An Exploration of Social Workers' Professional Identities within Health Settings in Queensland

By

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Abstract

Social workers make up a significant number of the professionals and are key members of multidisciplinary teams employed within the health sector in Queensland. Shifting government priorities such as increased governance, managerialism, privatisation and marketisation of the health sector in Queensland are consistently shaping health service delivery. These are subsequently reflected in the delivery of social work services in this context. This has prompted an exploration of how social workers develop and maintain their professional identity when working amidst the presence of medical dominance and evolving neoliberal ideology that underpin the operation of health services within Queensland.

In adopting a paradigm of exploratory qualitative research, this thesis explores the everyday lived experience of nine social workers within health settings in Queensland. Drawing on an epistemological position of social constructivism, this thesis interprets how the lived experience contributes to the social construction of social work professional identity within the health sector in Queensland. Semi-structured in-depth interviews were undertaken with nine social workers employed within health settings across Queensland and were analysed with the use of grounded theory analytical framework.

It was found that the participants attributed their social work values, alongside corresponding skills, knowledge and theory, as the foundation of their envisioned professional identities as social workers in the health context. This identified that the participants relied on a congruence between both the personal and professional sense of self in constructing their social work identities. Further, it was discovered that the participants' everyday experience of actuating their envisioned professional social work identity is stymied by the socio-political influence and heavily medicalised ideology prevalent within the health system in Queensland. This experience contributed to a significant number of the participants contending that their professional identity is not valued by the health system and that they experience a dissonance in applying their unique social work identities to the health system's expectations of the social work role.

A substantive theory was developed. The theory posits that the concept of 'passion', is paramount in developing and sustaining the unique social work identities of the participants in this study. Underpinning this theory were findings that explain the process in which

passion for social work is denigrated for the participants within the health context. Due to their identities assuming a dichotomous influence of ideologies, it was interpreted that this ensues a fragmentation of the potential for an articulate and robust unique professional identity for health-employed social workers. This challenge was found to predispose to experiences of job dissatisfaction and burn-out and to encompass an overall loss of passion for the development and maintenance of the participants' unique social work identity within the health context in Queensland.

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Declaration of Authorship and Originality

I, the undersigned author, declare that all of the research and discussion presented in this thesis is original work performed by the author. No content of this thesis has been submitted or considered, either in whole or in part, at any tertiary institute or university for a degree or any other category of award. I also declare that any material presented in this thesis performed by another person or institute has been referenced and listed in the reference section.

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Dedication

This thesis is dedicated to Judy Fisher.

Judy sadly passed away in November, 2016.

Judy was one of the most courageous and inspirational social workers I have had the privilege of knowing.

Judy, my desire to understand social work identity started with you.

Thank you Judy.

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Chapter One
Introduction

Social work, as a profession, has long strived for clarity regarding its professional identity (Weiss-Gal & Welbourne 2008). This has seen attempts to define the unique social work role within varied organisational contexts by adoption of professional registration and prescription of benchmarked values, ethics, skills and knowledge (Clarke 2005). The Australian social work professional regulatory body, the Australian Association of Social Workers (AASW), exemplifies this shift from unsanctioned education and poor practice guidelines to benchmarked education and regulation, better developing and defining the social work identity within the Australian health system (AASW 2011a).

Despite this being a perceived advancement in establishing the profession within the health context, the endeavour for professionalisation has undergone critique by critically reflective social work researchers and academics alike for the circumstances that underpin *why* and *how* it was professionalised (Beddoe 2014). This is characterised by arguments that the social work profession achieved professional status in adherence and compliance to oppressive ideologies (Howe 2009). In the context of health, it is claimed that the professions' unique power-with and humanistic foundations are being discarded by organisations adopting neoliberal ideology (Gilbert & Powell 2010). Health settings are increasingly adopting the rationalist principles of neoliberalism, in turn, imposing frameworks for practice that are consistent with bureaucracy, power-over and top down service provision (Jamrozik 2009). It has been identified that social workers can experience conflict and a sense of uncertainty when trying to incorporate this to their own practice framework and identity due to the professions' historical opposition to neoliberal ideology (Hibbs 2005).

This prompted the exploratory focus of this social inquiry. After my own personal experiences of professional social work identity development and consultation with the relevant literature, I reflected the need to better understand what comprised the social work identity in health within Queensland. Due to the ideological challenges the social work profession appears to face within the health context, I further reflected the need to consider the role of social construction in establishing professional identity.

This chapter will provide my personal account for developing interest in this research, as well as a tangible though non-constraining definition of 'social work' and an overview of the contents of this thesis.

Impetus for research

My significant interest in the exploration of the influences on social work professional identity was initially sparked during my social work field education placement within a mental health organisation for young people. There, I experienced the development and emergence of my own unique social work professional identity in the face of complex socio-political adversity that emphasised quantity as the quality. This often influenced a fast pace in provision of social work intervention to inform quick discharge of patients and clients from the organisation. This was despite occasions where the obvious need for ongoing social work intervention was substantiated. This presented a stark contrast to my own social work grassroots perspectives of humanistic principles such as respect for persons and their inherent dignity and worth. I believed that the people accessing these services deserved more of our time, care and attention. Despite the view that issues people presented with were a reflection of them as individuals and the 'life choices' they made, I saw that structural oppression resultant of systemic abuses played a significant role in the disadvantages they faced. I would often advocate for my critical position—that these 'life choices' were dependant on concepts such as privilege and the power relations that have constructed the narratives of oppression for the vast majority of people who accessed these services. Whilst I respected the position and necessity of biological and psychological understandings in the mental health context, I felt my critical social perspective was often not well received by other professionals, and more often than not, was rendered censored discourse.

These experiences prompted deep reflection and the writing of my first reflective article, which was published within the *Queensland Social Work Summer Edition* (see Appendix A) in which I considered my experiences and critically explored the concept of my social work identity and how it was received by both myself and the health system. Around this time, I began employment in another youth mental health setting. During this employment, I often felt as though my social work identity was being heavily influenced by the medical

context, which seemed the dominant model of practice. I found that the unique systems lens and anti-oppressive strengths-based perspectives I would adopt in my practice were usually deemed 'inappropriate' despite new mounting evidence supporting this approach as integral in adhering to policy informed psychosocial health service delivery. Feeling out of place within the organisation, I began adopting the dominant models of practice so as not to feel ostracised and my input depreciated. At the time of this employment, I had become jaded and unknowingly made a transition to adhering to principles that were at odds with my professional identity. In a consistently reactive service, my ability to reflect on my development as a professional was not prioritised. It was only when finally attending supervision with my social work supervisor that I recognised this insidious process had unfolded. I further reflected on this experience during the writing of my next published article (see Appendix B). I soon came to realise that the same difficulties I experienced in maintaining and developing a social work professional identity were being experienced by fellow social work professionals employed in the same context. These experiences ignited a desire and passion to interpret the unique challenges faced by social workers attempting to maintain and develop their professional identity whilst employed in the health sector. As well as completing this research higher degree, I continued to work in the context of health, employed as a mental health social worker in a private practitioner role. Whilst this role encouraged a sense of self-direction and autonomy in the development of my social work identity, the overarching system of health was still reflected as a source of influence on who I was and what I did as a social worker.

Defining Social Work

This section will provide a definition of 'social work' within the Australian context. It is acknowledged that varying meanings and applications of this definition may be available, and that this is by no means an exhaustive explanation. As this research utilises the tenets of grounded theory to generate ideas on social work identity, it was important not to constrain the emergent process by applying constrictive definitions. Therefore it is acknowledged that the role of this definition of social work is for the purpose of preliminary thinking entering the field. It is by no way intended to constrain the grounded theory process that was undertaken in data generation and analysis explored later in this thesis. It is acknowledged that throughout this thesis, various other terminology arise that have not

been defined within this section. This is due to these terminologies requiring definition in the context of their respective discussions throughout the thesis.

The social work profession has often been difficult to articulate due to its diverse practice application and resultant varied contextual understandings. In terms of providing a basis for understanding the foundational tenets of social work, the AASW (2017) draws on International Federation of Social Workers (IFSW) to define 'social work' as being a profession that aims to achieve social change, empowerment and liberation of oppressed and marginalised populations. The AASW (2017a) goes on to explain that, internationally, the profession is united by values of social justice and the primary goal of facilitating social change within society (AASW 2017a). The AASW (2017a, np) states that the role of a social worker draws on theories of '… social work, social sciences, humanities and indigenous knowledge' aimed at engaging '… people and structures to address life challenges and enhance wellbeing'.

The social work profession in the human services is defined as promoting quality of life through interventions aimed at improving individual, group and community access to resources and services by providing social support and personal care services (Healy & Lonne 2010, p. 7). As this thesis explores the social work experience of being employed by health services in Queensland, the need for clarity on the concept of 'health systems' and what constitutes this in Australia is noted. Definition and explanation of health systems in Australia and Queensland can be located within Chapter Two 'Background of Health Social Work' of this thesis. Brough, Wagner and Farrell (2013, p. 2) define social work in the health system as providers of psychosocial supports to clients within the health system as they navigate their journeys of illness or injury. It is explained that this involves social workers providing counselling and therapeutic intervention in their own right as a strategy of early intervention and prevention (Brough, Wagner & Farrell 2013). It is asserted by Brough, Wagner and Farrell (2013, p. 7) that social work will work in direct practice with the '… marginalised social, cultural, economic and political contexts from which many health inequalities emerge; and they advocate for the rights of vulnerable health consumers'.

Currently within Australia, to become a social worker an individual must complete a four year (or part-time equivalent) Bachelor of Social Work program or, alternatively, complete a

two year (or part-time equivalent) Master of Social Work-Qualifying program at a University accredited by the AASW. During their education, social work students will learn key skills and theories relating (and not limited to) sociology, law, psychology and social work and apply these to practice over two supervised field education placements which span for approximately 1000 hours combined over the final two years of the program (AASW 2017b).

Overview of thesis

Before providing the overview of this thesis, it is important to signify that this research adopted a grounded theory design which cautions undertaking a traditional review of the literature (Charmaz 2014). Constructivist grounded theory adopts the principle of 'researcher-driven' study that encourages the reflexive stance of the researcher (Hood 2007). This understands the unique place of a researcher in bringing preconceived ideas to the study that are sourced from prior consultation with the relevant literature and the influence of their own personal and professional experiences with beliefs and attitudes that relate to the focus of inquiry (Charmaz 2017).

Constructivist grounded theory calls for an ongoing consultation of literature throughout the research process. This is anticipated to value-add to the exploration of the focus of inquiry, as opposed to take direction of it. It is argued that consulting the relevant literature with this focus achieves an adherence to the constructivist grounded theory strategies of theoretical sensitivity and theoretical sampling (Hernandez & Andrews 2012). This ensures the resulting theory is grounded from the data and not entirely a result of pre-emptive preliminary reviews of literature (Holton 2007). These strategies will be explained in further depth within Chapter Three, 'Designing Research to Explore Lived Experience'.

Within this thesis, there are separate bodies of literature that were consulted before and during data analysis. Literature that was consulted in developing the ideas upon entering this research can be located in Chapter Two, 'The Background of Health Social Work'. Literature that was consulted during the analysis of data can be located in Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Six, 'Social Work Values and the Ideologies of Health'.

This first chapter has introduced the research by explaining the development of the research focus. This was provided by exploring some of the key literature and shared how this research topic resonated with my experiences before undertaking this research. This chapter has also provided the definition of social work that has guided the preliminary phase of this research.

Chapter Two, 'The Background of Health Social Work', draws on relevant literature to examine the historical roots of social work in Australia and explore how these relate to the contemporary identity of social workers today. This chapter will also provide a discussion on situating the social work identity within the health context in an overview of the health system within Queensland. Preliminary understandings of terms on social work identity, social work practice frameworks and social work roles in health have been put forth in this chapter.

Chapter Three, 'Designing Research to Explore Lived Experience', identifies the research paradigm and methods that were utilised in undertaking this research. The commencing sections of this chapter will provide an overview of the ontological and epistemological stances that guided this research. This is explained as a constructivist-interpretative paradigm which will entail discussion on the analytical framework it adapts in exploring the social construction of lived experience. The analytical framework will provide the reader with a basis for understanding the interpretation process of the findings within this research. This proceeding section will entail discussion on the use of constructivist grounded theory methods. The various methods pertaining to constructivist grounded theory that led the research process will be identified with explanation provided on how they were applied to this research.

Chapter Four, 'Social Work Research', provides an overview of the pertinent social work knowledge that was consulted in pursuing this study as social work research. The chapter will highlight prominent social work thinkers in three different sections that provide an overarching paradigm for exploring social work professional identity. In achieving this, the chapter first provides a framework for interpreting social work knowledge, theories and skills for practice. With this understanding established, the chapter goes on to explain the

various ideological positions the social work professional identity is reflected by, and how this is then adapted to social work practice.

Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', is the first of the two substantive chapters and will provide discussion on the participants' reported everyday experiences in undertaking their social work role in the health systems they are employed. This chapter provides an ontological focus in presenting the participants' ideas on what constitutes their everyday reality of being a social worker. The discussion provides the participants' view of relationships knowledge and its significance in social work practice in health. This discussion leads to the participants' identification of systems theory and how it is a key feature of their everyday work. This chapter closes with an exploration of participants' experiences in applying this knowledge and theory to their work, with a focus on identifying the challenges they face doing so in the health system.

Chapter Six, 'Social Work Values and the Ideologies of Health', is the second of the two substantive chapters and will discuss the influence of health and socio-political ideology on participants' professional social work identity. This will undertake exploration and interpretation of the participants' reported lived experience of the development and maintenance of the social work values embedded within their identities. This chapter will provide an overview of how relationships knowledge and systems understandings are underpinned by the participants' reported social work values. In establishing this link, the closing sections of this chapter will discuss the challenges faced by the participants in enacting their reported social work values amidst the constraints of the dominant socio-political ideologies comprising the health system.

Chapter Seven, 'Concluding and Reflecting on the Research', is the final chapter and will provide a section to summarise the thesis as well as provide discussion of the overall theoretical development that emerged from the findings. This chapter will go on to provide reflection discussion and evaluation on the use of grounded theory in this study. Lastly, this chapter will discuss the strengths and limitations of this study, the implications this research has for the social work profession, and the prospect of future research informed by this study.

Chapter Two
Background of Health Social Work

Introduction

The aim of this chapter is to situate the study within the context of social work in the health system within Australia and Queensland. This chapter will provide a thematic snapshot of the relevant literature that was drawn on in developing preliminary ideas and focus entering the study. The chapter will commence with an exploration of the emergence of Australian social work and provide discussions in the later sections on how social work is situated within the context of health in Australia and Queensland.

The emergence of Social Work in Australia

Drawing on his thesis, Gleeson (2007) puts forth an argument providing new perspectives on social work history in Australia. Gleeson (2007) draws his understanding of this history from the first and, to date, only, national history research of Australian social work, by author John Lawrence, which was published in 1965. Lawrence's account focussed on the emergence of medical social work, social work education and employment, and the development of the AASW as the professional association (Gleeson 2007). In Gleeson's (2007) account, the concept of Australian social work is said to have emerged around 1880, out of a combination of the influence of the Melbourne Charity Organisation Society (COS), the medical profession, and reliance on the British model of almoning, boasting a strong Christian foundation (Gleeson 2007). In the beginning, white, Christian, middle-class women were trained as 'lady almoners' by the Royal Melbourne Hospital's 'Almoner Department' in 1929, headed by experienced English almoner and first Directress of the Victorian Institute of Hospital Almoners Department, Agnes McIntyre (Gleeson 2007, p. 207). During the Social Work Colloquium 70th Anniversary speech, Scott (2011) referred to social work in Australia historically being regarded as a vocation, comprised of American influenced relevant field education training and a diploma in social service, which incorporated the study of psychology, political institutions, economics, problems of society, social organisation, social history, mental hygiene, child study, and nutrition (Scott 2011). Scott (2011) explains that whilst the social work curriculum has changed significantly in Australia, the emphasis on person-in-environment remains the same. With this training, almoners in Australia were

primarily tasked with investigating the economic circumstances of patients so as to discern the 'deserving' and 'undeserving' of health services. Gleeson (2007, p. 207 cited in O'Brien & Turner 1979b, p. 1) claims that Victorian medical social work became the 'elite field of [Australian] social work practice' and saw the later emergence of lady almoners in other Australian states as well as preceding the progression of social work type roles in to other areas of social welfare in government and non-government appointments (McMahon 2003).

Wilson (2005, p. 188) elaborates that the training courses offered by the three social work institutes in Melbourne, Sydney and Adelaide were later transferred to the universities within those cities during World War II. In the context of Queensland, these were then offered as two, three and four-year programs, with the first students beginning at the University of Queensland in 1956 (Wilson 2005). It has been observed that the Australian curriculum consisted of psychology, sociology, government, health and economics and maintained the social welfare focus of American and British influence (Camilleri 2005; Rosenman 2013; Wilson 2005). This influence constituted the welfare focus and by 1976, there were 11 social work schools in place. Enrolment increased with a combination of the introduction of free tertiary education by the Federal Labor Whitlam government (1972–75). Consequently, the growth and demand for social service workers kept pace with the government's planned social developments at the time (Wilson 2005; Mendes 2005).

