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‘I don’t know what I’m doing. How about you?’: Discourse and identity in practitioners dealing with the survivors of childhood sexual abuse.

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‘I don’t know what I’m doing. How about you?’: Discourse and identity in practitioners dealing with the survivors of childhood sexual abuse.

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Abstract

This research is based on interviews conducted with a voluntary group of health practitioners who care for the adult survivors of childhood sexual abuse in one area of Scotland. This project takes a broadly interpretive approach to the interviews, and examines the processes of sense-making apparent in the scripts of the doctors, community nurse and counsellors who comprise this voluntary Forum. Those interviewed were highly sceptical of traditional medical approaches to dealing with survivors of such abuse, and they all questioned the effectiveness of expert professional knowledge. The research highlights the role of patient disclosure as a key mechanism in the process of their treatment, which is akin to the confessional technology discussed in detail in the work of Michel Foucault. Combined with other medical technologies patient disclosure is revealed as a technique of normalization. In this particular case the experts themselves were engaged in unravelling this process in search of alternative approaches to caring for their patients, which were based on a relationship of equal partnership rather than of expert authority. This research thus begins to illustrate the processes of sense-making and identity formation which exist between professional health care workers and the victims of abuse for whom they care.

Keywords

Professional Identity, Self Identity, Discourse, Sexual Abuse, Disclosure, Normalization, Transformation, Foucault

"To talk about oneself a great deal can also be a means of concealing oneself." (Friedrich Nietzsche, *Beyond Good and Evil*)

INTRODUCTION

How individuals define themselves and their work has become an increasing focus of debates within organization studies and labour process theory (Kunda, 1992; Jaques, 1995; McKinlay, 2002, Starkey & Hatchuel, 2002, Willmott, 1997). The definition and evaluation of what we do when we are at work not only involves certain skills, knowledge and activities but is a fundamental part of how we define who we are as people. At times the changing demands of the working environment can give rise to internal debates about our selves and may involve a reinterpretation of our basic beliefs about self, job, work and the organization of work. The present debate involves a process of self-questioning and self-exploration as much as it is a narrative reflexively constructed by the researcher. This paper will examine the process of identity construction amongst health care professionals who deal with the adult survivors of childhood sexual abuse.

Foucault's work on the human sciences traced the rise of professional power throughout the eighteenth and nineteenth centuries, particularly through the development of medical and penal discourse (1971, 1973, 1977, 1981). On the one hand, a person was subjected to legal procedures, to establish their innocence or guilt and the imposition of an appropriate penalty. On the other hand a person was subject to medical procedures to diagnose their condition with respect to a norm, and prescribe a regime to return them back to normality and good health. Foucault observed that medicine and the medical

profession emerged during the eighteenth and nineteenth centuries as a major field of social control, which took as its focus the mind and body of the patient. Medicine came to have strong ties with the juridical apparatus, particularly with the extension of medical concepts such as illness and normality to cover a range of emotional, mental and legal concerns. The medical profession has developed a host of techniques for gaining control over the body, where Foucault has described the relationship between them in the following terms, “The body is a biopolitical reality; medicine is a biopolitical strategy” (2001: 137).

Historically, the treatment of illness and mental illness has been a matter for doctors and psychiatrists working within hospitals, but there has also been a strong countermovement against the medicalization of social problems from the very outset of psychiatry. As Foucault himself observed, “The whole of modern psychiatry is fundamentally pervaded by antipsychiatry, if one understands by this everything that calls back into question the role of the psychiatrist formerly charged with *producing the truth of illness in the hospital space*.” (2000, 45). Anti-psychiatry became a significant social movement in the twentieth century in the work of people like David Cooper, Thomas Szaz and R.D. Laing. In his writing on psychiatry Foucault observed that alternative approaches to dealing with emotional distress and so-called mental illness grew up at precisely the same moment that the large medical institutions were being established.

This present research concerns the treatment of victims of abuse in the voluntary sector and clinics and this takes place largely outside the confines of the hospital. This paper

will examine important themes that revolve around identity construction, including the way social problems are medicalized, the kinds of knowledge that are brought to bear in dealing with these problems and the kinds of interactions that exist between the health workers and their clients. The role of expert knowledge is challenged repeatedly by the majority of those interviewed for this research. This paper will examine the discourse of health care professionals and how this forms a part of the social construction of identity both for the professionals themselves and for their patients. It will address new ways that practitioners have devised in the treatment of their clients, how practitioners make sense of the client response to traditional practices, and the study of contrasting attitudes between medical and voluntary practitioners.

Before proceeding we wish to make clear the precise contribution of this paper. The main contribution is to the literature on sense-making within organization studies, and this research examines in some detail the narrative accounts of how doctors, nurses and counsellors make sense of their work. More specifically, this analysis shows how practitioners in mental health care make sense of their work in the voluntary sector as compared with their work in the statutory sector. Although these accounts do contain a number of critical remarks of the statutory sector, a critique of this sector is not the aim of this paper. This process of sense-making is part of the development of care, where the members of the Forum interviewed were all concerned with the concept of "best practice" in mental health care. This discourse also concerned how new ways of interaction between the practitioners and their clients are being created and tested.

