

RESEARCH INTO PRACTICE/PRACTICE INTO RESEARCH

In Search of Professional Identity: A Feminist Poststructural Quest

As part of a doctoral program, I am conducting research on what (in)forms 'professional identity'—our subjective experience of ourselves as practitioners. While it may be thought that the latter would arise from socialisation into our professional discipline, this is clearly only part of the story. For many practitioners, their professional practice does not neatly fit into a single discipline—couple and family therapy and its interdisciplinarity being a case in point. So does professional identity reflect expertise, collegiality, or some deeper sense of the self? What factors might influence its development, in particular, the changing circumstances of professional life? How does the learning provided both formally or informally by the workplace influence professional identity? Is professional identity something that can be 'told', as part of the ongoing narrative of our life history, or is it something that is rarely articulated, and not thought of as part of our own narrative?

My own experience as a practitioner bears witness to the forces which shape professional identity today. Government legislation is highly influential. As a consequence of the recent review of Family Law, 'marriage counsellors' became 'family and relationship counsellors', accompanying a clear shift to a concern with children in therapy. While this change has little meaning for some, for practitioners directly affected, it presents significant challenges to existing practice and skills. Assessing children, or writing reports on their behalf, seems increasingly to be looming as 'part of the job'. Yet until now, my work as a couple and family therapist has not required this of me, and most certainly, I was not employed on the basis of possessing such skills. So where does that leave me and my colleagues? While developing new skills seems an obvious way to go, how does one embrace such a prospect when it is driven more by external factors than by internal desire to change one's professional identity? Is it a matter of 'going with the flow', whatever the cost to existing expertise or sense of self, or rather of creating new possibilities by harnessing our 'agency'—the ability to act—and using this productively?

Local factors have also been significant to my sense of professional identity. In one counselling setting in which I worked, seeing clients more than once was not considered 'good' practice: my tendency to provide multiple sessions raised issues for my colleagues, and in turn, for myself. And finally, there is the importation of corporate management ideology into public sector organisations, such that clients are renamed 'customers' and therapists' professional lives are dominated by the completion of interview 'targets'. For me, this has meant a tension between the part of myself which has an allegiance to professional values, and the part of me

which aspires to the rationality and order of management. All of these influences point to a need to learn (or relearn) skills, as part of the 'reinvention' of the self required in the 'postmodern age'. Professional identity is influenced by an array of factors, in complex interaction and conflict, and reflects a changing, multidimensional self which adapts and survives.

But how does learning come into this process? What resources do practitioners use to retain a sense of efficacy in changing times? While formal learning processes—continuing professional education in the form of post-graduate courses and workshops—may be helpful, it is possible that more subtle processes are involved. Typical of informal workplace learning are: discussions with colleagues about workplace practices (which may be viewed as ways to strategise about change), learning which occurs from the ongoing practice of therapy, and team-work of one kind or another. My idea is to expand current thinking about what learning, both structured and unstructured, is useful for the ongoing professional development of practitioners.

What is feminist poststructuralism? In general terms, it is a combination of feminism, psychoanalytic theory and poststructuralism. Poststructuralists are interested in how and why we learn to become who we are, by reconceptualising the relationship between cognition and language, and between the individual and society. What distinguishes feminist poststructuralism is a focus on the ways in which the self is understood as male or female, and how these categories come to limit the way individuals see themselves, what they strive for, and how and what they learn (Weedon, 1987). There is a particular interest in how subjectivity is constructed through language and discourse, *discourse* being defined as a historically, socially and institutionally specific structure of statements, terms, categories and beliefs. (The impact of feminist poststructuralism on family therapy has been negligible, the work of Rachael Hare-Mustin being the most notable exception.)

My research accesses subjectivity through the concept of professional identity, assuming that the way in which practitioners describe themselves reflects various discursive practices which can be thought of as constructing the sense of self. For example, the ideology of 'quality', as advanced by the Total Quality movement, proposes certain ways in which professional relationships are described and experienced, reflecting a set of beliefs and practices sanctioned and enforced by employers and funding bodies in the current social and historical context. In real terms, what this means is that (for example) the therapeutic (emotional) relationship of practitioner and client is replaced by the (rational) one of service provider and consumer. By linking the notion of professional identity to the notion of learning—understood as a way of languaging the transformative processes of change—I want to describe the hidden

and often unconscious practices that professionals use to productively rework power relations, to subvert continual invitations and demands to redefine themselves.

The method for data collection I will use is based on the qualitative research interview. In order to develop my areas for questioning, I am conducting a pilot interview with (in this instance) a psychologist, while being observed by a reflecting team composed of researchers and practitioners of varied backgrounds. The function of the team is to comment on questions which are facilitative, as well as noting gaps, and silences, in order to generate themes for further exploration.