With the advancement of social work education, Australian social work also saw the emergence of its first professional association, the AASW. The AASW formed at a national level by 1946 with the aim of setting the benchmark for professional education and practice in social work, as well as the task of promoting and regulating it as a profession. Around the same time, the profession experienced a global shift in philosophical paradigm, influencing the professions' values, attitudes and beliefs, and promoting a release of the profession from its founding modernist mindset in Australia. The latter could be best described as the state's implementation of social work as an endeavour to overcome social problems through use of prescribed and traditional scientific frameworks (Payne 2005; Howe 1994; Dominelli 2007).

Whilst fragmented, during the 1970s this shift prompted the profession to deliberate upon, and eventually proceed with, professionalisation (Beddoe 2014). Internationally,

professionalisation of social work is said to have influenced the construction of professional frameworks for practice, and defined the social work role within varied organisational contexts by the adoption of professional registration and implementation of benchmarked values, ethics, skills and knowledge (Beddoe 2014; Clarke 2005). This process could be interpreted as sharing parallels to Kuhn's (1962) concept of reaching professional maturation through adoption of a standardised paradigm for practice held exclusively by a profession (Júlíusdóttir 2006). Debates surrounding both positives and negatives of such an advancement have been critically explored in national and international contexts (Dominelli 2007; Gilbert & Powell 2010; Howe 2010; Ife 2012; Beddoe 2014). These debates have provided a variance of views as to whether this advancement indeed professionalised social work for the cause of social justice, or rather enabled the profession to inadvertently, and perhaps unknowingly, become complicit with oppressive social and economic ideologies, as it could be considered was the case in its emergent identity within Australia.

The theme of power and its effects on the social work role have been explored in an analytical journal article *Power and Social Work in the United Kingdom: A Foucauldian Excursion* by Gilbert and Powell (2010). This article is a review of the relevant literature on power relationships in social work practice within the United Kingdom (UK). The analysis in this article was undertaken with use of a 'critical toolkit' aimed at critical inquiry, derived from the work of French philosopher, Michel Foucault. Their article provides an exploration of power effects in relation to enforcing what Gilbert and Powell (2010, p. 9) term 'disciplinary mechanisms' for professional expertise on to the social work role. They explore how disciplinary mechanisms are implemented to ensure the profession of social work adopts neo-liberal principles and frameworks for practice, even though this approach opposes core social work values and principles. This article effectively analyses the existing knowledge on the theme of power and how it both effects the construction of the social work profession and contributes to its' identity being devalued. It explores these themes from a top down perspective. In doing this, it did not capture the lived experience of social workers and convey a bottom up interpretation of power effects in this context. Conceptualising the pertinent level of analysis Gilbert and Powell (2010) provide, it could be considered they address what Bronfenbrenner (1994, p. 40–41) denotes as the *macrosystem* (the overarching fabric of societal cultures, sub-cultures and belief systems)

influence on social work identity. Which in turn, has not provided the *microsystem* (Bronfenbrenner 1994, p. 39–40) viewpoint (an individual's social role, pattern of activities and interpersonal relations) of social workers, explaining their lived experience of professional identity development endeavours. Nevertheless, Gilbert and Powell's (2010) interpretation of power's role in influencing social work identity proves beneficial in understanding system influence at a macro level, and has directed this research to explore the concept of socio-political influences on social workers constructing their professional identity in health settings within Queensland.

Contemporary social work identity

The social work profession is grounded in the acquisition of social work values, knowledge and skills (Bisman 2004; AASW 2010). To a degree, social workers in training are socialised into this triad through the process of forming their professional identity during the course of their undergraduate education and training. The AASW regulates relevant accreditation processes of tertiary education, ensuring social work students undertake education in conjunction with work-integrated learning practices, such as field education placements, in order to meet the standards set by the Australian Social Work Education and Accreditation Standards (ASWEAS) (AASW 2017b; Brough et al., 2014).

Anecdotally, the concepts of professional identity and practice frameworks in social work are often discussed interchangeably. I contend, however, that these are not two of the same concepts, but rather that professional identity encompasses the framework for practice:

> A lot of the time, these influences focus on 'what' social workers are, rather than 'who', which I feel tries to separate the skills/knowledge base away from the value system that informs our professional identity. In social work, we rely heavily on congruence of all these to construct our professional identity. (McNamara, 2015a)

Healy (2005, p. 216) argues that the social work framework for practice is a combination of learnt skills and acquired knowledge for practice within a specific context. Bowman (2013, p. 19) explains professional identity is more focussed on who a professional is, as opposed to what they do. In an application of this to social work, it could be considered that whilst it incorporates a framework for practice, the development of identity should focus on social workers' reflexive interrelationship with their micro and macro social environments (Harms

& Conolly 2009; Miehls & Moffat 2000). This establishes an understanding of a professions' principal and how it is emblematic of the myriad of exchanges it has within different fields of society (Beddoe 2010).

From her study on the construction of social work student identities within various organisational contexts in Western Australia, Wiles (2013, p. 854) suggests that social work professional identity as a concept is an ambiguous term, because it can either define a social worker's individual sense of self (values, beliefs and attitudes about being), or rather be used in a collective sense to convey the identity of the profession as a whole (framework of profession, disciplinary skills and knowledge). In the preliminary conceptualisation of this research, Wile's (2013) interpretation has been utilised to understand that in constructing professional social work identity, social workers draw on both of these interpretations to merge their personal (values, beliefs and attitudes) and social work professional sense of self (skills and knowledge). This is embedded within the collective identity of the profession. The collective component could be perceived as a constructivist aspect, as it signifies the identities' internalisation and exchange with external economic, social and political influencing factors. It is imperative to note that both these levels of identity interpretation comprise constant and inevitable change due to the competing ideologies contributing to their development and transformation (McElhinnery 2008). And further, that this can cause identity to be conflicted and fragmented at times, leading to a sense of identity disorientation and overall potential for uncertainty. One such ideology is medical, which is influenced by the dominant values of health systems which make up the service delivery within the health sector in Australia (Freidson 1988; Willis 1989). It is suggested that this is one of the key influences that contribute to the construction of social work professional identity within health settings (Coppock & Dunne 2010).

These contemporary challenges faced by social workers developing their unique identity in context presents the idea of context specific ideologies and how these influence the construction of professional social work identity. The difficulties of maintaining Australian social work identity have been explored by Lloyd, King and McKenna (2004) who conducted a quantitative study on social work and occupational therapists' undertaking of generic and discipline-specific roles within Australian mental health settings. In this study, 304 occupational therapists and social workers completed a cross-sectional survey, which

examined the extent to which social workers and occupational therapists undertook generic versus discipline-specific tasks. It was found that social workers performed more generic activities as opposed to the occupational therapists, who performed more discipline-specific activities. This provides a clear indication that social workers of this study adopted the generic role as opposed to incorporating the unique social work knowledge, skill and value set in to their practice. This study highlights the significant discrepancy between social workers and occupational therapists, and their capacity to incorporate discipline-specific roles to their practice within the mental health contexts. This is however a quantitative study and seldom provides an overview of this disparity as an experienced phenomena. Lastly, it is does not examine how socialisation of this discipline contributed to this disparity, as this was not a primary focus of the research aim. This has contributed to the aim of this research in exploring lived experience.

The social work role within health settings in Queensland

There is an estimated 23,166 social workers in Australia (AASW 2016). Australian health care has been established for more than 100 years and is the largest employer of social workers (Healy & Lonne 2010; Heycox et al 1999). Social work the third largest profession employed in the allied health workforce in Australia (Brough, Wagner & Farrell 2013). The health sector in Queensland is considered one of the largest employers of social workers in Australia (AASW 2011b).

The AASW (2014a, p. 5) state that health services within Queensland comprise of '… primary health settings through to acute and rehabilitation/sub-acute hospitals and their related services: outpatient, community and/or home-based'. The AASW (2014a) defines the social work role in these health settings as:

> … a key allied health professional member of the multidisciplinary team responsible for working with and supporting individuals and our community in achieving positive health outcomes. Social work's focus on complexity and the 'social' aspects of life provide a unique and vital contribution to holistic and comprehensive health care provision. (AASW 2014a, p. 22)

Understanding how social work is situated within the delivery of health services in Queensland, knowledge of the function of the overarching Australian health care system is required. The provision of health services within Queensland are underpinned by 'Medicare' —which is a part of Australia's universal health scheme. This is a Commonwealth

government program that guarantees all citizens and some overseas visitors access to Australian health services at some or no cost (Germov 2013). Medicare is also responsible for the provision of subsidised private services, or a private health service provider receiving funds from Medicare to either partially or fully bulk-bill a service user. Medicare receives its funding through general revenue and the taxable income of working Australians which funds the Medicare levy (Jamrozik 2009; Harris 2012). The information gleaned from this understanding of the Australian health system, and how this influences the delivery of health services in Queensland, are important in considering socio-political factors that impinge social work health service delivery in this context.

As I interviewed social workers in mental health settings, the unique role of mental health social workers was discussed. Social workers in Queensland are able to be employed or self-employed in private practitioner roles providing generalist or mental health counselling (Martin 2013). For social workers providing mental health counselling, they are able to be registered with Medicare and provide Medicare-subsidised private services (AASW 2015a). In order to be eligible to be Medicare registered, these social workers must be members of the AASW and must be an AASW Accredited Mental Health Social Worker (AMHSW). They are required to provide their mental health services in accordance with Medicare's Better Access scheme and its accorded Focussed Psychological Strategies (Martin 2013). AMHSW accreditation involves a social worker providing and demonstrating evidence to the AASW of extensive continuing professional development activities and at least two years post-qualifying, supervised social work practice experience in mental health or a related field (AASW 2015b).

Social workers within health settings in Queensland are required to practice within the AASW's scope and guidelines as set out by the AASW Code of Ethics (2010), AASW Practice Standards (2013) and the AASW Practice Standards for Mental Health Social Workers (2014b). Overall, these ethics and practice standards suggest that social workers in Australian health settings are to work from a psychosocial framework with overall holistic features that effectively respond to, and inform, system change, in addressing social justice issues by advocating emancipatory social systems and structures (AASW 2011a). This is despite the requirement of private practitioners to adhere to the narrow scope of Medicare's focussed psychological strategies to access Medicare rebate services (Martin

2013). It could be argued that the ability to engage in the professions overarching aim of informing social change is hampered by this constrictive and narrowly prescribed treatment emphasis.

In further considering the social work identity in the mental health context, a dated but relevant article by Peck and Norman (1999) explores these issues as faced by social workers working in a mental health setting within the United Kingdom (UK), including the concept of inter-professional conflict in adult mental health services. They achieved this by using a narrative approach to discipline specific group meetings with 61 participants of various direct care staff: psychiatrists, psychologists, nurses, social workers, occupational therapists, housing workers and community workers. The research focussed on analysing the profession's perceptions of their own and other discipline's roles. In this, they explain the challenges faced by social workers, and how this is due to the context being dominated by a medicalised ideology. Further, Peck and Norman (1999, p.7) allude to the notion of social work devaluation, explaining that social workers reported feeling they were outnumbered by their psychology and medical colleagues who, by tradition, are more aligned with the dominant ideology. Conversely, these colleagues expressed their criticism of social work's lack of a scientific knowledge base and poor ability to articulate their unique skill and knowledge set. Whilst only focussing on the influence of inter-professional conflict, this research provided a unique narrative of how mental health settings influence social workers' perceptions of themselves.

Peck and Norman (1999) concluded that medical ideology was at the forefront of the UK social workers' difficulties establishing and maintaining their identities. Similarly, the impact of medical ideology on social workers in mental health settings in Hong Kong was explored by Yip (2004). In a mixed methods approach, Yip (2004) set out to answer questions regarding the concept of medical dominance and whether social workers employed in Hong Kong mental health settings perceived this concept in their practice. This was focussed on interpreting whether this concept presented implications for the delivery of social work services within the context of mental health (Yip 2004, p. 415).

Using cluster sampling, Yip (2004) identified thirteen geographical districts in Hong Kong, selecting three of these with which to conduct in-depth interviews for the final sample

frame. The in-depth interviews focussed on factual and opinion questions and later explored the participants' feelings. Using statistical analysis, Yip (2004) analysed the factual answers to provide descriptive statistics and utilised qualitative methods such as categorising and mapping to analyse the opinion and feeling questions. Yip (2004, p. 419) discusses in the findings that around 80 per cent of participants admitted to feeling dominated by psychiatrists and, further, that many of the participants described feeling as though the psychiatrists in their service were autocratic, dominant and impatient with listening to 'social work language'. From his findings and in consultation with Eliot Freidson's works on medical dominance, Yip (2004) explains that the process of medicalisation of social workers in the mental health settings he explored, demonstrated a process by which social workers undergo both social work rationalisation and medical rationalisation. Yip (2004, p. 422) explains that for the social workers in his study, this appeared to be '…an internal process of justifying the values and contribution of social work knowledge, which involved an intellectual and a psychological struggle'. He further suggests that the intellectual process was the social workers feeling the need to explain or justify social work knowledge, whereas the psychological process was the struggle for social workers to represent this as their professional identity. Yip (2004, p. 422) argues that in the case of medical rationalisation, this was the process by which medical professionals justified their own values and medical knowledge. Yip describes (2004, p. 423) that in the process of medicalisation, '… social work rationalisation was gradually absorbed by the input of medical rationalisation'.

Yip's work is relevant in relation to the research that has been undertaken within this thesis. However, in attempting to connect Yip's (2004) study to Australian health settings, there is an obvious disparity between the Hong Kong health system and the Australian health system, as found in a Bloomberg study (Du & Lu 2016) on the most effective health care systems in the world. That is, that Hong Kong ranked as number one, and Australia ranked as number ten, only sharing some key similarities with their government funded health schemes. Further, this study explored the specific field of mental health social work, and does not provide an encompassing exploration of social work medicalisation across the broader health context.

The consultation of the key literature within this section has directed this research in exploring the role of medical ideology and socio-political ideology in influencing and shaping the social work professional identities in the context of health in Queensland.

The third section of this chapter also draws on key literature published by the AASW (2011a). This literature provides the AASW's (2011a) position on the scope of the social work role in the health sector within Queensland. This position paper included the analysis of 25 case studies of social workers' employed within the health sector in Queensland, and their undertaking of their health social work role. This paper provides findings that indicate the unique role of social work in health settings within Queensland. The AASW (2011b) present a compelling argument for the ongoing position of social work in the health sector within Queensland. In this, they overview the social work values, knowledge, theory and skills that are demonstrated by the health social workers within the 25 case studies and how these support the focus of health policy in Queensland. The AASW (2011a) support the idea that the social workers of their study presented as experts of the psychosocial issues that are manifested in health. They explain that social work employs this psychosocial focus with interventions aimed at preventing and/or minimising the psychosocial issues relating to illness and disability (AASW 2011a, p. 14).

Similarly, social workers in New Zealand are discerned by claiming expertise in the 'psychosocial' aspects of health and illness (Beddoe 2013). Using qualitative methods, Beddoe (2013) examined the problematic nature of professional identity for health social workers in New Zealand and identified the links it has to continuing professional education and queries of professional status. The study utilised a content analysis method and conducted semi-structured individual and group interviews of forty social workers within New Zealand health settings during 2010. Beddoe (2013) correlates the findings of the study to the relevant literature, to argue that social workers experience problematic professional identities within New Zealand health settings due to poor professional status, which the participants attributed to their belief that social work knowledge is 'weak'. Beddoe's (2013) article provides an analytical account of New Zealand health social workers' perceptions of themselves and, using a relational lens, uncovers key issues within the profession's foundation as contributors to this. This has established an aim of identifying the process of social construction in social work identity development in an Australian health context.

Summary

In summary, this chapter provides an understanding of the social work profession in Australia and how it is situated within the health context in Queensland. The discussion in this chapter has drawn on the relevant literature and provided insights on the challenges faced by Australian social workers and abroad, in their professional identity development endeavours. This chapter demonstrates how the focus of inquiry for this research has been established in its preliminary phases. The importance of situating this research within the context of social work knowledge paradigms has been established in this consultation of the relevant literature. Therefore, the next chapter will discuss the social work knowledge that was drawn on in directing the need for a value-congruent research design.

Chapter Three
Designing Research to Explore Lived Experience

Introduction

The research design of grounded theory studies comprises three key components: philosophy, methodology and methods (Birks and Mills 2010, p. 4). This chapter will provide a discussion on how and why a qualitative approach, informed by inductive, constructivist grounded theory interpretive methods are applied to the focus of inquiry in this study. This approach informed the overall design, which encompassed an interpretive-constructivist philosophical paradigm. It was important from the onset, to ensure the methods used were congruent with social works' emancipatory approach to research; therefore, this chapter will provide discussion on how the chosen design was congruous with this approach. This chapter will commence with a section identifying the overall ontological and epistemological stance employed within this research. This will include a detailed overview of the philosophical framework underpinning the interpretation of data within this research. Following this will be a section that explains constructivist grounded theory as the methodology informing this research with detail of the specific research methods utilised.