THEORETICAL APPROACH

This research adopted a broadly interpretive approach to data gathering and analysis (Burrell & Morgan, 1979). The data gathered is primarily qualitative, and was analyzed using a social constructionist perspective towards the nature of organization and society. The social constructionist approach holds that social reality cannot be understood apart from the intersubjective meanings of the social actors involved (Berger & Luckman, 1967; Geertz, 1983). The aim of social constructionist research is to understand how members of a social group enact their particular realities and endow them with sense and meaning (Rosen, 2001, 6). Geertz (1973) describes this quest for evidence of ascribed meaning as 'thick description' of human behaviour and its associated systems of meaning, where 'a good interpretation takes us into the heart of that of which it is an interpretation (1973, 18). Finding out how individuals interpret what they do within organizations places us within a tradition in which meaning can be derived principally from the stories and narratives relayed by the subjects selected for interview. The stories they tell account for what has occurred to them, what meanings they ascribe them, and how they evaluate their experiences overall (Goffman, 1959). This kind of research involves the analysis of 'metaphor, language games, stories, poetry, narratives, rituals and myths, rhetoric, texts, drama, conversations and sense making' (Oswick, Keenoy & Grant, 2000). Interpreting events and making sense of our lives requires making a record of accounts of past experiences and an analysis of how these narratives are framed (Goffman, 1959; Louis, 1980a, 1980b; Weick, 1979). This involves surfacing basic assumptions that individuals hold about themselves, their work and their institutional

prospects, all of which are important aspects for defining the conditions and methods of their work, to control the production of producers and to establish a cognitive base and legitimation for their occupational autonomy (Hodgson, 2005, 58).

THE SITE OF THE RESEARCH

The research was performed by invitation to join the meetings of a local Forum of practitioners involved in counselling adult survivors of childhood sexual abuse. As a local academic and contact of one of the members of the Forum the principal researcher had direct access to their meetings whose members included 4 Doctors, 6 counsellors and 1 community psychiatric nurse. This Forum was responsible for the treatment of clients within a discrete local area in Scotland. Each of the members of the Forum was interviewed individually by the principal researcher. These interviews were approximately one and a half hour in length. The format of these interviews was semi-structured and was focused on questions concerning guidelines for best practice, early training, formal treatment of clients, awareness of client response to that treatment, overview of the operation of the service and its effectiveness for clients.

ANALYSIS OF DATA

Central to our analysis were the ways in which contexts are interpreted or constructed and strategically and continually made relevant by and for participants (van Dijk, 1997b). Our methodology paid close attention to the talk of our subjects and the kind of narratives they drew on in constructing their practitioner identities (Boje, 1995; Halford & Leonard, 2006). Throughout the analysis of each interview we interrogated the text for

the discursive strategies they used to account for the role they play in the therapeutic encounter with patients, taking the position that it is useful to treat identity as a narrative (Czarniawska, 1997). In this respect, most contexts consist of multiple and fragmented discourses that provide actors with choices concerning the discourses on which they draw (Hardy, et al, 2000, 1232).

The traditional medical discourse concerns the practices that are associated with a range of control and therapeutic objects. The professional doctor is brought into being ‘as a particular subject through drawing on the varied discourses that make up medicine’ (Potter, 1996, 86). Judging by the accounts and narratives given by the medical practitioners involved in the present research, it would be difficult to discern quite such a clear-cut role. The narratives offered here involved a challenge to many of the existing assumptions of the traditional medical discourse, a discourse that is based upon the traditional practices of observation, diagnosis, prescription and treatment (Goffman, 1961). In particular, the narratives challenge the predominant role of treatments such as the use of drugs and of "disclosure work" in statutory mental health care. These traditional forms of treatment have been described by the social historian Michel Foucault as processes of normalization and knowledge of these processes form much of the basis of professional expertise (Foucault, 1977, 1981, 2000). Despite this the practitioners interviewed for this research were highly sceptical of the actual healing value of such processes of normalization, especially the use of drugs and disclosure work. This degree of scepticism is remarkable not least because these techniques of normalization form the basis of their professional expertise, but we will wait until the

discussion of the narrative accounts of the health care practitioners before examining the issue of normalization in greater detail.

The professional-client relationship in mental-health practice is of a very peculiar nature. For instance, Erving Goffman's classic study of this relationship described it as "a kind of grotesque of the service relationship" (1961, p. 321). The reasons for this peculiar relationship are historical, and can be summed up in the fact that psychiatric doctors exercise such a great power over their clients and inside the hospital they can intervene in almost any aspect of their clients' lives (Goffman, 1961, Foucault, 2000, Lupton 2003, Scott et al. 2003). For example, research has found that psychiatrists can use a diverse range of techniques to influence and normalize their clients' behaviour, they can prescribe drugs to control their moods, or they may prescribe some kind of work as a "therapeutic" activity, or they may even confine their clients if their behaviour is deemed too disruptive or dangerous (Goffman, 1961, Foucault, 2000, 2001, Lupton 2003). Indeed, Goffman (1961) observed that in the case of mental-health no aspect of a patient's life is supposed to be outside the realm of the doctors' examination. The latter also suggested that the real clients of psychiatric asylums are not the patients, but their families, the police, judges and society who may otherwise have to care for them**.**

In contrast to the traditional medical model, this voluntary Forum constituted a space for the health care practitioners to exchange their different approaches to care, often involving very straightforward and practical advice. Indeed, much of what was being described in the narrative accounts given by the health care practitioners that are

discussed below was an attempt to make sense of their working experiences and develop a new framework and new language for dealing with these experiences. In this respect the earlier definitions of discourse as construction would approximate more closely with the assertion that 'the question becomes not what is the true nature of the self, but how is the self talked about, how is it theorized in discourse' (Potter & Wetherall, 1987, 102). In many of the accounts given below we can overhear a discourse of becoming in which the participants are exploring their own identity and are uncertain what sort of discourse is truly appropriate with their clients (Chia 1995, 1996). This research will show that any challenge to the role of professional expertise and certitude seems to be linked with uncertainty over what should replace any deterministic discourse. In this light, we will explore the metaphors used by those involved in developing a new language to describe their social relations and the distinctive kinds of problems they perceive they are dealing with.

We will begin by going through the accounts of those interviewed, highlighting how those involved came into the field, what kinds of knowledge they draw upon in their practice, and how they see themselves as professionals or otherwise. Although the accounts all come from members of a particular local Forum, they have been divided into three separate subgroups for the purposes of analysis: medical doctors, psychiatric nurse and voluntary counsellors.

