, and there was an outside laundry room. At one point, a consumer-run organisation occupied one of the downstairs rooms.

Linkage with other service providers: Staff members made a concerted effort to establish productive links with other service providers involved with residents. This could include general practitioners, social workers at the mental health clinic, workers at employment programs, psychiatrists, etc. Contacts were made with the permission of the resident. Program staff supported and advocated with and on behalf of residents as negotiated with the resident.
APPENDIX B

PRINCIPLES OF PSYCHOSOCIAL REHABILITATION

According to VICSERV (peak body of the psychiatric disability support sector in Victoria), fifteen principles of psychosocial rehabilitation were developed in the mid 1980s in the United States, by the International Association of Psychosocial Rehabilitation Services. The fifteen principles were:

- based on a critique that much mental health service leads to an under-utilisation of full human capacity
- equipping people with skills (social, vocational, educational, interpersonal and others)
- people have the right and responsibility for self-determination
- services should be provided in as normalised environment as possible
- differential needs and care
- commitment from staff members
- care is provided in an intimate environment without professional, authoritative shield and barriers
- early intervention
- environmental approach
- changing the environment
- no limits on participation
- work-centred process
- an emphasis on a social rather than a medical model of care
- emphasis is on the client’s strengths rather than on pathologies
- emphasis is on the here and now rather than on problems from the past

(The final two principles were added by the 1990s.)

These principles were based on a definition of psychosocial rehabilitation as follows (Cnaan et al., 1988, cited in VICSERV, 2005, p. 2):

“The process of facilitating an individual’s restoration to an optimal level of independent functioning in the community… While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental
health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, educational and personal adjustment services.”

While the language of this statement could be critiqued, (for example, the phrase ‘personal adjustment’ and ‘social competence’ carry a certain normalising assumptions that could be challenged from a critical or anti-oppressive standpoint), the principles and the definition do imply a commitment to a client-centred, non-stigmatising, holistic and rights-based model.

In 1992, what was then called the community-managed sector in Victoria, decided that the term ‘psychiatric disability support,’ based on principles of psychosocial rehabilitation, more accurately described their work, and changed their name to reflect this. At that time they collectively adopted a set of ‘Characteristics of Non-government Community-managed Community Mental Health Rehabilitation and Support Services Principles,’ which follow:

- flexibility of structure and service models
- non-obligatory attendance
- support for mobility and choice of service options
- active participant involvement in services
- support for participant decision-making
- concentration on quality of relationships and interactions between participants and staff
- encouragement of peer support
- responsiveness to participants’ needs
- provision of most ‘normal’ environment
- effective psychosocial rehabilitation
- autonomous community accountability
- utilisation of a broad range of skills
- active community education function
- active advocacy function
- cost effectiveness: both operational and preventative

(VICSERV, 2005, pp. 2-3)
The Department of Psychiatry at the University of California, San Francisco (2006), words the psychosocial rehabilitation principles somewhat differently; they summarise the core principles as hope, respect, education, choices, inclusions/collaborations, and strengths, and state that these principles are demonstrated by the following practices:

- hope is recognized, preserved and instilled
- positive role models have an active presence in programs
- social change to decrease stigma and discrimination is promoted
- everyone is treated as an individual with unique beliefs and values
- care is provided in a comfortable and safe environment
- everyone is informed about patients’ rights and advocacy services and are held responsible in upholding relevant laws
- staff work collaboratively with clients and inform them fully about all aspects of their care and treatment
- everyone has the right to be an active partner in their own treatment planning
- people communicate with each other as equals
- voluntary status in an inpatient unit is a “cornerstone in creating a collaborative relationship and maximizes choices” (p. 1)
- all people have strengths and skills that should be nurtured; strengths are emphasised rather than pathologies
- all people have the right to develop their full range of skills and resources