Research aim and question

Chapter 1 'Introduction' and Chapter 2 'Background of Health Social Work' have identified the known salient issues faced by social workers constructing their professional identities within the health sector. My own experience outlined in the 'Impetus for research' section alongside the relevant literature cited within these chapters formed the following aim and question of this research.

Research aim

This research aims to explore social workers' experiences of developing and maintaining their professional identity within health settings in Queensland, Australia.

Research question

What are social workers' interpretations of how their professional identities are socially constructed within health settings in Queensland?

Interpretive-constructivist paradigm

In considering the need for human inquiry identified within the research aim and question, the design underpinning this research employed a qualitative approach. It is difficult to provide one all-encompassing definition of this approach. This is due to the flexibility of qualitative methods boasting an array of practical applications and philosophical standpoints (Snape & Spencer 2003). Wadsworth (2011) defines qualitative research as:

> [f]rom the Latin *qualus*, meaning 'what kind', this is a term used to describe the nature of answers (evidence) in verbal articulation, or written words, expressing the visual, feeling or other descriptive or narrative nature of responses to identify-forming questions about the 'who, which, what, when, where, how and why'. (Wadsworth 2011, p. 192)

Qualitative research provides a means through which the richness and complexity of the actions, interactions and social contexts of social experience in everyday life are explored. Qualitative methods often employ strategies of observation and in-depth interviewing or discussion to discover the multilayered and intricate experiences that are embedded within the everyday lived experience (Gubrium & Holstein 2002).

Qualitative research has automatic validity because of its persuasiveness in representation of the participants' world views (Alston & Bowles 2012). As a social work researcher, qualitative methods are valued for their ability to convey the uniqueness and nuance of lived experience. As a social worker situating myself within the context of research, I highlight the importance of this research adopting a research design that fits within the scope of my own professional and personal values, knowledge and skill set as emphasised by Völter (2008). With regards to social work research design, Trinder (1996) explains:

> How one goes about doing research is intimately connected to what is going on in the world and how one sees social work. Research perspectives are not ahistorical and methodologies are not innocent sets of techniques. Certain methodologies matter because they support and sustain particular approaches to social work practice. (Trinder 1996, p. 234)

In considering Völter (2008) and Trinder's (1996) points of view, this research has adapted an element of pragmatism. This implies action and pursuit of social justice in social work, with emphasis on undertaking research that has potential to make a difference to people's lives (Alston & Bowles 2012). Charmaz (2017, p. 34) explains that pragmatism provides a means for thinking about critical qualitative inquiry and constructivist grounded theory

presents itself as a means of doing it. This pragmatic approach will be adapted in the critical inquiry of power relationships explored within the findings of this thesis. Anastas (1999, p. 4) suggests that social work research is inextricably linked to social work practice, creating social work research practitioners who are encouraged to assume a place of reflexive and subjective participation in the research process as opposed to a stance of detached objectivity. In likeness, reflexivity is not only encouraged, but a key method of analysing data in constructivist grounded theory studies (Bryant & Charmaz 2007). Reflexivity in the context of social work research is understood as the activity of self-reflection and the application of these reflective ideas to actions (D'Cruz, Gillingham & Melendez 2007; Pawar & Anscombe 2015). This acknowledges the unique place of a researcher in the development of ideas pertaining to the study. Throughout this thesis, participants' conjectures, conceptions and lived experiences will be reflected upon my own. Consultation with my supervisory team ensured that this was balanced and did not overpower the participants' experiences. This reflexive approach is anticipated to demystify the traditionally hidden subjective stance of the researcher with the hope of adding defining context to the participants' experiences. This will be achieved by providing my interpretations of participant experience in drawing on my own world view and practical resources such as memos and past publications for which I have written.

Mackenzie and Knipe (2006) explain that from the early stages of research, a researcher will have adopted a preferred stance on the nature of their enquiry, more commonly known as an overarching paradigm of the research. They suggest that this paradigm influences the way knowledge is studied and interpreted, and therefore provides the foundation a researcher will draw on in addressing and answering the research aim and questions. It is argued that in this venture, a researcher must consider their beliefs about the nature of reality and how this shares congruence with the overall research design they choose (Mills, Bonner & Francis 2006, p. 2). These influences are known as the researcher's overall ontological and epistemological stance. Ontology is explained as the researcher's position on what constitutes the nature of reality and existence, whereas epistemology is concerned with the researcher's stance on how knowledge is generated and then communicated with others (Scotland 2012). These positions are utilised by the researcher in making sense of

specific content of the research and directs the researcher's choice in methodology and the methods it adopts, to collect, analyse and disseminate data.

The interpretive-constructivist paradigm I have chosen to adapt to this research is argued to have a relativist ontology, which acknowledges many possible realities alongside a subjective epistemology, which understands that these realities are constructed by individuals, alongside the world with which they interface (Snape & Spencer 2003, p. 13). The relativist believes 'concepts such as rationality, truth, reality, right, good, or norms must be understood' (Mills, Bonner & Francis 2006, p. 26). The joint interpretive-constructivist venture encourages theories of human inquiry that first explore the meanings embedded within an individual's reality and then elucidates how, as social actors, their language and actions construct this within a social landscape (Schwandt 1998). This focus of interpreting participants' experience as social actors within society warrants an examination of social construction. Undertaking research that aims to explore lived experience can elicit an exclusively individualist focus. Therefore, this research has applied Charmaz's (2017, p. 35) concept of methodological self-consciousness which encompasses a deeply reflective stance employing interpretative critical reflection on relevant structural contexts, power relationships and influence of ideologies embedded in the individual experience (Charmaz 2017). This has been considered as a crucial consideration for this research, as a social work approach to research is encouraged to take a position of critical inquiry of systems and scrutinise their accommodation of social justice and human rights perspectives (Bisman 2004; Payne 2014). Denzin and Lincoln (2005, p. 3) argue for the importance of this particular paradigm employing naturalistic, or rather, non-experimental methodologies, which made grounded theory compatible with the interpretive-constructivist paradigm adopted in this research.

Interpreting the social construction of lived experience

This chapter will provide an overview and discussion of the analytical framework that was developed to, first, explore the lived experience of participants, and second, interpret how this lived experience contributes to the construction of professional social work identity in health. The framework discussed in this chapter is derived from literature that was introduced to the study during data analysis. The literature that was consulted in this

chapter was consulted for its topical significance. This significance provided understanding of the meanings ascribed by participants in their explained lived experiences. The use of a diverse and eclectic framework for analysis was readily applied to the multifaceted nature of inquiry within this research. Whilst it is argued that adopting a theoretical framework deviates from the foundational tenets of traditional grounded theory study (Mitchell 2014, p. 2), the Charmaz constructivist grounded theory advancement proposes an analytical framework that encourages researcher co-construction in data analysis (Bryant and Charmaz 2007; Mitchell 2014). Therefore, it is argued that the analytical framework put forth in this chapter best serves the purpose of this research topic.

In use of theory and philosophical standpoints sourced from scholars of different disciplines to the participants of the study, there was a desire to ensure an overall sense of congruence with a social work approach to interpretation. Therefore, this analytical framework that informs the critical exploration and interpretation applied within the substantive chapters of this thesis has been structured in accordance with a systems levels understanding. It is widely and strongly evidenced that social work boasts a strong allegiance to systems theory in analytical thinking (Harms & Connolly 2009). This chapter will draw on the generalised term of systems thinking in social work, which denotes an interpretation of 'person in environment' (Harris & White 2013, p. 448; Bronfenbrenner 1994) and understands the individual as the 'micro', the 'meso' constituting either organisations or communities and the 'macro' being societal or global (Payne 2005, p. 43–8). The systems levels explored have been carefully considered, to ensure congruence with the school of thought adopted in the relativist ontology and subjective epistemology of the study. This understanding will support the micro exploration of participants' individual everyday lived experience that is undertaken within the first substantive chapter. The second substantive chapter will apply a meso and macro interpretation of how the participants' lived experience constructs their professional social work identities in context.

Overview of the interpretive framework

> The constructivist or interpretivist believes that to understand this world of meaning one must interpret it. (Schwandt 1998, p. 222)

The interpretive framework adapted to this research has drawn on three key thinkers on the topics of understanding what constitutes existence and how this is interpreted with a

constructivist lens. The aim of utilising these significant theoretical understandings within this study is threefold: first, what constitutes the existence of reality in lived experience; second, how does this reality become a subjective entity; third, how is the process of this becoming a subjective entity analysed? The use of Heidegger (1927) has been ascribed as a lens of interpreting how the participants' everyday realities constitute their perceived existence within the health context. In accessing the concepts provided by Berger and Luckmann (1966), these realities are considered in terms of how they are then socially constructed by participants within the health context. In achieving this understanding, Goffman (1956) is drawn on as a means of analysing the problematic nature of identity-in-context, which lies in gauging its authenticity and inauthenticity. As the concept of power was interpreted as being embedded within the lived experience and subsequent social construction of participants' identities, a small contribution from key works by authors Foucault (1976) and Lukes (2005) have been drawn on as a means of analysing this theme. Utilising Foucauldian power analysis is asserted by Gilbert and Powell (2010, p. 4) as crucial in understanding the social construction of social work identity. They explain that is due to the conception of the social work profession as an instrument of governmentality for the purpose of reproducing state discourse (Gilbert & Powell, p. 4). When considering the influence of power, the participants highlighted the significance of medical ideology in the operation and delivery of health services. Therefore, the seminal work *Medical dominance* by Evan Willis (1989) has been utilised in order to interpret the contextual influence of medical ideology on the participants' professional identities.

At the commencement of some sections within both substantive chapters, Eliot Freidson's (2001) book *Professionalism: the third logic* is drawn on. Freidson's (2001) work proposes that professions are constructed in a dichotomous gaze of both the profession itself and socio-political organisational control. Whilst Friedson's (2001) view is provided at the commencement of sections, it is noted that his work was applied toward the end of data analysis, so as to ensure the findings were not constrained by his views. It was found that what Freidson (2001) put forth as a construction of professionals, shared congruence with the reports of the participants' experience.

Understanding the nature of reality in lived experience

From the inception of this research, the aim of exploring lived experience has been paramount. The choice of a Heideggerian approach arose within the early stages of engaging with the relevant literature regarding methodology, shortly after collecting data. The ongoing direction of this research has since been drawn to Heidegger's particular focus on the concept of exploring the meanings embedded within individuals' undertaking of their everyday lives. This Heideggerian focus adopted the principle of explicating these in an open and inductive method as opposed to a more static and purely descriptive synopsis (Reiner 2012) which could have limited the depth of interpretation and not acknowledge the power which individuals do, and do not, possess in construing their own reality. It is noted that the use and application of Heidegger's *Being and time* (1927) has been partial rather than comprehensive. A Heideggerian approach in its entirety could have encouraged a more phenomenological methodology, which may have posed issues in achieving a consistency with the epistemology of the chosen constructivist grounded theory approach. McConnell-Henry, Chapman and Francis (2009) support the partial approach adapted to this research, by arguing a Heideggerian interpretation can be engaged to fit the needs of the researcher so as to ensure analogy with the field of enquiry.

Charmaz (2014) explicates the importance of the researcher being grounded in the data and immersed in co-constructing the meaning of the participants' lived experiences. This is in uniformity with a Heideggerian school of thought, which emphasises the importance of researcher co-construction in interpreting lived experience subjectively (Mulhall 2005). In achieving this, both hold the belief in the researcher possessing foreknowledge and structure, acquired in experience and beliefs relating to their area of enquiry (Thornberg 2012; McConnell-Henry, Chapman & Francis 2009). In summary, the concepts adapted from Heidegger's (1927) *Being and time* have been conceptualised to, first, suit the needs of this research enquiry, second, the need to formulate a substantive theory, and third, to remain congruent with a critical and emancipatory social work approach to research.

The first of Heidegger's (1927) concepts applied to this research relates to the overarching and ontological nature of his work: 'Dasein' or, using the English translation in accordance with Heideggerian exegesis, 'Being'. These are used interchangeably within Heidegger's

work. This can create confusion in terms of deciphering difference between language, dialect or theoretical concept. For the purpose of this research, the term Dasein is the chosen word of application.

Heidegger (1927) explains that the entity of Dasein is what it *means* to be within existence. The interpretation and application of Dasein to this research is what it means for participants' identities to exist as a social worker within the health system in Queensland. This application was adopted due to the interwoven nature of participants' experienced Dasein and how this incorporates social work in to their existing sense of self.

In order to bring the ontic nature of the concept of 'Being' from a position of historical misunderstanding, Heidegger (1927) critically analyses thinkers before him, such as Aristotle and Plato, who, he felt, conceptualised 'Beings' as too obscure to be definable. He further explains that in order to commence an interpretation of a 'Being', one must formulate the question discernibly and with maintained focus on its [the 'Being' in question] distinct character. Heidegger argues (1927, p. 22–3) that this exploratory venture in discovering distinct nature paves the understanding for his term Dasein. He goes on to explain that in order to understand Dasein, one must not resort entirely to logic (Heidegger 1927, p. 23). In the interpretation of this research, this aims to unpack Dasein's lived experiences of the research inquiry, in tandem by both researcher and participants. In the instance of this research, this is the participants' reported experiences of their social work professional identity alongside researcher interpretation of the correlation of this to the distinct character participants attribute to their identities within the health context. This will entail discussion on how participants signified the meaning embedded within their everyday experiences as a social worker in health settings in Queensland. Exploring these reported everyday experiences is with an emphasis on interpreting the underlying or veiled meanings embedded within these. In providing discussion relevant to the overarching question of this research, the constructivist approach has been drawn on in interpreting how this embedded meaning constructs an understanding of their social work identity. This is anticipated to highlight the richness in their identity and the importance in their core articulation of professional self as a social worker in health settings within Queensland.

The entity of Being cannot be conceived without interpreting its relevance to ‘time’. And time cannot be conceived without reference to ‘temporality’ (Mulhall 2005). In this research, participants described their sense of self in statements to the effects of ‘beliefs of making a difference’ in their intrinsic ‘value of social justice’. This is making reference to a point in time, and perhaps place, in which this sense of themselves was distinguishable. Therefore, when applying Heidegger’s temporality to their lived experience, the Dasein of self cannot be separated from a layer of identity which is their professional social work self. It could be argued that these layers are interconnected.

Heidegger (1927, p. 39) states that time is the initial conception of Dasein. When existential questions of existence arise, this is when the temporality of Dasein’s entity is considered. This research adopts *everydayness* as the temporality of the participant’s Dasein. This research submits that in the case of social work, Dasein is a point of reflection (past, present and future considerations)—a moment in which social workers stop and reflect on cognitive dissonance. This is argued as the point at which social workers recognise issues in identity. In the application of time, which manifests itself as experiences of temporality, their meaning of Dasein is moved beyond being purely ontic, and is able to be conceptualised in terms of Heidegger's other concepts, such as 'Being in the world' and 'Mineness'.

This moves on to understanding one of the branches of Heidegger’s ‘Being’. The concept of ‘Mineness’ which, in application to this research, denotes an individual’s exposition of their ‘Being’, or ‘my Being’ as coined by Heidegger (1927, p. 78), as their own, and how it is they regard this as being theirs. In applying ‘Mineness’ to this research, it is aimed to interpret what the participants purport is theirs in terms of their Dasein as a social worker working in a health context.

Heidegger highlights the significance of Dasein possessing the conditions for an individual to expound either ‘Authenticity/Inauthenticity’ in their experience of Being-in-the-world, but argues that Dasein is still existent in both of these modes (1927, p. 78). He explains Being-in-the-world as Dasein’s experience in exposition of self within the contextual parameters of society (Heidegger 1927, p. 77–9). In terms of this research, it will be considered how the participants experienced authentic or inauthentic sense of self with their perceived reality of social work identity construction within the health context.

Analysing the social construction of reality

In their treatise on the sociology of knowledge, Berger and Luckmann (1966, p. 194) explain how the identity of individual lived experience is interconnected to a more unified social construction of a particular group. They explain this by arguing identity, as a subjective reality, stands in a dialectical relationship with society (1966, p. 194). Much in line with a Marxist school of thought, this is essentially the understanding that identities are formed by social structures and then maintained or reshaped by social processes:

> Not only is the material of my activity given to me as a social product (as is even the language in which the thinker is active): my *own* existence *is* social activity, and therefore that which I make of myself, I make of myself for society and with the consciousness of myself as a social being. (Marx 1844, p. 44)

Marx makes reference to consciousness in this quote, which is undeniably his acknowledgement of his *own* existence in relationship to socially constructed reality. Berger and Luckmann (1966) propose the importance of maintaining a view that the consciousness of this social construction not lose its uniqueness of individual experience (1966, p. 194). To achieve this, they submit to the necessity of engaging philosophy to understand the intrinsic meaning of everyday reality. In drawing on the Heideggerian framework outlined above, the theoretical stance is proposed: that in undertaking a constructivist analysis of the lived experience of the participants, the richness of their everyday reality must be interpreted so as to reflect the nuance of uniqueness. In justification, this approach is encouraged by Heidegger's (1927) view that '… by having regard for the basic state of Dasein's everydayness, we shall bring out the *Being* of this entity in a preparatory fashion' (1927, p. 38). This provides the means for considering the Dasein of participants' exposition of experience as duplicity in authenticity and inauthenticity. In terms of exploring identity, this consideration was paramount in ensuring that the uniqueness and wholeness of the participants' identities was discovered. It is believed that the reality of an individual's existence comprises a difficult dialect in the everyday of authentic and inauthentic experiences of self-identity (Heidegger 1927).