THE DOCTORS' NARRATIVES

For medical practitioners the amount of time spent in full-time study, the syllabus

followed and the gradual exposure to outside practice and patient exposure suggests that the formal discourse associated with medical practitioners is well documented and assured. The medical practitioners included in this study took many different routes that eventually led them to work with childhood sexual abuse survivors. All of them have been in the field for more than 20 years and one has just retired after pioneering different methods of treatment in a hospital, ward-based environment. For each of them general medical training moved into either personality disorder, psychiatric services, or working with patients with addiction problems. In the words of one practitioner:

We drifted into disclosure work.

The resonance of this remark reflects their original training discourse and was extended in the narrative of one Doctor, active for thirty-eight years in the field:

The whole issue of woman making it up was a dominant view – that most of what you heard was fantasy and worse than that was wish fulfilment. That whole idea would underlie what used to then be called 'hysterical personality disorder'. I suppose the other side of it was that it was a sense of excitement, that it was all a bit titillating, that part of your role as a psychiatrist was to uncover the details of this which, looking back, was very sinister and voyeuristic

This description is salient for all the different practitioners in the field and undermines the need for disclosure of childhood sexual abuse by a patient as an essential part of a

treatment. Work by Draucker (1992, 17ff) has found that what starts as mainstream adult mental health work, has uncovered sources of patient unease which are bound up with historical events, both traumatic and highly personal. However, this work also highlights a continuing debate among practitioners about the wisdom of seeking to surface details of such events and whether such disclosure is cathartic or not. There are even stronger opinions about whether practitioners should attempt to trigger such accounts and to what extent such disclosures are likely to bring about a confession of relief, which once told, might release the sufferer from their burden of guilt. All the medical practitioners referred to the danger of diagnosing conditions and labelling people. One practitioner who has been active for 38 years referred to his early years as being dominated by the label 'hysterical personality disorder,' another to the prevalence of the label 'borderline personality disorder' and both suggested that this kind of labelling could often lead to predictive treatments, often drug-based, which while they may have alleviated the symptoms, more rarely addressed the underlying causes. The focus of the treatment seemed to be pragmatic in that, according to one of the medical practitioners, it comprised of practices with which clients needed to become familiar and would condition their future behaviour. In the words of the community psychiatric nurse:

Coping strategies, safety strategies, establish goals, gaining control of themselves without them being dependent. A hierarchy of activity reinforcing the kind of plan the patient came up with in the first place. Sometimes they think they must have disclosure work. But our support is quite practical – not necessarily identifying the abuse at all.

More regularly mentioned was attachment theory described by one medical practitioner as a substitute re-parenting exercise:

Which is about maintaining establishment of the boundaries. The person has formed object relations and basic assumptions about relationships which are kind of dysfunctional or problematic. It's how you relate together within that therapy relationship which is actually where healing, mending, experimenting, learning is going on for that person

What is most evident is the message of accommodation: the acceptance of the individual to the existence of the past experience and coming to terms with it – 'living around it', as one practitioner put it. As to how long the treatment will last, the answers were consistently extended. Though working to cover a treatment of 10 – 16 sessions, the most experienced practitioner confirmed that one patient had been seeing him since she was 18 and was now a grandmother of 48. In his words:

She will probably always need to see me.

It comes as no surprise, then, that doctors often express fears about long term patient dependency. If we return to writers who have researched the dangers of such dependency, then the message is clear: "To suggest that they may need to see a specialist might well reinforce the survivor's perceptions of their needs as extremely complicated or unusual thereby increasing their sense of isolation and their view of themselves as being

different" (Draucker, 1992, 10). His colleague who has worked to write up behaviour guidelines for all practitioners working in the Forum, made a similar point:

There's not been any well developed clinical framework within which we as psychologists work with people with these sorts of difficulties. We are trying to develop better practice – more integrated practice, more evidence based – though there is very little evidence to base this work on.

For him, clients get 'a pretty eclectic, pretty variable service depending on which psychologist people happen to see'. Medics traditionally liked to take refuge in such terms as 'borderline personality disorder' – but nobody is convinced that what they are doing is right. He, too, mentions attachment theory and establishing the boundaries in the relationship with the client:

It's how you relate together within that therapy relationship which actually is where healing, mending, experimenting, learning is going on for that person.

Having suggested that better investment in training would have included psychodynamically informed work or dialectic behaviour therapy, he suggests that Cognitive Behavioural Therapy, which the Government has alighted on as the funded training for practitioners, is the easy option in which clients are focused on reframing their early experiences of abuse together with an honesty on the part of the practitioner, which includes the ability to say, perhaps surprisingly, to the client during the sessions:

I don't know what I'm doing, how about you?

Based on the voices of the medical practitioners we observed a similarity in their interpretive schemes emerging from their discourse on patient care and their experience of clients. This interpretive schema can be summarized by the following six points: 1) a move away from the predictive labelling of years gone by, 2) no single, well-developed clinical framework within which psychologists can work with people with 'these kind of difficulties,' 3) reframing and boundary maintenance in their relationship with their clients, 4) de facto acceptance that dependency is likely with some clients with no permanent resolution in prospect, 5) a deep suspicion of the damaging treatments by some practitioners in the statutory sector, 6) an uncertainty with respect to the efficacy of the work undertaken by the voluntary counsellors.

THE NURSE'S NARRATIVE

The path to qualification for the community psychiatric nurse proved to be as circuitous as for her medical colleagues. As a psychiatric nurse she studied at her own expense in psychology and eventually received training in Cognitive Behavioural Therapy. She had been initially seconded to Social Services as a Therapeutic Worker where her work in the community began. Nothing had been organized, so the pattern of visits to clients' homes that developed was a self-managed programme. Two areas are approached in the early visits: anger management and touching. The weekly visits would last typically for up to twelve weeks with a therapy break to allow the practice of techniques learned:

The client would have to agree on how long that break would be. Sometimes just four weeks, sometimes it would be three months. It would really depend on the client. And then we'd start up again once a month with meetings and review where they were at and what they required work on. I think the person I saw most had forty-five sessions but there were therapy breaks in between.