Examples of the types of questions I want to explore include:

- What things might you be doing when you feel strongly identified with being a [psychologist]?
- At what point in your work life did you become aware of 'having' an identity as a [psychologist]?
- In what ways do changes in funding policies affect your professional identity?
- What aspects of your professional identity do you think are staying the same, and which aspects would you regard as changing?
- How much of your learning as a practitioner is directed by yourself, and how much is 'forced upon you' by external factors?
- What learning experiences do you value the most in maintaining a positive and clear sense of your professional identity?
- In what ways does your learning involve developing ways to positively resist change—in other words, to transform unworkable or negative changes into more palatable changes?

So as part of my quest, I invite practitioners who would like the opportunity to consider the issues I have raised to contact me if they are interested in being interviewed. At this formative stage in my research, any reactions from the professional community would be most welcome.

References

- Hare-Mustin, Rachael (1994). Discourses in the Mirrored Room: A Post-modern Analysis of Therapy. *Family Process*, 19-35.
- Weedon, Christine (1987). *Feminist Practice and Poststructuralist Theory*. London, Oxford.

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In Search of The Counter-Intuitive

In my view one of the notable omissions in research is discussion of counter-intuitive research results. People rightly claim that many studies in the social and behavioural sciences are involved in 'motherhood' research. Such research examines something which, it is argued, any mother (and presumably any father, in these non gendered times) could tell you about. For example (drawing from social psychology, which is notorious for

this type of research) if an unknown male stands very close to another male who is urinating in a public place, will the male who is urinating move away? Or, from a study we carried out as undergraduates in Camberwell shopping centre, if two people, one neatly dressed and the other shabbily dressed, fall over in the street and feign illness, which will generally be helped more quickly?

Clearly studies that provide empirical support for what most people would intuitively guess to be true do have their uses. However, findings that do not make any logical sense at first have often proven very influential, and can help clarify a thorny problem. For example, for most of the 1970s, both research and clinical data in the marital and sexual therapy fields supported the belief that anxiety produced erectile problems in males, and for this reason, all sex should be devoid of anxiety. However, some clinicians and researchers observed that while certain individuals responded badly to anxiety provoking situations, others found some tension necessary for enjoyable sex, and moreover there appeared to be clear personality differences between these two groups. Were these simply anecdotal observations? In 1983, Barlow, Sakheim, and Beck found that males could indeed learn to increase their arousal in response to anxiety (produced by electric shock). They also reported data suggesting that males who have suffered from a sexual dysfunction are more negatively affected by anxiety than those who have not been symptomatic. These findings led to modifications in intervention in arousal problems, and branched out into research into arousal with forensic populations.

In my own research (Kennedy and Over, 1990) an unexpected and counter-intuitive result occurred which altered the nature of the study. I had carried out an investigation of the sexual functioning of spinal cord injured males, with the main focus being on measures of both subjective and physiological arousal. No similar studies had been carried out before with spinal cord injured males, and so I had little in the way of previous findings to draw on. I asked the males (both face to face and in questionnaires) whether they had experienced erections since their injury. The questions were detailed and unambiguous, and I ensured all the males understood what was being asked of them. All were educated, sexually experienced, had been in one or more relationships since their injuries, and were more liberal and open than usual—all features of those who volunteer for sexual research. All had consumed various forms of erotica since their injuries. About half of the males reported they had experienced erections in response to erotica since their injuries, and about half reported they had not been able to.

Unexpectedly, when tested physiologically over 90 minutes using three different forms of erotica, some of those who stated they had had erections in the past did not do so at all in the laboratory, and some of those who had stated they could not produce erections in the past could do so in the lab! The result indicated that some males' knowledge of their own sexual response

was relatively inaccurate. Intuitively, I had anticipated that these males in particular, who were an atypical group in their level of knowledge and interest, would have investigated their own response very carefully, and this result ran contrary to our predictions. As this was initially a minor question in the study, I was prepared to downplay the finding as one of those aberrant and unexplainable results in research, until Professor Ray Over suggested that in fact it was the most interesting finding in the data. It seems likely that due to the lack of feedback emanating from lack of sensation and other factors, such as embarrassment, many spinal cord injured males may well have inaccurate knowledge of their sexual responses post injury. The clinical implication of the finding is, of course, that spinal cord injured males should be formally assessed at various stages to ensure that they are aware of the possibility of their being sexually responsive post injury. As in general programs in the area of sexual arousal, the awareness of response is the first stage of dealing effectively with arousal problems which now happens in many spinal and rehabilitation units.

This example illustrates that fact that often in research, the most important findings are initially peripheral to the central research questions, or are stumbled on accidentally. If the research is designed to consider the possibility that the non-intuitive findings may prove the most valuable, some discovery is more likely to occur, and the researcher is more likely to consider apparent randomness as part of the pattern. The principle of recognition of the contradictory is central to both clinical and research endeavours, and the ability to embrace and understand such contradictions is one of the hallmarks of sound practice in both areas.

References

- Barlow, D. H., Sakheim, D. K., Beck, G. J., 1983. Anxiety Increases Sexual Arousal. *Journal of Abnormal Psychology*, 92, 1: 49-54.
- Kennedy, S., and Over, R., 1990. Psychophysiological Assessment of Male Sexual Arousal Following Spinal Cord Injury. *Archives of Sexual Behavior*, 19, 1: 15-27.

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