The limit of Heidegger's work is that it is purely ontological, and whilst providing concepts to interpret, they are seldom readily applicable to critically analyse. Therefore, Goffman's (1956) seminal work has been drawn on, which utilises the dramaturgy of symbolic interactionism theory. This theory is aimed at depicting 'frontstage/backstage' as the 'public

and private' of individuals' presentation of self in everyday life (Hillman 1999). In this work, Goffman (1956) proposes a framework to analyse the way in which an individual presents themselves and their activities to others. This is with a focus on understanding how this is conveyed to impart a desired impression of one's self to particular audiences. In this research, participants are often imparting their identity daily within the health context. Within their interviews, it is observable that they provide either frontstage or backstage portrayals of their identity, with this being hinged on the social contexts they interface. Goffman's (1956) symbolic interactionism theory provides a means of explicating the characteristics that delineate both a front or back stage performance and how this relates to authentic and inauthentic presentations of self.

An interpretive-constructivist paradigm warrants research methods of interpretation and analysis that employ researcher curiosity and exploration. This overall approach to interpreting the findings of this research is in congruence with a constructivist grounded theory stance. In adopting this paradigm as a proponent of this approach, the researcher is encouraged to assume a position of reflexivity when drawing on relevant analytical frameworks as interpretive lenses when co-constructing findings (Charmaz 2012, p. 12).

Medical dominance

Chapter Six, 'Social Work Values and the Ideologies of Health', will in part, undertake an interpretation of how the participants' individual identities interacted with dominant ideology in health systems within Queensland. Therefore, this research has adapted an understanding and application of pertinent concepts relating to the social structure of health care delivery, as put forward in Evan Willis' seminal work *Medical dominance* (1989).

The concept of medical dominance is defined and discussed in reference to Evan Willis' book (1989), as, to begin with, this was one of the first in-depth sociological analyses of the production of health within Australia and, secondly, as a part of this research, I have drawn on Willis' work as my lens of interpretation during data analysis.

Willis (1989, p. 4) defines medical dominance as the paradigm of medicine's economic, political, intellectual and social domination over the health sector, manifested in the medical profession's ability to control the knowledge in which healing is based. In previous

publications (McNamara 2015a; McNamara 2015b), I have provided a critical social work reflection on my own experiences of medical dominance when employed in health settings within Queensland. I explained that, as a social worker, I instead identified '… the social and environmental causes of illness' and sculpted '… an anti-oppressive, systemic and strength-based intervention' as my conjecture was that '… empowerment and connection are, in effect' a social worker's 'treatment' (McNamara 2015b, p. 28). I further argued that this was at odds with the prevailing medical dominance model within the health organisation in which I was employed and often lead to my social work role being devalued and under the scrutiny of staff who were more aligned with the dominant ideology.

Willis explains (1989, p. 2) that 'Medical dominance in the health division of labour is sustained over three different levels: over its own work, over the work of others; and in the wider health sphere'. Willis (1989, p. 8) elaborates that this is achieved through medical dominance sustaining legitimacy by proving '… autonomy, authority and medical sovereignty', which Willis (1989, p. 3) expands upon as society's belief in doctors being 'institutionalised experts'.

Willis (1989, p. 6) puts forth three modes of domination within health settings. The first is '*subordination',* which he explains as occupations that work under the direct control of doctors and are 'overwhelmingly female' and correlate with the sexual division of labour. The second is *'limitation',* which refers to occupations which do not have 'direct medical control' but some 'indirect control' through 'legal restriction on their occupational territories' and 'medical presence on their registration boards.' Lastly, *'exclusion'* is explained as occupations who are excluded from the legitimacy of formal licencing and registration and are widely known as alternative. Whilst not included in these modes, Willis (1989, p. 6–7) explains the potential of other modes being possible, such as *'incorporation',* which occurs when an occupation is absorbed in to medicine and loses its separate identity.

These concepts will be explored in relation to participants' reports of interpreted influences on their professional social work identity.

Constructivist grounded theory

This research adopted methods consistent with the constructivist strain of grounded theory methodology. Sociologist Kathy Charmaz's work, from 1994, to the release of her book in 2006, saw the emergence of the constructivist approach to grounded theory. However, grounded theory as a methodology has existed for some time. As Charmaz (2014, p. 5) explains, it emerged out of tension between quantitative and qualitative research during the 1960s, with claims that qualitative research lacked clarification of set field methods in collecting and analysing qualitative data. Charmaz (2014, p. 5) further suggests that during this era, sociologists Glaser and Strauss refocussed qualitative inquiry on to a set of articulate and consistent methods. From this, grounded theory emerged from their successful collaboration in studying death and dying in seriously ill patients. Following this was the publishing of their book (1967) in which Glaser and Strauss articulate grounded theory to be a systematic, qualitative research methodology that aims to empirically and inductively discover or generate a theory rather than test an existing premise (Birks & Mills 2010). This early approach to grounded theory sought to discover patterns of behaviour within the data and attempted to conceptualise the properties of these through abstraction (Charmaz 2006). In adopting a constructivist approach, I aimed to understand the differences and variations amongst research participants and sought to co-construct the meanings of their experiences alongside them. Charmaz (2014, p. 12) defines the constructivist approach to grounded theory by stating that it 'adopts the inductive, comparative, emergent, and open-ended approach of Glaser and Strauss's (1967) original statement', whilst also encouraging a researcher's co-participation in the interpretation and analysis of the phenomena being explored. Constructivist grounded theory could be considered to promote the belief that the researcher constructs theory as an outcome of their interpretation of participants' stories. Thornberg (2012, p. 6) explains that in adopting the relativist-subjective stance, a constructivist approach to grounded theory assumes that '… neither data nor theories are discovered, but are constructed by the researcher as a result of his or her own interactions with the field and its participants'. Therefore, applying a constructivist approach to grounded theory research, the element of reflexivity is introduced and underpins the researcher's approach to data collection and analysis (Gardener, McCutcheon & Fedoruk, 2012).

The process of data collection and analysis in grounded theory involves cycles of data collection that coincides with the grounded theory methods of coding, writing of memos and building theory through the emergence of categories that are identified within the data (Birks & Mills 2015; Charmaz 2014). Further, a method of constant comparison of new data through theoretical sampling is utilised to identify codes and emerging categories, until a point is reached where no new information is being uncovered; this is known in grounded theory as 'theoretical saturation' (Kelle 2007). These methodological tools allow for the triangulation of the study by constant interaction between data, participants, researcher and other members of the research team (Charmaz 2014). In the constructivist approach to grounded theory, the process of data collection and analysis is relatively similar to that in the classic approach. However, with its reflexive nature, the concept of a shared reality is construed by the researcher, and the historical, cultural and structural perspectives that underpin formation of the reality shared between the researcher and participant exchange of the phenomena being explored (Charmaz 2000). In constructivist grounded theory, the importance is emphasised in the researcher taking a more interpretative lens than critical in their overall analysis (Hood 2007). In summary, the constructivist approach acknowledges and interprets the phenomena being studied in relation to the researcher and participants' relationships with macro social, political and environmental influences. For the research within this thesis, applying this has culminated in the co-construction of a substantive theory, demonstrating a combination of both the researcher and participants' stories.

Data collection and analysis

Distinctive of grounded theory is its simultaneous data collection and analysis process. Charmaz's (2014, p. 18) prescribed process on constructivist grounded theory process was drawn on to direct the overall development of this study. It provides specific instruction on how the process of data collection and analysis is engaged throughout the research process. Within this process, Charmaz (2014, p. 18) indicates that memo writing be undertaken from the *Recruitment and Sampling* of participants phase to the *Writing up/Dissemination* phase. Further, she suggests that the use of constant comparison be undertaken from the *Data Collection* phase to the *Theory Building* phase. She demonstrates the unique constructivist approach in indicating that theoretical sampling be undertaken from the *Research Question* phase until the point of *Focussed Coding and Categorising* phase.

In Charmaz (2006, p. 11), a clear visual representation of the constructivist grounded theory process is provided. This visual representation has been adapted from Charmaz (2006, p. 11) and provided as a visual aid in demonstrating the process that underpinned the progress of this research.

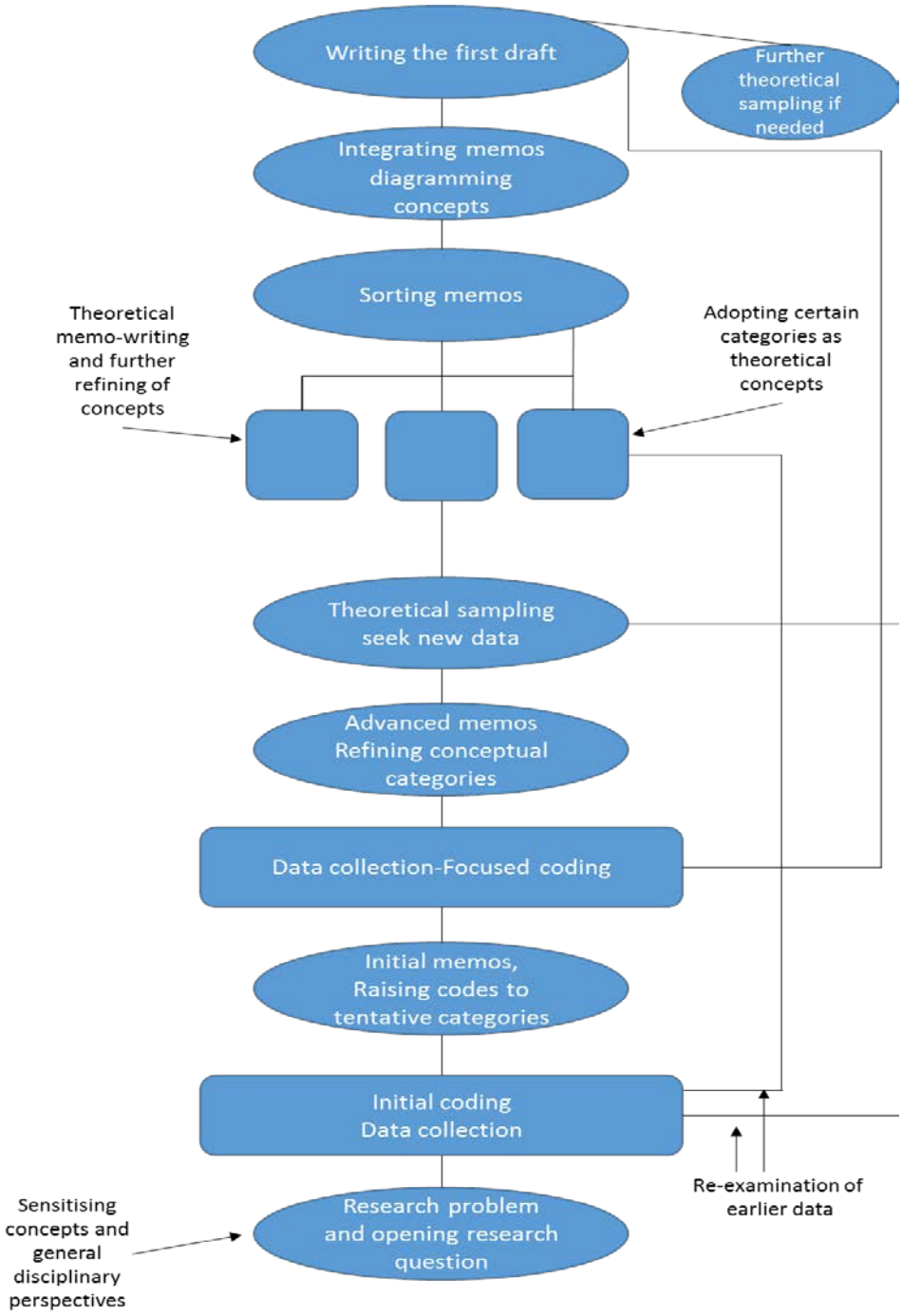

Figure 1: Constructivist Grounded Theory Process

Charmaz (2014, p. 23) states that '[g]athering rich data will give you solid material for building a significant analysis', and explains that the purpose of gaining this rich data is to seek 'thick' description. The concept of thick description is aimed at creating a plausibility of the participants' experiences, so as the events being described evoke a reader's sense of connection to the events being depicted in the study (Creswell & Miller 2000, p. 128–9). This is explained by Creswell and Miller (2000, p. 128) as establishing credibility through the lens of the reader due to the ability of narrative accounts to transport them in to a setting or situation identified by participant lived experience.

Charmaz (2014) signifies the importance of the researcher using the most suitable method to obtain rich data. It is argued that in-depth interviews yield more data (Hillman 1999), providing more fruitful means for extracting thick description. As the focus of this research was to explore each participant's lived experience, a narrative approach to the use of semi-structured, in-depth interviews obtained via multi-media (by audio [telephone] or video [Skype]) was utilised as the method of data collection. The use of multi-media was encouraged for various reasons as it enabled more efficient data collection, was not logistic-laden, and further, cut cost on the overall research budget as the researcher did not have to travel to conduct field work. The guiding interview questions (see in Appendix H) were both open-ended and closed and focussed on exploring each participant's experience of their role as a health social worker. The questions aimed to prompt the participants' explanations of their unique social work identity and what they considered to be influential about the construction of this identity within the health context. Each interview was recorded with an audio-recording device and then later transcribed by two professional transcribers.

Recruitment

Recruitment commenced following approval from CQUniversity Human Research Ethics Committee and the AASW Ethics Committee. Following this, a Recruitment Notice (see Appendix C) was advertised by the AASW (see Appendix D). As a method of recruitment, a snowball sampling technique was utilised when conducting interviews. Snowball sampling is argued to be a recruiting technique aimed at targeting a specific participant population. To implement snowball sampling, the researcher encourages participants to facilitate a word-of-mouth that promotes recruitment among the participant population (Babbie 2009;

Heckathorn 2011). With this understanding, the participants of this study were asked if they knew of anyone eligible to participate in the study, and if so, they were provided with a recruitment notice to share with the interested parties.

Upon expressing interest in participating in the research, participants were provided with an 'Information Sheet' (see Appendix E) and 'Introductory Letter' (see Appendix F) outlining the content and parameters of the proposed research, as well as an 'Informed Consent Form' (see Appendix G) for their consideration before they provided recorded verbal acknowledgement and consent prior to their interview.

Participants

Qualitative research generally undertakes purposeful selection of participants, which is aimed at best informing the focus of the study (Sargeant 2012). This research focussed on the construction of social work identity within the health sector in Queensland. Therefore, the participants of this study were social workers at varying experience levels who, at the time of data collection, were employed full-time, part-time or on a casual basis, in social work specific or generic roles within any health setting in Queensland. Participants were willing and ready to share their lived experience of development and construction of their social work professional identity within the health context. All participants remain confidential and have been given a pseudonym* in discussion of their experiences throughout this thesis. In order to ensure confidentiality, any foreseeably identifiable information relating to the participants has been omitted from the thesis. The participants' pseudo-names, specification of whether they occupy a generic or social work role and the years of experience they have as a social worker is outlined in the table below.

Table 1. 'Participant Overview'

Name*	Social Work or Generic Role	Years of Experience
Leanne	Generic	20+ years
Jane	Social Work	20+ years
Rita	Generic	Unknown
Sally	Generic	10+ years
Barbara	Social Work	5 or less years
Anne	Generic	5 or less years
Catherine	Social Work	5 or less years
Sharon	Social Work	10+ years
Jacinta	Generic	10+ years

Coding

Charmaz (2014, p. 111) generally defines coding in constructivist grounded theory to be categorising segments of the data with a short name that summarises accounts of participants' experiences, followed by selecting, separating and sorting data for the beginning of analysis. Charmaz (2014, p. 109) signifies coding as the first point of analysis, as it prompts the researcher to begin asking interpretative questions of the data they are gathering. Charmaz (2014, p. 109) elaborates that not only do codes provide the first point of analysis to interpret understanding of studied life, but also help direct the researcher to subsequent data-gathering. This is known as theoretical sampling, which will be discussed in later sections of this chapter.

In the reintegration process of coding, conceptual abstraction of the data takes place (Holton 2010, p. 21). In this research, the processes of initial coding and focussed coding were employed to first fragment the data and later reorganise these fragments into the conceptual themes that will be explored within Chapters Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Six, 'Social Work Values and the Ideologies of Health'.