Client dependence formed no part of the discourse here at all. When asked whether she got to a stage of where she indicated to clients that she had done as much as she could she was very positive:

Yes, we do… well it's, it's a very two-way type of therapy, so the client is very much involved in what we are doing and we do get to a stage where we say, 'Right, I think we've done all we can now. It's up to you to keep working on it.'

For CBT treatment the emphasis is on coping strategies and confidence; learning to stop pleasing others in order to secure a good relationship with them. It is about how clients feel about themselves and relaxation techniques.

From the nurses point of view it is about rapport with clients, not taking the revelations to heart. Disclosure is something that may occur when dealing with anger management but not something looked for as a therapeutic release or point of catharsis. The virtuous circle of coping and practice asserts itself and seeks to place the survivor in a position of

assertive confidence. Restructuring occurs by reframing the narrative that one sees oneself a part of, where in the nurse's own words – "you change the ending" of the narrative. Another associated purpose of this reframing is to change the result of the recurring flashbacks from which clients often suffer. For this particular practitioner, the constant demand of continual referrals demanded a cyclical approach to visiting clients at home and a disciplined approach to weekly sessions centred on coping strategies, safety strategies and the eventual reinterpretation of childhood sexual abuse.

THE COUNSELLORS' NARRATIVE

For the counsellors, the path into the treatment of childhood sexual abuse survivors also developed by circuitous routes. Some entered from a background of social work, often, just as in the case of the medical practitioners, coming to the problem via counselling alcohol abusers. Training in techniques and the theoretical assumptions underlying practice was minimal for most volunteers, in some cases no more than two weeks. But for most, there was a belief that in-house development and group working had enhanced their understanding of how to help survivors.

Current guidelines and good practice have moved away from the predictive diagnosis and chemical intervention favoured by traditional medicine. Instead they were to assist survivors in finding meaning in their past experiences to facilitate their ability to cope with future life events. This approach has been noted in previous research which has observed that, "Once survivors have retrieved and validated memories of the abuse and fully described their experience, counsellors can assist them in reinterpreting the abuse

from an adult perspective." (Draucker, 1992, 58)

For the voluntary practitioners, their involvement requires being next to the clients, rather than diagnosing across a desk. For all of them the safety guidelines and coping strategies to help clients avoid self-harm and manage encounters with others was considered the first priority. In the words of one group organizer with 15 year's experience, this would include:

Safety in their own homes; re-experiencing feelings and emotions for the first time; developing new coping skills; learning to live differently in the world; developing their potential.

One counsellor who had worked in the medical sector in mental hospitals was more forceful and recognised the pattern of predictive diagnosis that the medical practitioners had alluded to:

Psychiatry has no empirical model. It relies on medical diagnosis and then puts people on medication to treat the symptoms. If the medication doesn't work it blames the patient. New diagnosis: ECT. If that doesn't work it's the long-stay ward.

For another counsellor the view of the medical practitioners' discourse is even more destructive for those they seek to treat:

Mental health practice destroys people. It creates a culture of dependency and blame. It makes you dependent and then blames you for it. It strips away the whole person and then leaves you on your own instead of becoming a partner in your journey.

The chemical intervention of drugs was seen to have deleterious effects on clients treated in this way:

So many of them were on Diazepam – which simply made their symptoms worse. It is more addictive than heroin.

As with the medical practitioners the worst condemnation is reserved for psychiatrists:

Psychiatrists are in despair, many of them. You breathe in this philosophy of abnormality, dysfunctional. It's like carbon monoxide poisoning. You don't notice it overcoming you and it kills you.

One voluntary agency organizer put her antipathy against such practitioners even more directly:

We wouldn't employ people working from a psychoanalytical background.

For voluntary counsellors, the commitment to the journey of making sense of abuse, reinterpreting past experience using adult interpretive schemas, remains the driving force

behind their work. The journey they have made is now one that can be shared with other sufferers. The essence of treatment is not expert knowledge possessed by the practitioner which is then imposed on the patient:

These women were experts on themselves – they had the expertise not me. They need to say the words they need to say. I mean it's their stuff, not mine. I would tell them regarding disclosure – I don't need to know that.

For another long-service counsellor there was a similar disinclination to espouse prior knowledge about patient conditions and predictive diagnoses:

It's not really about having lots of different knowledge about different things. It's really about exploring what it is and means for the person individually. I think people who say, 'I know exactly how you feel' should be struck off.

For these voluntary practitioners the signs of their clients turning the corner seemed more identifiable than they were for medical practitioners. Firstly, there was the immediate effect of being believed and having your admissions accepted. Secondly, the client could change their conception of the past by reframing the present as something which one has power over. Thirdly, they could gain independence, a sense of their own identity and learn to cope with their situation. But side by side with the reinterpretation of significant past events in order to redefine their meaning, goes a hard-headed approach to the future:

Behaviour modification techniques? No, in fact, I tell people if you employ new-found assertiveness skills, the hostility of the abuser may well increase. Very often the individual has to leave in order to start again in relationships.

…it's about where people start to make connections you can see them beginning to move along.

The counsellors continue their work in the hope that others may find the self-sufficiency they perceive they have found themselves. At times the work is unremitting hard labour with few successes to show for it:

The only cases I don't have a lot of experience of is closure and happy outcomes. How do you give a child back what she's lost? You can't. You can't go back.

But the determination to avoid the traditional interventions of medical practitioners is strongly expressed. One voluntary counsellor, herself a survivor of an abusive partnership, said:

Psychologists? I'm not sure what they do. A referral to one Hospital Unit took 4 years to set up. They feel safe in their office behind their desk. There's too much of this tendency to give people sedation and power down their minds. A man may rape you and give you a good kicking, but he won't mess with your head the same way.