Initial coding

The first stage of coding is open in nature and known as initial coding. The researcher will study fragments of the data; of this, the words, lines, segments, and incidents are closely examined for their analytical significance (Charmaz 2014, p. 109). Charmaz (2006, p. 47) explains that initial codes provide a commencing understanding of participants ideas on the meanings of their experiences, the language they attribute which impels the researcher to consider these problematically in constructing emerging themes. The idea of reflexivity is considered in this, as the codes that arise are resultant of the researcher actively 'naming data' (Charmaz 2006, p. 47).

In this research, the initial coding was undertaken using Charmaz's (2006, p. 50) guidelines on line-by-line and word-by-word techniques of coding, in efforts to 'stay close to the data' and develop ideas that are just as much participant led as they are led by the researcher. By studying the data this way, it is proposed that fundamental processes and hidden assumptions are made both visible and explicit, in turn giving new insights on what participant's experience in their everyday life (Charmaz 2005, p. 55).

The line-by-line technique is said to be the first coding technique applied in a grounded theory study (Charmaz 2006, p. 50). This technique was found to be particularly useful in this study, as the sheer complexity of the participants' experiences made extraction of clear meanings initially difficult. In the line-by-line technique a researcher will read each line of an interview transcript and ascribe a meaning to that line (Charmaz 2006, p. 50).

Charmaz (2006, p. 50) explains the word-by-word technique as the act of attending to images and meanings and analyses these according to the chosen analytical framework of the research. This is understood as the act of scrutinising each and every word of the participant narrative for, first, their interpretation of what they say, and, second, how their meanings relate to the focus of the study. This approaches both structure and flow of words, and explores how the researcher makes sense of this, as well as the specific content that is imparted (Charmaz 2006, p. 50).

An excerpt of my interview with participant Leanne is provided below (Figure 2). It demonstrates the process of line-by-line and word-by-word coding as undertaken in this

research. It is interesting to note that this initial interpretation contributed to the later formed category of the 'Cost of being a rebel'.

Line-by-line & **word-by-word codes**	Excerpt of 'Leanne' (P:) interview
Governance in health services. Influence of policy and procedural. Believes clients aren't considered by organisation. No options, other than to work how the organisation enforces? To reject this is to leave. Being a rebel. Resistance of the governance. Disclosure that this affects her person. Allegiance to values. Values weren't enough to continue. Having to forfeit employment. A place where she can be herself. A place that supports her values? 'Backstage' (Goffman) of Leanne?	**P:** um, so that's why I can only say people who make policies and, and put procedures in place for whatever reason , and I believe **[signifying belief]** it's not always in um, in the, for the benefit **[in their best interest?]** of the client but it suits the organisation better for whatever reason so if you accept employment in that area that how you will work **[forced]** **P:** Otherwise, find other employment **[ultimatums - force]**. **I:** Yeah, so how did this influence your construction of your social work identity in that setting? P: I think I was always a bit of a rebel **[activism?]** I couldn't do it, so in the end it affected me as a person **[her entity as a 'person']**. Um, and but I couldn't let go **[not forfeiting – rejecting and resisting]** of my personal stroke professional values **[this situation affected her person which affected her values].** Um, so at some point when I, I **[staggering on 'I', was this a difficult topic?]** just couldn't do it anymore I had to move on **[letting go]** um, and hopefully find a better one. A better place where I can work but that's difficult sometimes for a social worker to find a place where - where you feel you can be who you are **[These values are 'who you are' – as a social worker]**

Figure 2: Line-by-line and word-by-word coding example

Focussed coding

Focussed coding is a process characterised by a more selective and directed approach that aims to conceptualise the data into categories that have started to form (Charmaz 2006,

p. 57). This more focussed process allows for larger segments of data to be funnelled through the codes that have already been established for their analytical significance. Holton (2007, p. 272) identifies that this process moves from ascribing meaning in a mostly descriptive manner, to a process in which conceptualisation of the relationships between codes and their categorical significance will see the early stages of theorising commence.

In explaining the use of focussed coding in this research, Figure 2 can be drawn on to provide an example of how this occurred. The code of 'Being a rebel' proved to be significant in not only directing subsequent data gathering, but the creation of one of the first core categories to emerge from the data. This type of code is what Charmaz (2006, p. 56) would term an 'invivo', defined as words that condense a meaning that participants consider everyone to share. This led me to explore other participants' interviews and focus on experiences that described rebellion, resistance to the status quo, or activism. It was interesting that the majority of participants identified similarly in their experiences, which assisted in theorising the role of resisting oppressive ideology in their social work service delivery. This led to the naming of one of the core categories of 'Being a rebel' in the ending stages of the research.

In grounded theory, a category is defined as a theme that has presented significant patterned and relational value in addressing the overall focus of inquiry (Kelle 2007). It is not often the case that an initial code will remain the same and go on to form a category as part of final theorisation (Hallberg 2006). When moving through the coding process, the initial codes, focussed codes and even categories take on new understandings and meanings as subsequent data gathering assists in refining, reorganising and theorising data. An example of how a code changes during the data analysis process can be provided by looking to the excerpt from my interview with Leanne in Figure 2. In this excerpt, Leanne discusses the affect being a rebel has had on her person. This was an interesting discovery, in that proceeding participant interviews, they described similar circumstances. In identifying this overwhelming relationship of lived experience amongst the participants, I focussed attention on exploring the circumstances that surrounding these 'affects' and what this constituted for the participants. It was clear that there was a cost to asserting the social work identity for the participants, which contributed to this being a core category and finally named 'The cost of being a rebel'.

Constant comparison

In constant comparison, or rather, an interpretative analysis of this initial coding, the researcher will aim to focus the coding to answer questions that may have not been answered in the initial coding phase, and move towards categorising these into themes (Charmaz 2014; Hernandez & Andrews 2012). To achieve this process, the topics associated with the focussed codes are explored in the ongoing interviews with participants (Sbaraini et al. 2011). This process is clearly outlined in the previous sections on initial coding and focussed coding which discussed the analysis of an excerpt of an interview with participant Leanne (see Figure 2).

Theoretical sensitivity

Hernandez and Andrews (2012, p. 62) explain that theoretical sensitivity in a constructivist approach to grounded theory relies on the '…researcher's intuitive and interpretive analysis of the data', or, as they explain in other words, is '…researcher-driven'. This is in contrast to classic grounded theory, where theoretical sensitivity is data-driven by withholding the researcher's reflexive research-drive so as to discover theory within the data (Hernandez & Andrews 2012, p. 62). It is understood that constructivist grounded theory's enhanced theoretical sensitivity is strengthened by the researcher's knowledge on the research topic, even if this derives from the relevant literature (Mruck & Mey 2007). This warrants methods that explore literature relevant to the focus of enquiry so as to make appropriate theoretical comparisons (Bryant & Charmaz 2007, p. 17). This is recommended as a non-traditional approach to literature review, with Chapter Two, 'Background of Health Social Work', of this thesis serving this purpose. This is argued to still ensue an inductive process, where the theory grounded in the data is ensured as a bottom-up product that is emergent and not forced (Holton 2007). Theoretical sensitivity in alignment with the above definition and suggested application was utilised by this study. This was achieved in consultation with the relevant literature prior to data analysis and during the data analysis process. Evidence of the literature sourced prior to data analysis can be located within Chapter Two, 'The Background of Health Social Work', whilst Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Six, 'Social Work Values and the Ideologies of Health', provide the literature that was drawn on during analysis of the data.

Emphasis has been placed on the consultation of relevant literature in this section. This is due to the constructivist strain of grounded theory impelling the usefulness of literature in guiding the process of data analysis (Charmaz 2006). However, theoretical sensitivity also relies on a consistent interface of grounded theory methods to ensure the data that is being collected and analysed remains congruent with the tenets of a grounded theory study. To achieve this, it is the expectation that the researcher adheres to processes of theoretical sampling, memo writing and appropriate coding practices (Alberta 2006). This is said to ensure the final product presents not only new ideas, but boasts a rigorous analysis.

Theoretical sampling

Charmaz (2006, p. 96) argues that theoretical sampling in both constructivist and classic approaches to grounded theory are aimed at refining categories by seeking out the relevant data. This ensures that data seeking is correctly aligned to the continued interpretation of the emerging concepts of the research (Beckenridge & Jones 2009).

As the themes of this research were emerging, it became clear that whilst drawing on the 'Interview Question' template, it was necessary to ensure the testing of emergent themes was addressed in subsequent interviews with participants. An example of this was the theme of the 'survival mindset' which required further understanding of how this process takes place. This was achieved by asking questions that focussed on an open encouragement of participants to share experiences in which they felt positive about their social work identity, alongside the challenges they faced in asserting it. This approach was found to enrich the themes by yielding thicker descriptions, resulting in their allocation within a core category (Morse 2007).

It is important to note that a snowball sampling technique was utilised as an adjunct sampling strategy in this research. This ensured information-rich participants were sought out in achieving theoretical sampling.

Memo-writing

Montgomery and Bailey (2007, cited in Thornberg 2012, p. 14) describe memos as the product of merging field notes and other data documentations into theoretical explanations. Charmaz (2014, p. 162) adds that memo-writing is a crucial method in

grounded theory as it prompts the researcher to analyse data and codes early in the research process and, further, become actively engaged in the materials in developing ideas, fine tune the subsequent data gathered, and engage in critical reflexivity. Charmaz (2014, p. 163) elaborates that the above is achieved by the memo-writing providing a space and place for the researcher to make '… comparisons between data and data, data and codes, codes of data and other codes, codes and category, category and concept and for articulating conjectures about these comparisons'. Memos are identified as a key data analysis process, as they assist in the final theorisation of categories and theory emergent from these (Dey 2007; Kelle 2007).

As a social worker, I identify a significant link between the core social work practice of reflective writing and reflexive learning (Harms & Connolly 2009) and have brought forth my own education and practice wisdom relating to reflective writing endeavours. For this research, I engaged in memo-writing. In this, I have incorporated Charmaz's (2014, p. 165) analytical style of memo-writing and kept a 'memo bank' to arrange a library of memo themes. These memos greatly assisted in distilling ideas on new data, and an integration of these to existing data in this research. An example of the use of memos in theorising is provided within Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', where the concept of institutionalisation is explored. It was in the writing of a memo on participants using the word clinical that I reflected on my own use of this word, particularly in the interview transcripts. This proved significant in providing theoretical insights on the process of institutionalisation for social workers employed in the health sector.

Reaching saturation

Theoretical saturation is an integral process that signifies when the collection of data will cease and findings are disseminated accordingly. It is therefore important to define and explain theoretical saturation and its significance in grounded theory studies. Within most quantitative analysis processes, completion of predetermined sample elements signifies the end phase of data collection, whereas in qualitative studies, the nature of inductive and contingent non-probability sampling poses an end point when 'saturation' is reached (Hood 2007, p. 161).

In grounded theory, theoretical saturation signifies the point in which no further data is required due to overwhelming confirmation of the established categories' substantiation (Charmaz 2006). It is argued that this point is reached when very little new information is being obtained and, subsequently, no new theoretical insights are gained (Charmaz 2006; Hood 2007). The concept of 'saturation' has been widely debated and contested for its sufficiency—this argument usually revolves around matters of sample size (Mason 2010). Alberta (2006, p. 639) explains that signals of saturation *can* include repetition of information, confirmation of categories and a demonstrated pragmatic approach to identifying these. Whilst Alberta (2006) suggests repetition of information is a signal of saturation, it is argued that scoping for repetition should be considered critically, as some grounded theory studies may not present significant repetition due to small sample sizes (Charmaz 2006). Instead, demonstrating thick description by portraying the richness of lived experience is said to supersede an emphasis of large sample sizes (Charmaz 2006), as it is considered by Charmaz (2006, p. 114) that small sample sizes have the capacity to meet the needs of a project.

Saturation in this study was recognised through drawing on the guidance of Charmaz (2006). Saturation was evident in the final two interviews of this study, which provided no new theoretical insight or changes to the categories that had taken form.

Summary

This chapter provided an overview of how the data is explored, interpreted and then viewed through a lens of social construction. This chapter highlights the significance of understanding identity in relation to the layers it expounds. This has justified the use of an eclectic analytical framework, which underpins a thorough exploration of uniqueness and nuance in identity as well as direct an inquiry of how this is socially constructed. The overall analytical framework has been aligned with the tenets of the constructivist grounded theory design explained within this chapter. This has provided insight into the ontological and epistemological stance of this research and explained how this directed the application of constructivist grounded theory methods within a guiding interpretive-constructivist paradigm.

Chapter Four
Social Work Research

Introduction

The purpose of this chapter is to demonstrate how this study is situated in the context of social work informed inquiry. It will serve the purpose of introducing a social work knowledge paradigm to a study that focusses on exploring professional identity. This is achieved in ascribing core understandings sourced from relevant knowledge in social work research that have been drawn on to inform the analytical framework used in my own research explained in the previous chapter. It is imperative to note that the scope of relevance in which focussed aspects of this knowledge were drawn on was directed by the data of this study. The first section of this chapter will provide an overview of how to interpret social work knowledge, theories and skills for practice as put forth by Payne (2014). In consultation of Connolly and Harms (2012), the second section of this chapter will provide an overview of the four key social work viewpoints on what influences how social workers interpret their value positions in practice and how this contributes to their application of knowledge, theories and skills to practice. Drawing on Payne (2014), the final section of this chapter will widen the understanding of what influences social work by identifying political knowledge paradigms and how these inform the viewpoints identified within the previous sections. The sections within this chapter will provide details of how this chosen paradigm was developed in consultation with the findings in this research. It is noted that the brief discussion of findings within this chapter do not constitute full and final discussion of the dissemination of findings. The complete discussion of the findings are contained within both Chapter Six, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Seven, 'Social Work Values and the Ideologies of Health', of this thesis.

The triad of social work knowledge, theories and skills for practice

Chapter Six, 'The Everyday Lived Experience of Health Social Workers in Queensland', explores the lived experience of participants reported everyday use and application of social work knowledge, theory and skills in practice. Participants' reported experiences in undertaking their working days was varied, in terms of the factors underpinning their

employment at the time of their interview. These factors included (but were not limited to), where they were geographically located, the positions they were employed in as a social worker, the types of tasks that were governed by their position descriptions, and where they were employed. Whilst this thesis includes discussion that encompasses some of the specific factors outlined above, the overall nature of analysis is that of a holistic interpretation of the knowledge, theory and skills for practice subject matter.

In articulating the triad, the participants explained the relevant features of their everyday role as a social worker in the health system within Queensland. It is important to identify what the terms of this triad mean in relation to social work identity, and how they will be applied to this thesis. Payne (2014, p. 5) outlines that *theory* and *knowledge* are interconnected but different concepts. He explains this by attributing *theory* to the act of thinking about something, whereas *knowledge,* he suggests, is depicted as the description of reality. He goes on to explain that reality is a view of the world that is accepted as 'true'. Interpreting *practice* in relation to *knowledge* and *theory* defines the transfer of these into the practical application of social work practice.

The four interpretive lenses of social work

Throughout the course of their interviews, participants' often spoke of an innate focus or drive that underpinned their everyday work in health. This was often in discussion of their value base and personal view of the social work disciplinary role in health. Therefore, this section seeks to provide an understanding of how social work as a profession interprets its own value standpoints and how these influence social work practice. This is achieved in discussion of the four interpretive lenses put forth by Connolly and Harms (2012). Connolly and Harms (2012, p. 1) explain the necessity of exploring the disciplinary nature of social work in understanding how this influences social works' knowledge and theory application to practice. They identify these as four intersectional lenses: the relational lens, the social justice lens, the reflective lens, and the lens of change (Connolly & Harms 2012, p. 2). The social work relational lens is defined as a social worker's capacity to develop relationships from micro to macro levels primarily in 'helping' service users overcome social issues. It is argued that this lens, if utilised in isolation of the other interpretive views, can become deficit focussed and manipulated by capitalist ideals to ensure a policing of the poor and

disadvantaged (Howe 2009). This can be observed within Chapter Six, 'The Everyday Lived Experience of Health Social Workers in Queensland', where participants identified the problematic nature in utilising relationships' knowledge to foster their connection and networking with various facets of the health system. It was identified that achieving such relationships appeared positive, but in turn, complied with oppressively considered models of practice. Further within Chapter Six, significance of systems thinking is highlighted by participants. In likeness to the social justice lens as defined by Connolly and Harms (2012, p. 4) this is the interpretation of social workers striving to advocate for the amelioration of systems that oppress and marginalise individuals, communities and societies as a whole. The social justice lens is claimed to have encouraged social works' development of anti-oppressive paradigms of practice rooted in various radical theory (Dominelli 2002). Again, the same criticisms of the relational lens apply to the social justice lens. It is believed that due to social workers often being employed by the state, they operate in a duplicity of compliance with socio-political control and the desire to be an agent of social change (Connolly & Harms 2012). This was highlighted by participants in their reports of feeling as though their everyday practice was in a dichotomy of wanting to practice what they view as 'social work' but adhere to the ideological constraints of the health system. Connolly and Harms (2012, p. 6) define the reflective lens as social workers' capacity to reflect on their sense of self professionally as well as personally and consider the various cultural influences in constructing their professional identity and application thereof. The participants of this study identified the role of reflective practice and how it is embedded within their social work identity. This concept will be explored in relation to participants' reports within the last section of Chapter Six, 'Social Work Values and the Ideologies of Health'. Lastly, the lens of change is defined by Connolly and Harms (2012, p. 8) as social workers' interpretation of how to create positive change in human systems. In Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', participants' highlight their belief of being part of a wider scale systemic change in their social work roles in health. They indicated this in identifying the relationship between their application of systems' thinking and desire to be part of and inform societal change relating to health disadvantage.