For these counsellors, then, the accounts given differ from the medical practitioners in that it offers a reflexivity often born of experience. Finding their own way to sanity enables them to help other sufferers to see reality using different assumptions to interpret past abuse events and thereby derive different meanings and ascribe different values. The interpretive schemas of the counsellors contrast with medical practitioners in another striking way: they are confident, self-assured and definite in their beliefs about the nature of how childhood sexual abuse affects those who have suffered it and therefore stand in marked contrast to their medical colleagues who express far more tentative views about the condition and their part in effecting healing.

The remaining sections of this paper are devoted to a discussion of the above accounts in terms of the role of professionalism, the kinds of knowledge being brought to bear on the situation and the medicalization of self identity. This will be addressed in two separate sections, the first involving a detailed analysis of the role of "disclosure work" in identity construction and the second section concerning the use of metaphor in creating an alternative language to the traditional medical discourse for dealing with their experiences and problems.

THE CHALLENGE TO EXPERTIZE

It is rare to find an opportunity to research different archetypes side by side within a single work context. Most professions tend to keep a discrete distance from the workings of other professionals even if they share the same work sector. There is a certain amount

of rivalry displayed in the accounts of doctors, nurses and counsellor outlined above. Previous research has found some evidence to support the fact that professional rivalry exists between the different employees of the statutory sector. Scott et al (2003) have explained this rivalry in terms of organizational culture, where nurses and doctors have each developed their own distinctive subcultures. These authors observed that, “Studies of the interactions between doctors and nurses tend to support this idea – doctors talk mostly to other doctors of similar rank, and the same is true of nurses” (Scott et. al 2003, 25). There are sometimes boundary disputes between the different subcultures, where power struggles may take place. Lupton has also found that “Nurses working in hospitals must deal with professional conflicts over responsibility for the patient, negotiate struggles over power with physicians and contend with sexism and paternalism on the part of both doctors and patients.” (Lupton, 2003, 131). However, it is important to stress that the present analysis found that the narrative accounts of the members of the different subcultures involved in this case shared a great deal of ideas in common, including a fairly critical view of the traditional medical model of mental health. This level of consensus may be due to the fact that although such rivalry may exist in the everyday life of hospital wards in the statutory sector, this particular study is focused on a Forum in the voluntary sector, where participation is more open and the traditional boundaries of the medical hierarchy are far less apparent.

The practitioners in this Forum could be seen as operating within a wider social context of power relations, which are grounded in a highly structured regime of medical knowledge concerning the diagnosis and treatment of their patients. Nevertheless, the

accounts discussed here reveal a discourse that deconstructs the traditional certainties of acquired medical professionalism and expert autonomy. The Foucauldian project has revealed that expert discourse supplies its users with the linguistic resources for a particular identity and style of professional working which is controlled by a symbolism that enables them to convince their clients of their uniqueness and competence (Alvesson, 1994, Fox 1991, Rose 1989). The above narrative accounts revealed much disquiet concerning the role of expert knowledge as a basis of professional power, and admitted that such knowledge could be little more than a strategy of domination.

These interviews also offered an opportunity for individuals to reflect upon their own identity. They considered how far individual practitioners turn their professional knowledge and practices back on themselves. To what extent can knowledge of the self become a practice which entails a care of the self (Starkey & Hatchuel, 2002)? This last question is especially important when considering processes of transference and supervision and the concerns that each practitioner has that the burden of hearing harrowing accounts of abuse will either overwhelm them or give rise to inappropriate behaviours which need to be modified by external advice from a fellow professional. In this research, we will see how the construction of professional identity is uniquely tied to the construction of the identity of their clients.

DISCLOSURE WORK AND THE MASTERS OF TRUTH

The relationship between doctor and patient may be framed in terms of the consultation

process, where the doctors examine a patient and give their diagnosis. In dealing with cases of sexual abuse, this consultation traditionally takes the form of a disclosure on the part of the patient, where the doctor listens, questions and then provides an expert judgement or interpretation. This has strong parallels with the ritual of the confessional, which Foucault saw to be the basis of therapeutic relationships. He observed that, “Since the Middle Ages at least, Western societies have established the confession as one of the main rituals we rely on for the production of truth…” (1981, 58). This ritual permeates all levels of society, and exists to some degree between parents and children, judge and accused, and what is of most relevance to the present research, between doctor and patient. Social discourse is thoroughly imbued with the confessional attitude and its associated techniques, “one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles…” (1981, 59). According to the expert medical discourse, closure can only be achieved as a result of expert interpretation and diagnosis. The question of health and the possibility of healing are directly related to establishing the condition of the sufferer. Truth and healing are intimately related in the consultation between doctor and patient, most clearly when dealing with so-called mental illness, as Foucault has explained, “Spoken in time, to the proper party, and by the person who was both the bearer of it and the one responsible for it, the truth healed.” (1981, 67). If a patient is reluctant to speak, this is only a sign of desperate need for deeper analysis, “the truth is corroborated by the obstacles and resistances it has had to surmount in order to be formulated.” (1981, 62). By virtue of his training and his expert knowledge, the doctor became “the master of truth” (1981, 67).

The confessional discourse is also intimately associated with the concept of guilt (Richardson, 2000). The confessant must unburden themselves of their guilt by talking about themselves, by talking to an appropriate authority, who will listen, interpret and offer judgement (of the sin) or diagnosis (of the illness). This association exists even in the case of the victims of abuse or the victims of criminal acts. They must unburden themselves of what they have suffered and endured, on the one hand as part of a juridical inquiry for the establishment of guilt, and on the other hand as part of a therapeutic inquiry for diagnosis and treatment. In this confessional discourse the speaker forms a passive self-relation, one of being a victim, one who has been violated, one who is not in self-control which is attested by the act of violation itself, and by having to account for it afterwards. One has to account for what was done and what was left undone, and how this led to the event.

The process of disclosure was one of the most widely discussed issues amongst the doctors, nurse and voluntary counsellors who were interviewed for the research. All these individuals recognized the profound problems surrounding disclosure work. One volunteer explained why he was not interested in following a psychoanalytic approach to disclosure in the following damning terms, “there is a very sinister undertone to it all which is basically that you don’t trust what patients say to you because they are out to manipulate you, entice you, trap you, engage in a relationship which is not healthy.” Another observed simply that, “disclosure could be damaging.” Many practitioners questioned the value of disclosure on the basis that, “sometimes counselling and extensive talking, exploring abuse can really feed the trauma rather than clear it up.”

Several individuals including both doctors and volunteer workers noted that the discourse between the helper and client need not involve disclosure of the abuse at all, in the words of one doctor, “In point of fact, often the support you give is quite practical and not necessarily identifying abuse at all.” There may be no need to recover the past or pick at the scab of the wound. Instead the treatment, if it might be so called, is future-orientated and concerns how to cope better and establish more secure relationships. One doctor conceded that talking about “ordinary things” may be a more successful strategy than disclosure. One acts in the role of a sounding board rather than as an expert in any sense.

The interaction between the patient and the carer can be mundane and does not necessarily involve the use of any expert knowledge. The interviewees often explained that the relationship with their clients was one of equality rather than of authority, it is more akin to friendship than to traditional therapy. In fact, the question of expertise in this relationship is undermined again and again by the words of those interviewed. One practitioner claimed that, “even a three-year-old knows themselves better than I know them.” Another explicitly contrasted the expert analytic discourse with genuine practical knowledge, “these women were the experts on themselves, they had the expertise - not me…. they may not have analysed themselves, but they know themselves.” This practitioner was deeply suspicious of the idea that there may be hidden meanings in everything their client tells them, and rejected the idea that they could or should attempt to provide an expert interpretation of their client’s words.

METAPHOR AND THE TRANSFORMATION OF SELF-IDENTITY

This research found that the forum of medical practitioners interviewed have embarked, wittingly or unwittingly, on a quest of self-exploration and professional self-doubt which seeks outcomes through interaction with the clients rather than imposing a normalized identity upon their patients. We should be clear that these narratives are not rejecting the traditional medical model in toto, but rather are making a space for experimentation and the development of alternative forms of mental health care. A key part of this space is the move into the voluntary sector, which is not constrained by the same forces as is the case of the statutory sector. Another key part of this space is the development of a critical distance from the traditional medical model, and these narratives focused on the use of disclosure work as particularly problematic**.** It is clear that the sub-group of voluntary counsellors did not consider themselves to be historically associated with the traditional medical discourse and so did not feel the same need to dramatically change their basic working assumptions. These counsellors continued to question the appropriateness of the traditional medical discourse and to facilitate alternative paths for their clients to develop coping skills and strategies that set them free from past guilt and enabled them to reconstruct their lives.

AN EMERGING DISCOURSE

Now we will elaborate further the ongoing struggle of doctors, nurses and counsellors to develop a kind of knowledge and associated practices that help their clients, and which neither treated clients as normalized victims, nor represented their own role as an expert one. Those who were interviewed for this research often explained their relationship with

their clients as a process of becoming, as an open ended practice, which was both experimental and heuristic. We will examine the way in which certain metaphors are used by those interviewed to create a new language to describe their practice. A very important function of the role of metaphor is not merely as a representative device but as a means of transformation. The philosopher Friedrich Nietzsche used metaphor in precisely this way, where he described language as a mobile army of metaphors (Nietzsche, 1980). To understand the transformational nature of metaphor is to appreciate that the world is a process of open-ended becoming. A similar point has been made in the study of organizational becoming, by Anne Wallamacq (1998). In her inquiry into the emerging forms of network organization, Wallemacq found that the people who worked in these organizations did not really know what the term network meant, "at least initially, there was no need to know the exact meaning of the word. It was as if the aim of the word was less to denote than to evoke" (1998: 601). In her investigation she found that the metaphor of the network was used more like a totem than as a mere descriptor, which allowed flexibility for those who used it to change and innovate in their practice. The use of labels and metaphors is a significant feature of the accounts given by those who were interviewed for the current research. Those who were interviewed were deeply suspicious of the labelling that traditionally forms a part of the diagnosis and treatment of the victims of abuse. The metaphors we use to describe a situation embody assumptions that we make about the nature of the problem situation we think we are dealing with. However, one can contrast the use of a metaphor as a label which is supposed to represent a hypostatic condition and is a part of a medical discourse alien to the victim's own language, with the use of metaphor as means of experimentation and exploration

into new territory, a point of relay on a journey, which may lead to a desired end, but may also be one of exploration and survival. As one interviewee reported, “It’s not about having lots of different knowledge about different things, it’s really about exploring what it is and means for the person individually.” In fact, the metaphors of the journey and survival are recurrent themes and dominant metaphors in these interviews, which highlight the fact that what is happening is an open process rather than a static condition.

The metaphors used and practices engaged in by those interviewed in the process of exploration and self-transformation are divided into two general kinds, the first concerns the techniques of self-control and the creation of a safe area within which to develop and the second concerns the more open and uncertain processes of experimentation. Perhaps the main descriptor of the non-medicalized approach to victims of abuse was the idea of the ‘coping strategy’ to help create a safe environment within which to deal with one’s emotions. One social worker described this as analogous to dealing with addiction, where clients need to establish some control over their habit, on the basis of which control may be extended to other aspects of their lives. The first step in this was to, “establish goals that they [patients] can then use in a way of gaining control themselves without them being dependent for reconvening treatment.” The coping metaphor allows for medical treatment, but recognizes this as a last ditch strategy since it may end up creating other problems associated with dependency. Related to this is the idea of asserting boundaries between doctor and patient, again to encourage self-control and prevent dependency and other inappropriate relationships. Trust is crucial to maintain a stable boundary between the practitioner, their client and the outside world, which itself may be continuously

tested and reaffirmed, in the words of one of the doctors, “I find I get tested by survivors, you get constant testing. If you pass their test then you are maybe someone who can be trusted.”