The influence of knowledge paradigms on social work

Deconstructing the significance of how paradigms of knowledge inform social work approaches in health, it is imperative to draw on Payne's (2014, p. 21) illustration of political influences that underpin the nature of social work. This is due to the considerable influence political ideology has on the intersections between health service policy, health service operation and subsequent delivery of health services. Payne (2014, p. 21) proposes that social workers operate from a triangle of Empowerment (social democratic), Problem-solving (liberal/neo-liberal) and Social change (socialist):

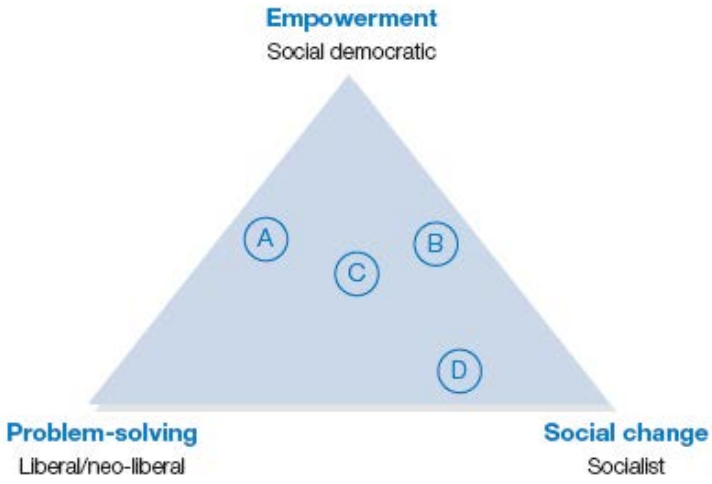

Figure 3: Three Views of Social Work

In providing examples of each: a social worker employed within the probation and parole system would likely be influenced by the Problem-solving focus; whereas a social worker employed within a non-government agency providing counselling for families experiencing relationship issues would likely be influenced by an Empowerment approach; and operating from a Social change approach would see a social worker engage in community scale change projects, likely employed with activism at the forefront of their practice approach. Whilst these seem clear and easily allotted to particular practice areas, the complexity in application of each is embedded within a system's interpretation. Payne (2014, p. 22) provides an overview of each of these practice influences. This understanding has been applied to the example of a social work child protection worker, who is employed by a state government department to distribute services of statutory welfare. It is likely that the department's focus is that of problem-solving in utilising child protection legislation. The

social worker's role in applying this may entail practice underpinned by an approach of empowerment in their provision of supportive counselling and advocacy to clients. Further, this social worker may hold the value of social justice, likely in hope of opting for objectives that are more proactive rather than reactive in fostering healthy relationship attitudes within the community toward families experiencing child protection issues. This demonstrates that social workers are not limited to operating exclusively from either of these focuses, but rather, adopt them systematically. This systematic adaption factors in the social worker's unique approach, the approach of the profession and the expectations of the organisation in which the social worker is employed. The expectation of the social worker is to prioritise these influencing factors accordingly (Payne 2014).

Summary

This chapter has provided an overview of the three sets of relevant social work knowledge that have been drawn on to establish the overarching social work knowledge paradigm that guides design of this research. The discussions from this chapter will be gleaned from and explored in further depth at relevant points during the dissemination of findings within Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Six, 'Social Work Values and the Ideologies of Health', of this thesis.

Chapter Five
The Everyday Lived Experience of Health Social Workers in Queensland

Introduction

> *So, as a Social Worker I use a lot of my referral sort-of knowledge base that I've developed over the years. And also, I think just the assessment skills are a lot more finely tuned—I think as a Social Worker. So I think now I can take a more holistic approach to picture of what's happening to that person. One of the key things that we look for also, in the assessment is—social supports. And then if they don't have a lot of social support, in terms of quitting, look at providing referrals for social support. Because, if they don't have social support, there's often a lot of other socio-economic issues happening as well. Anne*

The participant's quote above is supplied to provide a snapshot of what is explored in this chapter: the everyday role of a social worker in health. This chapter will provide participant views on what constitutes their professional social work identity in exploring their application of the triad of social work knowledge, theories, and practice/skills to their practice. This chapter will discuss how the participant's everyday experience of the social work triad contributes to their social construction of their social work professional identity. This is the effort to demonstrate uniqueness of lived experience and the social construction of reality for the participants. The first section of this chapter will provide discussion on Friedson's (2001) view of application of knowledge and theory to practice. Friedson's (2001) understandings were drawn on during the data analysis phase of this research and provided insights in line with the participants' stories of how the everyday of knowledge and theory are integrated into practice. The purpose of providing his view is to establish an understanding of this process purely for interpretive direction. It is important to note that this study found social work values were integral to the process of developing knowledge and theory and then applying it to practice. Therefore, the theme of social work values is identified and explored in greater depth within Chapter Six, 'Social Work Values and the Ideologies of Health'. The final three sections of this chapter will extricate the concepts of

social work knowledge and theory and explore how the participants translate this into social work health practice in Queensland. In line with the interpretive constructivist research paradigm employed in this research, this chapter will interpose an interpretive presentation of the data alongside a constructivist discussion of findings.

Relationships as the everyday social work knowledge in health

> *The success we feel is when a patient has been able to go out into the community and with a social set that helps them to rehabilitate, and to not have to come back into the hospital system again. Some people come back, they call them 'frequent flyers' because they have such a lonely life out there, they develop illnesses through their loneliness. Jane*

Jane's discussion of her belief that illness is developed through the concept of loneliness was one of the initial interviews where the significance of relationships in social work was highlighted.

In articulating the knowledge underpinning daily tasks associated with the scope of their roles, participants often discussed their focus on interpreting patients' and clients' health issues from a relationships perspective. The participants articulated relationships knowledge as a clinical component of their work, as part of the social perspective they draw on, and discussed the difficulties they experienced in asserting a relationships focus.

In his book *Professionalism: the third logic*, Eliot Freidson (2001) provides his understanding of the term *everyday knowledge.* He explains that *everyday knowledge* is the type of knowledge an individual must possess '… in order to perform the everyday tasks of daily life from the knowledge and skill needed only by those who work at particular jobs and occupations' (2001, p. 28). This definition is interpreted as the everyday knowledge in social work practice is linked to a general accumulation of insights, gained through experience and intrinsic wisdom (Drury Hudson 1997). This is knowledge that is acquired through the lifespan of intersubjective interaction with various informal and formal institutions such as family and schooling (Berger & Luckmann 1966). Freidson (2001, p. 33) proposes that this everyday knowledge is the foundation for acquiring formal knowledge for endeavours such as employment. The importance in interpreting everyday knowledge lies in its intrinsic

nature. This situates the participants' interpretation of their inherent knowledge base as not only that of the social work profession, but innately that of their own. This ensures a more holistic appreciation of the participants' unique lived experiences of social work identity construction.

As explained by Payne (2014), the concepts of knowledge and theory are different but interconnected in social work practice. For social work, this is best understood in the example of interpreting knowledge of social issues through a lens of relevant social theory. Freidson (2001, p. 29) terms this formal knowledge; he explains it is abstract in nature and is institutionalised into a specific discipline for use, as part of their everyday knowledge.

The word 'clinical'

The word *clinical* arose on numerous occasions within the analysis of the data that focussed on these daily tasks. For Australian social work, the word clinical is often associated with social workers who possess AMHSW accreditation and undertake social work roles primarily in mental health settings (Martin 2013). It is noted, however, that AMHSW accreditation does not constitute formal registration within Australia. The social work profession in Australia is excluded from formal health registration with the National Registration and Accreditation Scheme (NRAS). The NRAS was established in 2010, and is an Australian government authority, tasked with the regulation of qualifications, standards and practice for health practitioners (AASW 2014c). The AASW has been lobbying to have the profession of social work included within the list of professions that are formally registered within the health sector by NRAS. Their attempts have not been successful to date. This rejection from formal registration could be considered in applying Willis' (1989) concept of 'exclusion'—where the hegemony of medicine excludes particular health disciplines from formal registration for the purpose of protecting and preserving their domination of class, status and overall ideological foundations (Willis 1989, p. 162–3). The influence and impact this has on the construction of the participants' professional social work identities is explored further within the next chapter.

During the 1970s, United States social workers working in health-related roles advocated for their role to be considered as 'clinical', in order to achieve the status of formal registration

as the sub-field for health social work (Berzoff & Drisko 2015). Berzoff and Drisko (2015, p. 263) provide the following definition of clinical social work in the United States:

> Clinical social work is oriented by the profession's unique person-in-situation paradigm and integrates the psychological and the social worlds of clients in order to foster human growth and change. It is practiced through relationships with knowledgeable, value-oriented, skilled and well-educated professionals.

Information regarding the AASW's definition of clinical social work is often embedded in applications for AMHSW accreditation or the AASW Mental Health Practice Standards (2014). The AASW (2016) assert within the AMHSW accreditation application that the primary means of demonstrating clinical social work practice is for the purpose of aligning these to Medicare's Focussed Psychological Strategies (FPS). In essence, the focus of aligning with these strategies seems to be key in becoming accredited as an AMHSW and receive recognition for practising 'clinical' social work. As it is outlined within Chapter Two, 'The Background of Health Social Work', it is not a requirement for social workers working in Queensland hospitals or community settings to possess AMHSW accreditation. It is only considered advantageous when a social worker is embarking on private practice endeavours to gain access to bulkbilling services through Medicare's FPS.

For the participants, the word *clinical* had a varied application. Most significant was their attribution of the word to describe either a practice task, descriptor of their role, or in description of the various health settings in which they are employed. One participant provides an example of how the word clinical overviews the process of a daily task as well as a descriptor of mental health position of employment title:

> *Basically, at the moment management, but also supervision, and clinical review of the mental health clinicians in the team. Leanne*

Further, it was often attributed to describing the type of settings where the participants were employed:

> *And then I think just the actual design of the 'acute rooms' that is very de-humanising for people ... but that's natural I guess. There's some aggressive people who come in saying they don't know why there's not lovely bits of furniture and paintings around the walls—yeah it makes it very clinical, very stark … Anne*

The difference in disclosing experiences of the word clinical between Leanne and Anne could be considered using Goffman's (1956) frontstage/backstage theory. Leanne's exposition of her role and tasks as a social worker entailed position-specific language. Leanne provided this answer as a result of being asked about her role early within the research interview. Goffman (1956, p. 1) explains that upon first interactions, individuals will seek out the relevant information about the other, ensuring they enter the dialogue in a socially appropriate way. This entails acquiring information regarding the others 'socio-economic status, his [sic] conception of self, attitude toward them, his competence, his trustworthiness, etc.' (Goffman 1956, p. 1). In the instance of the researcher and participant relationship, participants are often in a position of perceived less power than the researcher (Charmaz 2006). Therefore, perhaps they felt vulnerable to the ambiguous nature of the semi-structured interview style I employed. This is often due to a conception that a researcher is a well-informed and insightful individual, who seeks to question a participant about the researcher's area of authority (Rubin & Rubin 2005). Therefore it could be interpreted that in the instance of Leanne's response, she was in the process of gauging her audience (myself) and provided a frontstage explanation of her social work role and its clinical function. This explanation could be considered to be consistent with Leanne's exposition of herself as a social worker partaking in clinical practices. Perhaps in her health employment, this exposition of herself is what Goffman (1956, p. 17) would explain as an established role, which is often provided by the social context. In viewing Leanne as the actor, and the health system as the social context, it could be understood that Leanne has been provided with an established *clinical* role. This acquisition by the actor is described by Goffman (1956, p. 17) as an actor's primary motivation to perform the tasks set by the social context in order to maintain the desired frontstage exposition of self.

In Anne's discussion, the word clinical arose much later in her interview. Anne expresses her experience with what she deems clinical settings as dehumanising. By this point in her interview, Anne and I had already uncovered the frontstage representation of her social work identity. This presentation mirrored the portrayal of competence and professionalism seen in Leanne's response above. Through the interviewing process, we had become familiar with each other's styles of communication and had developed a rapport accordingly. In the interviews, I assumed a position of reflexivity. This was often in the hope

of developing a sense of shared meaning and purpose with the participants. I felt as though I authentically presented myself as a curious learner and acknowledged the participant as the expert on their experience. I felt strongly regarding the undertaking of this position, as, to me, it shared congruence with an emancipatory social work approach to research (Volter 2008). Goffman (1956, p. 70) explains that in these mutual and trusting types of rapports, the participant (Anne) affords herself the opportunity to relax and drop the frontstage presentation by forgoing her lines and stepping out of character. In summarising, it appeared Anne was comfortable at this point to share her true feelings regarding clinical settings. And that this was perhaps a backstage representation of her social work identity.

Jacinta provided a rationale for imparting a clinical approach to social work students she supervises within the health organisation where she is employed:

> *I always make my students have clinical experiences with other disciplines because we know ourselves as much by what we don't do as what we do do. Jacinta*

Interestingly, Jacinta uses the word 'make' in her statement. Whilst I am not sure of Jacinta's understanding of the relationship between power and discourse, or if lack of more power-with terminology was not accessible to her, for whatever reason during the interview, I interpret this word as a potential of connoting a stance of power-over. This interpretation was gleaned from interpreting the power of control embedded within medical discourse. This is where medical doctors are believed to shape the norms regarding social interaction through their application of top-down styles of discourse (Waitzkin 1989, p. 225). Leanne, another participant, explained how she views the role of discourse in the health setting she is employed in:

> *… there is usually someone up there that tells people down there what to do and I think it's very similar in the medical model we need even on the treatment basis. Leanne*

Whilst the overall approach to this research is interpretive, the need to understand the function of language and the meanings it embeds was considered. This is due to its implicit role in shaping the social work identity and could be considered relevant to Jacinta and

Leanne's construction of self. Heidegger (cited in Stassen 2003, p. 267) explains 'Man [sic] acts as though he were the shaper and master of language, while in fact language remains the master of man'. This statement provides consideration of how power relations construct the power in language and how it applies to an individual's construction of self. Therefore, the means in which I have interpreted this is through the lens of a Foucaldian discourse analysis from ideas represented in Michel Foucault's (1976) famous work *The birth of the clinic*. Foucault's (1976) work is drawn on here for its significance in content knowledge and as a practical tool for analysis of discourse. Foucault (1976) imparts the mechanism of discourse in first establishing, and then maintaining, power relationships embedded within health systems through the concept he coined as 'the medical gaze'. This concept asserts that knowledge is to power as medicine is to healing, which results in medicine's sovereign over the healing of the human body. A key author on the topic of discourse and how it relates to this belief is Ivan Illich, who states '[s]ociety has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people' (1976, p. 5). Similarly, Willis (1989) proposes the concept of medical dominance, with a facet of this theory possessing the stance that discourse shapes the belief that medicine is the primary means upon which healing is based. In shared views, Foucault (1976), Illich (1976) and Willis (1989) are signifying the reliance on discourse that articulates the position of medical doctors as infallible healers of the human body. In understanding how this discourse then goes on to shape the presentation of relationships between those who access health services and those who provide them, Goffman (1956, p. 4) suggests '… the specialist often maintains an image of disinterested involvement in the problem of the client, while the client responds with a show of respect for the competence and integrity of the specialist'.

In terms of this relating to a social process constructing reality, the potential of this representing power-over discourse permeates not only the ideology of healing, but also socially constructs the operation of the health apparatus (Germov 2013). With this correlation in mind, it is a widely held view of those who critically explore health system operation, that dogmatic chains of command are part and parcel of health hierarchy (Turner 1995), where it is believed the inherent stance of social work is that of power-with in views on leadership (Gilbert & Powell 2010). This then fosters a belief of duality in professional

relationships and employing principles of distributed leadership among team members (Lawler & Bilson 2010). It is evident that differences in how these contrasting views are established is from discourse used and how it frames the discursive naming, describing and undertaking of health service delivery.

The discourse used by Jacinta demonstrates a process in which the social work students she supervises are socialised to the health systems belief of hierarchy. This is when they are *made* to develop knowledge of 'clinical' tasks. It was identified in a recent report (Clarke, Ellis & Tully 2015) that students often reciprocate this position by expressing they feel at the bottom of the hierarchical food chain in health settings. Student social workers are known to be placed in a position of limited agency and are often in a subordinate position to their social work supervisor (Dove & Skinner 2011)—who are, in turn, usually in a subordinate position within the hierarchy of health (Willis 1989). This is an interesting consideration in terms of establishing preliminary socialisation of social workers into the health context.

Throughout the interviews, a clear understanding in terms of definition of the word clinical was not reached by both participants and researcher. It is noted that the word clinical has a varied application in terms of its definition. This was particularly apparent in this research. It is reflected that in the realm of social work in Australia, it has perhaps become an add-on in identity dialogue for the purpose of legitimising the social work identity. Therefore, Berger and Luckmann's (1966, p. 72) concept of *Institutionalisation* has been ascribed to the participants' application of the word *clinical* to their identity. In applying this concept, I have interpreted the everyday use of this discourse as a social process in which the participants of this study shape their everyday knowledge and transfer of this to tasks. Berger and Luckmann (1966, p 72) explain this process to be a habitualised action, achieved in reciprocal typification among a group in order for social capital to control human conduct. Interestingly, it is evident throughout participants' interviews that I repeated this word on more occasions than the participants. I reflected in memoing my position in legitimising the word 'clinical' alongside participants and how this was established through the process of reciprocity (see in Appendix I). It was within this memo that I conceptualised the process of institutionalisation and how the process may be involved in the identity construction of social workers.

Social work and social issues

In revisiting Jacinta's statement, it appears she also highlights the significance of educating students on the boundaries of health roles held by different disciplines. Jacinta explains this further in her interview:

> *… occupational therapy focus on functional aspects, cognitive and physical ability to interact with the environment whereas social work look at the interpersonal and relational aspects. Jacinta*

Freidson (2001, p. 36–7) proposes that an activity can only be defined as *specialised* when put in context in relation to something else. This is mirrored by Jacinta's belief that in understanding other disciplines' roles, this will help shape the knowledge of a social work role. This is interesting in terms of participants' use of applying the specific word of clinical, given the overwhelming stance of the relevant literature, reporting social work identity as presenting an unclear image (McMichael 2000). As a template to interpret participants' reports of their knowledge base and how this relates to the word clinical, Berzoff and Drisko (2015) have been drawn on. The authors provide a summary of the knowledge base that informs social work *clinical* approaches in health settings:

> The knowledge base of clinical social work includes professional ethics and values, biopsychosocial development, psychopathology, interpersonal relationships, environmental determinants, clinical methods, prevention and resilience, cultural and racial awareness, attention to socially structured oppression, strengths and practice research. (Berzoff & Drisko 2015, p. 264)

This knowledge base is best described as broad, and encapsulates biological, psychological and social bases. Whilst most of these were identified as knowledge they had drawn on, the understanding and application of knowledge relating to *interpersonal relationships* was signified as a key feature of social work practice in health for the participants. This seems logical, as *5.2 Working collaboratively with relevant people* of the AASW *Practice standards* (2013) highlights the significance of employing knowledge of interpersonal relationships to social work practice tasks. Participants often explained the use of this knowledge in addressing issues of micro to macro significance; from patients' experiencing relationship discord, to addressing issues of patient relations with welfare agencies and wider society. This often coincided with a belief of systemic and structural oppressions, in which the participants felt it was their role as a social worker to address matters of equality and

equity. This is obviously significant due to its relationship to the AASW's *Code of ethics* identification of these principles underpinning the social work core value of social justice (AASW 2010). Therefore this will be unpacked in greater depth later within Chapter Six, 'Social Work Values and the Ideologies of Health', when the concept of social work values is discussed. The significance of possessing interpersonal relationships knowledge was highlighted by a participant, who termed 'relationships' as an identifying feature of social work everydayness:

> *… we, we work with the social issues, I mean there's a legal person, there's a physical person, there's all these people but I see social work as the ground work … relationships, it's what we do on a day to day basis and that's why actually I think social work informs many other disciplines if they will just accept that we can do that. Leanne*

When Leanne was prompted to explain her statement of 'if they will just accept that we can do that', she replied:

> *I don't think they [other health disciplines and the health system][1] see social work as something that can make a difference … I'm just wondering is there enough being done during training to give social workers that, that sense that they know what their worth are. So social workers see themselves as, as valuable … Leanne*

These remarks by Leanne and Jacinta demonstrates their sovereign over 'relationships' as the everydayness of social work knowledge base and is relatable to Heidegger's concept of Mineness (1927, p. 78). As it is outlined and defined within Chapter 4 of this dissertation, Mineness denotes Dasein's exposition of an individual's sense of self. Heidegger signifies the challenges to Mineness by Dasein's Being-in-the-world, which renders feeling either authenticity or inauthenticity as a result of situating Dasein in context.

[1] This was the context in which Leanne and I were discussing this theme within her research interview.

The cost of being a rebel

Within the previous discussion, Leanne identified her belief that knowledge of relationships is integral to everyday social work practice in health settings. She expresses, however, that weaving this element of herself into her social work role is not received by other health professions or the health system as valuable. When Leanne was prompted to discuss the impacts these types of issues had on her social work identity construction in health, she replied:

> *I think I was always a bit of a rebel. I couldn't do [it], so in the end it affected me as a person. I couldn't let go of my personal and professional values. So at some point when I, I just couldn't do it anymore I had to move on, and hopefully find a better [one]. A better place where I can work, but that's difficult sometimes for a social worker to find a place where you feel you can be who you are. Leanne*

It could be interpreted that the dissonance between Leanne's view and the view of other health disciplines and the health system has potential in contributing to Leanne's rejection of outside influence on her identity construction. Perhaps in Leanne's choice to be a 'bit of a rebel', she has defended her Mineness of relationships knowledge, but interprets this exposition of her Being-in-the-world as problematic in constructing and maintaining an authentic social work identity. The fact that Leanne is faced with employment instability due to advocating for her identity is troubling. Leanne explained that her ability to 'be a rebel' was not always achievable in terms of her past history of being a social worker. In this, Leanne described instances in which being a rebel proved too difficult, and she had to 'conform' to the views of other health professionals and the overall health system:

> *A lot of that was sometimes stifled in some work places. Where you had to conform. Leanne*

Of most concern, Leanne's overall health was affected:

> *I became quite burnt out. Because I cared a lot for the group of clients I worked with and I had to work against constant resistance so over time and under that kind of stress and pressure I did get quite burnt out so, um,*

it was really a tough time. Physically, I mean even my health was affected. Leanne

Jane, another participant, disclosed her experience when discussing a similar situation within her interview:

It's made me 'sick'—to be honest. Jane

Sharon, another participant of this study providers her experience of feeling a similar sense of being devalued, but explains her attempt to mitigate this with her knowledge of relationships:

Definitely occasions where you know you don't feel valued and you don't feel involved and you've really got to fight for that. But I think you know I've been at the [names employing organisation] eight years now so I've been able to develop relationships where I think people do value myself and my profession. Sharon

Sharon explains her experience in using relationships knowledge to impart her value to her medical colleagues. Previous studies have found that in the relationships social workers build with medical colleagues there is often an underlying value expense (Yip 2004; Yalli & Cooper 2008). This is explained by McMichael (2000, p. 177) who suggests social workers who possess status are usually engaged in an ongoing venture of 'proving' themselves, much in line with Goffman's (1956) belief of an actor tirelessly assuming an established frontstage role designated for them by the audience and entity that directs the presentation. This could be perceived as a tiring process, in which social workers such as Leanne describe experiences of burn out[2]. Or perhaps, in receiving status, part of what underpins this relationship building with other health professionals is potential for compliance with the dominant health ideologies.

[2] The concept of 'burn out' is believed to be a process in which a worker's physical and emotional wellbeing is impacted as a result of high physical and emotional job-related stressors (Freudenberger 1974)

Systems thinking

> Eventually, everything connects—people, ideas, objects. Charles Eames (Bizios 1998, p. 494)

The discussion in the previous section on relationships and knowledge was found to strongly influence the type of theory utilised by the participants within their practice context. The origin of relationships knowledge in social work can be located in the theoretical underpinnings of systems theory (Payne 2014). It is difficult to provide one all-encompassing definition of systems theory in social work. This is likely due to its wide and varied philosophical, theoretical and practice base applications (Forder 1976). A pertinent summary of systems theory for application to this chapter is provided by Payne (2014) who contends that:

> The main contribution of systems and ecological ideas to social work is to integrate interpersonal interventions involving individuals with interventions that also engage with families, communities and other social agencies. This is done through a focus on how social and personal factors interact, helping people to adapt their social environment and their reactions to it so that they can live more harmoniously (Payne 2014, p. 184).

Psychosocial focus

When discussing everyday practice, Rita, one of the participants, explained her use of social work theory as a 'respect approach':

> *I think it's more a respect approach—I do tend to look more around housing, relationships and all the other aspects as opposed to looking at it more from a medical perspective, or just managing the symptoms. Rita*

This could be relatable to Rita's value base, which Chenoweth and McAuliffe (2015, p. 65) explain to be a significant influence on social work practice. The medical perspective is also identified within Rita's statement as she explains that she feels her approach encompasses perspectives such as relationships and housing issues, which could be considered as a social perspective. It is interesting that throughout Rita's interview, she makes reference to the difference in her approach and that of her medical colleagues. In this, Rita explains that in treatment of patients, she respects the necessity of the medical perspective, but feels her social perspective is equally as important:

So, if they have a life event, or something happens, and they feel that the symptoms are starting to come back, all they need to do is ring up for an appointment because they're already known to me. They already know me. So, they just book an appointment and come back. They might only need one (1) more session and then they're fine again, because they've just had someone that-they can talk to. So that prevents the symptoms getting any worse, when you might need to go back on medication, or anything like that. Rita

In likeness to Rita's understanding of systems theory, the AASW (2015c) propose that the scope of Australian health social work interprets systems thinking as the interface between an individual and their environment. This relation is explored so as to consider the impact of economic, social and cultural factors on the health and wellbeing of individuals, families and communities accessing health services (AASW 2015c). The AASW (2015c) asserts this particular application of systemic thinking as providing the basis for psychosocial theory, the key contribution of health social workers in Australia.

Another of the participants provides her experience of utilising psychosocial theory and how this draws on her knowledge of relationships:

… we tend to be looking at the psychosocial side of people's lives and, also advocating for perhaps not that it needs … ECT[3] yet. You know … maybe we can just hold off on that one and, we can look at seeing how the particular relationship they're in pans out and, are they going to have the strength to deal with the issues and that before we throw them into ECT … Anne

[3] To provide defining context to Anne's above statement, ECT is an acronym for a procedure called Electroconvulsive Therapy. Beyond Blue (2016) describes ECT as a procedure utilised in treating certain psychiatric disorders. The procedure involves passing controlled amounts of electric current through the brain in order to affect brain activity. This is aimed at relieving severe depressive and psychotic symptoms. Historically, ECT has been a controversial procedure and is still often critically received in both the professional and public domains (Kellner 2011). Whilst controlled and evidence-based as possessing a high success rate, its critical reception is likely due to the procedure being known as intrusive and posing risk of memory loss (Fritz 2014).

Anne's approach demonstrates her priority in viewing her patients' relationship difficulties through a psychosocial lens. Perhaps in Anne's view, the psychosocial factor of relationships was impacting the patients' capacity to engage in healing or recovery practices to minimise symptoms of mental ill-health. Beddoe and Deeney (2012, p. 1) explain that the psychosocial approach in health social work practice often incorporates social, psychological, spiritual, cultural and ecological factors, which promote holistic care. When considering this in the specialised area of mental health, this holistic treatment focus is known to be a key aspect of a social work approach which adopts a framework of addressing the social consequences of mental ill health (Bland, Renouf & Tullgren 2009). In her statement above, Anne attributes this to a focus on developing the patient's strength in socially addressing the health issue with which they have presented. Anne demonstrates an everyday experience in advocating for a less physically intrusive social approach to be considered in contrast to a medical approach that may pose risks for her patient. As it was seen in Leanne's discussion on relationships within the previous section of this chapter, relationships are a key feature of social work knowledge in intervention activities. In likeness to the discussion on Leanne's experience, it could be interpreted that Anne demonstrates Heidegger's concept of Mineness in social work identity of relationships knowledge. Further, it could be considered that this is a backstage exposition of Anne's identity as it shares congruence with an inherent social work position as highlighted in the literature below.

The AASW (2015c) outlines the underpinning theoretical base and purpose of psychosocial intervention:

> Social workers bring specific skills and knowledge to an assessment process including considering a person's psychological wellbeing and social context. By understanding the impact of these factors social workers can then identify and develop interventions in order to improve wellbeing and functioning. This includes problems and strengths in social role functioning; in meeting financial and other basic needs; in family interactions, significant relationships and other social supports, and cultural factors. (AASW 2015c, p. 3)

It is evident that Anne and the AASW (2015), share the same endeavour of improving patient social functioning in developing strengths and accessing social supports. Again, the premise of relationships knowledge appears to be rooted in application of psychosocial theory. This is supported by Berzoff and Drisko's (2015) understanding of theories in clinical social work:

> Clinical social work draws upon multiple theories of human development, including psychodynamic theories, social interaction and intervention as well as drawing on critical thinking and biological knowledge. In practice, clinical social work also draws upon several types of empirical research knowledge. (Berzoff & Drisko 2015, p. 263)

Jane, one of the participants, explained her use of therapeutic techniques to deliver pain and stress management to patients who had experienced strokes:

> *I worked in another area- which was [named organisation where she was employed] I was doing pain management which I loved and I was doing stress management and working with people before the Physiotherapist took them into their therapy room so that they'd be fine. They'd have the visualisation of themselves walking. Jane*

Although considered an alternative healing approach, creative visualisation techniques are gaining significant respect in the relevant evidence base worldwide (Allen & Spitzer 2016). In conceptualising this as an intervention for patients, it is clear in Jane's explanation that she may draw on an approach that requires an organic understanding of the body and brain and its relationship to stress (Zittell, Lawrence, Wodarski 2002). This can be linked to Berzoff and Drisko's (2015) assertion of what encompasses a clinical approach.

Social work, in the name of it

Jane went on to explain that the roles she has undertaken in the health settings where she has been employed have been social work specific. She also explained the changes that occurred when her position moved from one practice area to another, with the same health employer:

> *It's specific social work … in the name of it, but it's not specific social work, the work that you do is not social work. I mean, I've got my Mental Health accreditation; I use none of that. I can't use any of [it]—the patients that have any mental health issues- they're referred to the mental health section ... so, they come up to see that patient. So, all that's really left for- the social worker to do, and what they've become accustomed to, is to expect that the social worker does 'accommodation' and 'travel'. Jane*

Jane states that she has AMHSW accreditation, but feels she cannot utilise this in her employment context. Accommodation and travel is often an administration task undertaken by social workers in ensuring patients and their families have access to hospital facilities (Cleak & Turczynski 2014, p. 205). Jane was prompted to explain how this made her feel about her social work professional identity:

> *Devalued! And, they [the staff in her new practice context] see this as my role there. And, that's developed over time… there is not a recognition of social work within [the new practice context] that has any value. Jane*

Jane discussed later in the interview that she felt as though she was fulfilled in her social work role in her previous practice context, whereas she felt she was not utilising specific social work theory in her new social work role. This is despite Jane being employed in a social work specific position in both of these roles. This is clearly where matters of context arise, and how these subsequently shape the social work theory and knowledge utilised as a result.

In terms of Jane's reality of existence in these two contexts, it could be considered that Jane has experienced similar to what Heidegger (1927, p. 74) explains as *throwness* in to a *there*. Heidegger (1927) uses this to explain Dasein's emergence and an occupancy of Being primordially. Heidegger (1927) explains this as:

> The characteristic of Dasein's Being-this 'that it is'-is veiled in its "whence" and "whither", yet disclosed in itself all the more unveiledly; we call it the "throwness" of this entity into its "there"; indeed, it is thrown in such a way that, as Being-in-the-world, it is the "there". (Heidegger 1927, p. 174)

Heidegger (1927) explains that human beings come into *Being* without choice, which is the *throwness* and that the circumstances they are born into constitute the *there.* However, I have applied this concept in considering the temporality of Jane's employment transitions. Whereby Jane's sense of *Being* in her previous practice context, takes on a new reality in the context of her new social work role. The difficulty arises in applying one perceived reality to the next. In this case, it is the transition of Jane's social work theoretical knowledge, and how she finds these to exist differently in the two health contexts of her everyday lived experience. I find this concept relatable in terms of explaining a transition of *Dasein's* reality to another experience of Being-in-the-world. Whilst Jane may have had choice (this aspect

remains unknown) with regards to transitioning from one context to the other, she concedes the difficulty in the perceived social work role in this new context. She goes on to explain that whilst she feels devalued in this role, it was established and already *there*. This state-of-mind is explained by Heidegger (1927, p. 174) as '[t]he "that it is and has to be" which is disclosed in Dasein's state-of-mind …' In analysis of the dissonance in Jane's new reality of *there* it is imperative to explore her perceived practice fit between both of these roles. It could be viewed that Jane's sense of fulfilment in undertaking her work in her previous social work role related to what she felt was utilising theory in her every day practice that aligned with her backstage and authentic sense of identity as a professional social worker. This is evident in Jane's assertion that she was not using her social work training in her new social work role. Utilising Goffman's (1956) frontstage/backstage theory, it could be understood that Jane is assuming the frontstage position of the actor, playing out the new practice contexts' established role for her. This represents the challenge of Jane's resistance to this reality. Berger and Luckmann (1966, p. 74) explain that in a social structures typification of an individual role, the individual's reciprocity of this role habitualises it in the process of institutionalisation. Jane identified that the social work role she had transitioned into had 'developed over time'. Perhaps as Berger and Luckmann (1966, p. 194) propose, it could be considered Jane is in the dialectic of her perceived subjective reality and its intersection with the new practice context. Both experiences constitute Jane's reality. However, it has been delineated in this analysis that in terms of her theoretical application, her experience in her previous role could be considered her preferred authentic identity. In terms of how this affects social work identity construction, I [I] asked Jane [J] to explain what she felt the impact was for her social work identity to be situated in this dialect:

> *I: Ok ... Do you feel that this medical model influences your identity at all?*
>
> *J: Nothing will influence my identity. But, I find it difficult to work with-work within. It's made me 'sick' —to be honest. Jane*

After discussing what Jane felt was her consequent sickness as a result of the difficulties in maintaining her social work identity, she was asked her to explain the process in which she resists outside influences on her social work identity:

> *I: Yeah ... So, what happens when you know this model influences, or it tries to influence, and you say you'll go against it, and nothing will influence you—what happens in those times?*
>
> *J: Well, you just feel 'dull' … and I feel as if a lot of social workers may not- they might just- and I've known it- I've seen it and never said anything to them, but I can identify people who have thought—'well, this is it'. Jane*

Knowledge and theory in practice

Initially, participants disclosed various experiences related to a more generalised identity construction. When using the term 'generalised', it is understood that these are the experiences they reported of professional identity construction without discussing the ubiquitous contextual or wider socio-political influences in which they are employed. Participants reported that they draw on a wide range of values, skills and knowledge which they have acquired from personal and professional life experiences, relating to tertiary education as well as general social work formal and informal postgraduate experiences such as further higher education, social work supervision and professional development activities. One of the participants, Sally, explains that in acquisition of her mental health accreditation with the AASW, she felt she has achieved a '… unique niche …'.