Of all the different metaphors used that emphasize the importance of safety and self-control, probably the most significant is that of the “survivor”. The survivor metaphor is quite different from the label of a passive victim or sufferer of a condition. The idea of the survivor is a positive affirmation of the individual’s own power to endure. This metaphor was often used instead of the term “patient” or “client” to describe the victims of abuse and of the medical system itself. Those interviewed also discussed the practice of self-harming in some depth, which is one of the more serious and life-threatening behaviours of those who have been subject to violence and abuse. This was not addressed simply by preventing self-harm by medication or physical restraint, but entails what one counsellor described using the metaphor of “managing” self-harm. The practice of self-harm was itself accorded metaphorical status and reframed where one carer went so far as to say that everybody self-harms, not just victims of abuse. This carer suggested that it is normal to self-harm, and that it is only prejudice that sees such behaviour as different from say that of smoking tobacco or drinking alcoholic beverages, which are no less forms of self-harm, if more socially acceptable. Given the current levels of stress amongst the ‘flexible’ workforce of today, one might just as easily say that working is a form of self-harm. Self harm should therefore be seen as far more than a cry for help (though it can be that too), it could also be an expression of self control, as one carer asked, “what is it about, what does it give you, is it the pain you need, do you need the

pain to know that you're alive?.... You're looking for the pain, you're looking for blood, looking to be in control…" In a certain sense, self-harming can be understood as an exercise in self-mastery, perhaps even a practice of the care of the self.

More tentative language was used to describe the more uncertain and experimental aspects of the practice. Various practitioners simply described the process as a learning process, or more specifically "learning to live differently in the world." Several of the participants in this research also noted the open-ended nature of this learning and that sometimes they had to tell their clients that they were not sure how to proceed in certain situations. The metaphor of "experimentation" was drawn on by several practitioners which also emphasized the fact that the outcomes of the learning process were by no means certain. The experimentation metaphor is further supported by other similar metaphors that practitioners used including the practice of being "able to flow with the patient" and "making connections." These metaphors – flowing, experimenting, connecting - appear to conceive of the self as a processes of open ended becoming, rather than as a normalized condition. Those interviewed often referred to the need to "be human", but the human condition was almost the only condition that they were willing to label either themselves or their clients.

CONCLUSIONS

The first part of this paper was devoted to the way in which each member of the voluntary forum made sense of their work in the voluntary sector. This sense-making

developed along two broad lines, the first line involved an extensive critique of the way things are done in the statutory sector and the traditional medical model on which it is based. All those interviewed observed that the traditional medical model was the dominant discourse operating in the statutory sector, an observation which is supported by much of the existing literature (for example see Goffman, 1961, Lupton, 2003, Scott, 2003; Hyde & Davies, 2004). If the first line of sense making was cast in somewhat negative terms, then the second line was cast in very positive terms, describing the voluntary sector as a space of experimentation and learning. Those interviewed make sense of their work in the voluntary sector with the claim that it is only within this space that alternative, more efficacious approaches to mental health care can be developed. It could be argued that the traditional medical model is simply inappropriate for the special case of sexual abuse, and it is certainly true that the area of sexual abuse has become a distinctive concern for mental health care. However, this argument that sexual abuse is a special case is not actually apparent in the discourse of those interviewed for this research, and the researchers are reluctant to violate the text as presented in the narratives of the various doctors, nurses and counsellors who were interviewed.

The Foucauldian project has demonstrated how professional groupings constitute themselves and exercise their power through the information and knowledge which they control (Fox, 1991, 721). Foucault's work detailed the discursive and non-discursive practices through which social reality is constructed, with particular emphasis on how the human sciences have become a constitutive element in the formation of power-relations in society since the classical period. Under expert medical discourse self-identity came to

be conceived in terms of a passive normalized individual (Foucault 1977, 1981). This present research has focused on the kinds of knowledge that are brought to bear by doctors and other practitioners in the treatment of patients who have been subjected to violence and abuse in their childhood, where the effectiveness of the traditional medical discourse has itself been brought into question by those involved. Where once the mechanisms of normalization and therapy provided techniques of self-regulation this paper has shown that the basic assumptions underlying the traditional psychiatric practice are now under question by the very practitioners who might once have depended on them for their professional expertise and their identity. If the psychological sciences were once regarded as intimately bound up with the government of the soul (Rose, 1989), their foundations are now questioned by the practitioners who once depended on them for certitude of practice and client management. Indeed, the forum of practitioners interviewed for this research, suspicious though different sub-groups may be of one another, all exhibit a humility in the face of the sufferer of childhood sexual abuse and largely reject traditional normalizing practices.

The practitioners and clients were involved together in a process to establish an active and creative relation to oneself, rather than reflecting a preordained medical discourse which presupposed a normalized, true self. This research explored these processes by examining how the self was talked about by those involved rather than how was theorized in traditional medical discourse. In this research the search for the self unites the practitioner and sufferer in a joint quest which largely precluded past certainties of medical discourse. Even for counsellors, it ceased to be counselling and became support:

It's a process of thinking, of continually reflecting on how things should be; of going to this much deeper place and becoming more connected with the experience.

In other words, the title of the paper, "I don't know what I'm doing, how about you?" finds the practitioner in a common search for self with the client, having abandoned the certainties of traditional psychiatric and psychoanalytic practice in search for what is possible, within a safe context, exploring uncertain processes of becoming to jointly construct their future.

References

Alvesson, M. & Willmott, H. (1992a) On the idea of emancipation in management and organization studies, *Academy of Management Review*, 17, 432-464.

Alvesson, M. (1994) Talking in organizations: managing identity and impressions of an advertising agency, *Organization Studies*, 15(4), 535-563.

Boje, D.M. (1995) Stories of the story telling organization: A postmodern analysis of Disney. *Academy of Management Journal*, 38, 997-1035.

Burrell, G. & Morgan, G. (1979) *Sociological Paradigms and Organisational Analysis: Elements of the Sociology of Corporate Life*. London, Heinemann.

Chia, R. (1995) From modern to postmodern organizational analysis, *Organization Studies*, 16(4), 579-605.

Chia, R. (1996) Metaphors and metaphorization in organizational analysis: thinking beyond the thinkable, in: D. Grant & C. Oswick (Ed) *Metaphors and Organization* London, Sage.

Chia, R. (2000) Discourse analysis as organizational analysis, *Organization*, 7(3), 513-518.

Czarniawska, B. (1997) *Narrating the Organization.* Chicago: University of Chicago Press.

Draucker, C. B. (1992) *Counselling Survivors of Childhood Sexual Abuse.* London, Sage.

Foucault, M. (1971) *Madness and Civilization.* London, Routledge.

Foucault, M. (1973) *The Birth of the Clinic.* London, Routledge.

Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison.* London, Penguin.

Foucault, M. (1981) *Will to Knowledge: The History of Sexuality Volume 1* London, Penguin.

Foucault, M. (2000) Psychiatric Power, in Ethics, in: M. Foucault (Ed) *Essential Works of Michel Foucault*, pp. 39-50. London, Penguin.

Foucault, M. (2001) The Birth of Social Medicine, in Power, in: *Essential Works of Michel Foucault 1954-1984*, pp. 134-156, London, Penguin.

Fox, N. (1991) Postmodernism, rationality and the evaluation of health care, *Sociological Review*, 39(4), 709-744.

Geertz, C. (1973) *The Interpretation of Cultures.* New York, Basic Books.

Goffman, E. (1959) *The Presentation of Self in Everyday Life.* Garden City, NY, Doubleday.

Goffman, E. (1961) *Asylums: Essays on the social situations of mental patients and other inmates*. Harmendsworth; England; New York: Penguin.

Halford, S. & Leonard, P. (2006) Place, space and time: Contextualizing workplace subjectivities. *Organization Studies*, 27(5), 657-676.

Hardy, C. Palmer, C. & Phillips, N. (2000) Discourse as a strategic resource. *Human Relations*, 53(9), 1227-1248.

Hodgson, D. (2005) Putting on a professional performance. *Organization Studies*, 12(1), 51-68.

Hyde, P. & H. Davies (2004) Service design, culture and performance: Collusion and co-production in health care. *Human Relations,* 57(11), 1407-1426.

Jaques, R. (1996) *Manufacturing the Employee: Management Knowledge from the 19th to the 21st Centuries*, London, Sage.

Knights, D. & Morgan, G. (1991) Corporate strategy, organizations and subjectivity: a critique, *Organization Studies*, 12(2), 251-273.

Kunda, G. (1992) *Engineering Culture: Control and Commitment in a High-Tech Corporation*, Philadelphia, Temple University Press

Louis, M. (1980a) Surprise and sense making: what newcomers experience in entering unfamiliar organizational settings, *Administrative Science Quarterly*, 25, 226 - 251.

Louis, M. (1980b) Career transitions: varieties and commonalities, *Academy of Management Review*, 5, 329-340.

Lupton, D. (2003) *Medicine as Culture: Illness, Disease and the Body in Western Societies.* London: Sage.

McKinlay, A. (2002) Dead Selves: The Birth of the Modern Career, *Organization*, 9,

595-614.

Nietzsche, F. (1980) *'On Truth and Lies in a Nonmoral Sense' in Philosophy and Truth: Selections from Nietzsche's Notebooks of the early 1870s*. Humanity Books, New York, pp 79-100.

Oswick, C., Keenoy, T. & Grant, D. (2000) Discourse, organizations and organizing: concepts, objects and subjects, *Human Relations*, 53(9), 1115-1123.

Potter, J. &. Wetherall, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London, Sage.

Potter, J. (1996) *Representing Reality: Discourse, Rhetoric and Social Construction.* London, Sage.

Richardson, J. (2000) What can a Body do? Sexual Harassment and Legal Procedure, in: J. Hassard, R. Holliday. &. H. Willmott. (Eds) *Body and Organization*, pp. 215-229 London, Sage.

Rose, N. (1990) *Governing the Soul: The Shaping of the Private Self.* London, Routledge.

Schein, E. (1985) *Organizational Culture & Leadership.* New York, Jossey Bass.

Schein, E. H. (1991) What is culture? in: P. J. Frost, L. F. Moore, M. R. Louis, C. C. Lundberg & J. Martin (Eds) *Reframing Organizational Culture* USA, Sage.

Scott, T. Mannion, R. Davies, H. & Marshall, M. (2003) *Healthcare Performance and organizational Culture.* Oxford: Radcliff Medical Press.

Starkey, K. & Hatchuel, A. (2002) The long detour: Foucault's history of desire and pleasure, *Organization*, 9(4), 641-656.

Townley, B. (1995) 'Know thyself': Self-awareness, self-formation and managing, *Organization*, 2(2), 271-289.

Townley, B. (2002) Managing with modernity, *Organization*, 9(4), 549-573.

Van Dijk, T.A. (1997b) *Discourse as Social Interaction: Discourse Studies: A Multi-Disciplinary Introduction. Volume 2.* Great Britain: Sage.

Wallemacq, A. (1998) Totem and Metaphor: The Concept of Network as a Symbolic Operator, *Organization*, 5, 593-612.

Watson, T. J. (1995) Rhetoric, discourse and argument in organizational sense making: a reflexive tale, *Organizational Studies*, 16(5), 805-821. H/C.

Weick, K. E. (1979) *The Sociology Psychology of Organizing* (Reading Mass).

Weick, K. (1995) *Sensemaking in Organizations* (Thousand Oaks, Sage).

Willmott, H. (1997) Management and organization as science? *Organization*, 34, (3), 309-344.