The act of transferring knowledge and theory into everyday social work practice is deeply entwined in the profession's signature pedagogy. Ledger (2017, p. 64) explains signature pedagogy as the '… habitual and pervasive way in which a profession teaches and socialises students in preparation for practice'. It is considered internationally, across varied realms of social work education, that the key feature of the signature pedagogy for social work surrounds the concept of 'walking the talk' (Boitel & Fromm 2014). This refers to a social worker's demonstrated competence in transferring their knowledge and theory to the application of every day social work practice. The development of this competence is said to

evolve during the course of tertiary social work education, where student social workers are required to undertake sanctioned field education placements. Students on placement experience a transformative experience, where they learn to be reflexive in the acquisition of new theory, knowledge and skills. This is achieved through the unique student and supervisor relationship, fostering the student's kinaesthetic application of learning in a real world experience of participating as a provider of social work services (Beddoe & Maidment 2009). Larrison and Korr (2013, p. 194) explain that this competence is achieved through the professions '… integration of practitioner knowledge, performative action, and awareness that emphasises the development of the professional self'. Freidson (2001, p. 33) suggests that a profession's ability to distinguish what formalises their skill and knowledge base establishes control, sovereignty and ownership over the bounds of their specialisation. Freidson (2001, p 33) further suggests that skill development is resultant of knowledge and theory employed in achieving a task. In the case of social work, this could be identified as the profession's ever evolving reflection of new learning and reflexive application thereof.

Task-centred practice

In considering the participants' application of knowledge and theory to practice within the context of health, they often described practice tasks that required everyday knowledge of relationships, alongside their social work lens of systemic thinking. Participants explained that everyday tasks were often underpinned by the daily aim of planning discharge of patients from health services. They reported that this process was undertaken alongside their medical and multidisciplinary teams. The participants explained that planning discharge is achieved in undertaking psychosocial assessments, facilitating family meetings and case management that encompassed communication tasks such as interviewing and assessing:

> *So, from the moment that the patient comes to our ward- I do a comprehensive 'psychosocial' assessment which means that if the patient doesn't have any 'delirium'—or, they can communicate, I do an interview—I interview them and speak to the family. And, this is the networks around them whether they be friends, or service providers who had been involved with them—who are involved with them prior to*

admission—so that I can get a true picture of what's happening at home and how they function in the community. Barbara.

This is congruent with what the relevant literature considers as the typical everyday practice of social workers employed within health settings (Cleak & Turczynski 2014; Yalli & Cooper 2008; Zittel, Lawrence & Wodarski 2002).

One of the participants reported that her daily social work practice was aimed at assisting patients and their families in navigating the health system:

The family meetings, its work with families. It's a good role in that- when someone's discharged, you can make sure you can, well, you can do your best so that patient doesn't 're-admit'. And they have family supporting them, and then you look at all the social network that they need of the people and the organisations to assist them in their rehabilitation into the community once they've been discharged. Jane

The AASW (2016) affirms that the role of the health social worker in Australia is to assist individuals and their families accessing health services. The AASW (2016, p. 3) clarifies that this is aimed at minimising 'the negative impacts of illness and hospitalisation'. Jane further reflects on this in her explanation of what she feels is the purpose of undertaking everyday social work practice:

Our role, I feel ... is to assist people—their well-being, to empower them, to be able to cope but gently, because when you've had a shock, like a 'stroke', or an accident, it's just not empowering in saying—'I'll leave you … you can do this … you can do that'. It is actually guiding people through, and their family, so that they can function to assist this person to get back and function as well as they can with their new situation within the community; within the family and the community." Jane

This relationship between the AASW and the participants' assertion of the social work role in health appears congruent. Although, whilst congruent with the AASW surrounding knowledge and theory, the process of integrating this in to their everyday social work practice was conceded by participants as problematic.They expressed the feeling that these

were not valued within the health system. In light of this, it was considered if there were any barriers for participants enacting what they felt was the transfer of knowledge and theory into their everyday social work practice. One of the most significant impacts of this was described by participants as the urgency of discharge of their patients from the health services where they are employed. The requirement of being a task-centred practitioner was highlighted by the participants. They explained the necessity of assigning this to their practice approach due to the fast pace of the health system:

> *Because, it is short, sharp assessments … and it's just- it's cut and thrust .. It's just basically a numbers game. You're just churning people through ... Look at them- tick, tick, tick, ask a few questions and then make a decision. Anne*

Another participant, Catherine, explains feeling as though she is situated within the competing demand of discharging patients from the service quickly and, at the same time, ensuring a thorough treatment:

> *Well I mean I guess in our systems, you know, there's kind of this idea that we get a referral and at the same time as there being a pressure to do something with, I mean I work in a [names organisation where she is employed] as well so there is a difference between the [names organisation where she is employed], you know my people aren't always strapped to a bed, you know they're out in the community living their lives so complications come with that but you know I just think we've got this pressure to get a referral, do something with it as quickly as possible. But then also there can be backlash that comes back to you when there's questions of saying well why didn't you do these things, why didn't you go down these paths, why didn't you explore more into fixing this person's situation when there's also the pressure of get it done, get them out, get rid of them. Catherine*

Ideal vs. reality of the social work role

Whilst the theme of neoliberalism within the following discussion will be outlined in greater depth within Chapter Six, 'Social Work Values and the Ideologies of Health', it is imperative

to highlight the significant challenge it poses to social work practice identified by Catherine in her above statement. The dichotomy outlined by Catherine identifies an ideal existence versus reality. Heidegger (1927, p. 371) explains that whilst both these co-exist and constitute an individual's *Being-in-the-world*, an individual is thwarted in situating these within an authentic experience of Dasein. The reality of health systems is that they are dependent on mechanistic operation, where the flow of patient/client admission and discharge is guided by policy and the set allocation of funding (Germov 2013). This renders the care and treatment of individuals who access health services to be viewed as an almost cost per unit consideration. This is due to the health systems requirement of functioning as per neoliberal ideology that encourages a focus on efficiency and productivity of services (Turner 1995). The difficulty in applying this reality to the ideal of proactive and less reactive treatment lies in the sheer complexity of the social lives of individuals accessing health services. Social workers employed in health services are tasked with the ideal of addressing a myriad of complex social situations that require a holistic and change-invoking treatment. The expectation is that social workers undertake this work ethically as set out by the AASW's Code of Ethics (2010) and within the guidelines of pertinent health policy, which spans across both public and private health sectors in Queensland (Queensland Health 2016). Both the AASW Code of ethics (2010) and pertinent health policy in Queensland specify a focus on accountability to the safety of those who access health services in the state. It is difficult to address the requirement of efficiency and productivity whilst synonymously being tasked with addressing complex social situations and ensuring accountability. Complex social situations require more time and attention to facilitate holistic changes for those accessing the services of the health system (Healy 2010). This expectation of the health system for social workers to be accountable, inform holistic change whilst pushing for efficiency and increased productivity could be considered an almost impossible venture in social work service delivery for the participants to achieve

Another participant, Jane [J], explains her experience of this difficulty in greater depth. She explains her frustration of working her way around being able to do what she feels is social work practice:

> *J: I've always worked my way around being able to do it. There was- there was just no recognition of it, no ability in [the health*

organisation she is employed]. In the [the health organisation she is employed], they've had patients who have asked for me to come and see them. Not because of me, only because they have needed a social worker who can do relaxation and stress management with them. And, you do that, there have been patients who have not slept for days—no matter what medication they've given them. The nurses would call me up and say— 'wow!. That lady slept during the day for eight (8) hours'. Jane

I: How does that make you feel when you get that feedback?

J: Probably a little frustrated that- that isn't set in place for all the patients. It only takes half-n-hour to do that—Probably a little bit longer, but, it makes me happy that patient has had some sleep and relief from her problem, but.. It does make me frustrated that there is the time-limit …-Jane

In applying Goffman's backstage/frontstage theory, Jane is clearly imparting her backstage experience of frustration with having to maintain the established role of problem-solver, in order to achieve the desired result for patients. In explaining her experience of this restriction on her ideal role, another participant explained her observation of how this ideal is achieved in the reality of the health system:

… so people fudge things. Jacinta

During the interview, I asked Jacinta to explain what she meant by the term 'fudge' and to explain what she had observed. Jacinta explained that she felt diagnosis was, at times, incorrectly entered into their client management system by other members of her team. Jacinta disclosed that she observed this was done to ensure continued adherence to KPIs (Key Performance Indicators) which in turn achieved continued funding of the organisation.

This could be perceived as a difficult situation for Jacinta, as it clearly poses an ethical dilemma for her in relation to safety, record keeping, accountability and integrity (AASW 2010). It could be considered that Jacinta's established role, alongside that of Jane's and Catherine's, is that of juggling various facets of expectations regarding health service

delivery: those of the health system policy, professional standards, and those of the self (McAuliffe 2014).

Reality: drain of 'self'

When considering the efforts to appease these competing demands, the drain of resources is considered. Social workers are considered their 'tool for practice'. This notion of social workers being their own tool for practice is entrenched in the conception of *use of self.* Chenoweth and McAuliffe (2015, p. 288) define the use of self in social work as utilising themselves as the main instrument of practice. They identify this by contrasting social work use of self to other professions, who utilise equipment or drugs as their instruments of practice. In applying this understanding to the experience of participants outlined above, it is considered their resource of self is drained in mitigating their own vision of their work versus that of the health systems. One participant, Jane, discussed this in her interview and summarised the impact this has had on her professional identity over time by stating 'You feel "used"'. This was also seen within previous sections of this chapter how a drain of the self can result in experiencing the feelings of devaluation and burn-out. In referring to social work literature, this consistent act of balancing competing demands on practising as a social worker is considered commonplace (Healy 2005). Therein, the expectation is that social workers are first mindful of this difficult conundrum, and second, that they expend resources in facilitating this in accordance with prioritisation of practice context, professional standards and self. Establishing a congruence between all of these has been socially constructed as the Holy Grail (Wiles 2005) of what could be interpreted as social work *Being*. Heidegger (1927, p. 375) defines this endeavour for congruence as the concept of *resoluteness;* he explains that this relates to an individual's comprehension of the meaning embedded within their words and actions and how this resonates in the truest sense of themselves. It could be critically understood that this strive for resoluteness is a contrived venture for the participants when applying an understanding of power.

Problem-solving

Interpreting these daily experiences of Catherine and Jane, their application of knowledge and theory to practice is considered as resultant of the longstanding social construct of social workers as 'problem solvers' in their endeavour to serve humanity (Ashford & LeCroy

1991; Fortune 1984; Oliver et al. 2012). In likeness, another participant Jane explains that her everyday work revolves around problem solving '…family or getting accommodation, or sorting Centrelink'. Serving humanity and practice frameworks deriving problem-solving approaches seem integral underpinnings of social work knowledge, theory and skill set and demonstrate the competence of a social work practitioner. Competence is interpreted in its relationship to the concept of power: power possessed by the participants and the power possessed by the health system—in this triangulation of views on power, it is concluded that the social work service of problem solving could be utilised *authoritatively* by the system of health in *manipulation* of the social work value base to maintain compliance with dominant health ideology.

For the participants, they identified the 'working around' health constraints as ensuring their dedication to professional and self-interests. However, it could be considered that they problem solve in compliance with the health system's neoliberal agenda. The terms manipulation and authoritatively are used deliberately above. Lukes' (2005) prominent work, *Power: a radical view,* provides definition, and my application of the concepts of *manipulation* and *authority* in interpreting power relationships identified in this section. This literature provides a content knowledge for undertaking analysis in interpreting the intricate means in which power is established and then maintained on an everyday basis within political, social and individual milieus. When interpreting power relationships, it is not as simple as declaring who or what asserts power over another. The intricacy of power is often unobservable, with modes of establishing and maintaining it cloaked either intentionally or unintentionally in a covert fashion. Lukes (2005) highlights these throughout his work, identifying three views of power and how each of these operates. He identifies the first as a pluralist focus on behaviour and method, whereby power is usually obtained through the mode of force (Lukes 2005, p. 16). The second view explores power exercised on a macro governmental level; in setting the agenda for decision-making endeavours, government utilises the mode of authority to reign overt or covert control over the means in which policy and legislation decisions are established and continue to be maintained (Lukes 2005, p. 20). The third and last view, which was added by Lukes (2005) as a revision of his previous works, is that of an ideological power. Lukes (2005, p. 26) explains that this last view suggests ideological power is ensued by exercising authority and manipulating socially and

culturally structured patterns of behaviours. The party attempting to establish power over another often undertakes this view with the hopes of not rousing conflict. Without the resistance of conflict, the oppressed party may be aware of the power over them, but are led to believe their compromise still serves their ideological view.

With regards to the conundrum faced by the participants, Lukes' (2005) third view provides the essential understanding that ideological power is dependent upon value. In the interest of this research, the view is applied that human praxis informs value drive; social workers develop their sense of value through their lived experiences. It is clear within the reported lived experience of the participants that their understanding of being a problem-solving practitioner is essential in their everyday practice. It is observable within their reports throughout previous sections of this chapter that this is derived from their value base. Whilst experiences of frustration for the participants arise, they continue to strive for ideological value congruence to practice endeavours. The proposed interpretation of this is that, in the meanwhile, this value strive is manipulated by the authority of the health system in order to maintain the political ideology of the health status quo.

Survival mindset

Later in the interview with participant Jane, she reflected on her observations of the social work profession as a collective and related this to her earlier outlined frustrations:

> *And, I really feel for social workers that go straight into the medical model, - into a Health-into a hospital- where maybe there's not that recognition of social work, we need to express that to the management. But- they're not using their social work skills, they're past that frustration and they just say—'this is it, this is the "job", I've got to do this, I've got to do that …' —and, social work is something that becomes a 'mindset' with them and may lose their identity. Jane*

It is interesting that Jane expresses a mindset that demonstrates a stage beyond frustration, a stage where the resistance wanes and helplessness takes place. The reality of this lived experience was then found to result in compliance with the ideals of the health system, for the purpose of survival:

> *… so that's why I can only say people who make policies and put procedures in place for whatever reason, I believe it's not always for the benefit of the client but it suits the organisation better for whatever reason so if you accept employment in that area that is how you will work … Otherwise, find other employment. Leanne*

It is clear that when the participants critically discuss their frustrating dialectic between realities versus ideals of practising as a social worker that they are in a position of perceived powerlessness. Lukes' (2005) second view of power is observable within this end result, as participants demonstrate insight of the conundrum they are situated in, but feel helpless to initiate change, as the agenda is set by the system in which this reality exists. Heidegger (1927, p. 172–9) uses the concept of *state-of-mind* to impart the function of the reality of everydayness through the experience of mood. He attributes this concept to a Dasein's internal process of presupposition in their experience of *Being-in-the-world* and how this relates to their background sense of belonging. Applying Goffman's (1956) frontstage/backstage theory, it could be interpreted that in the display of *practising* professional identity, the participants are in a consistent exposition of the problem-solver façade. However, they report their backstage experience of this as contrived due to feelings of frustration and helplessness for the purpose of survival. When considering this subjectively, it could be considered that the participants' experience of this over time habitualises a hindered sense of belonging within the health system. This leads to the health system's overall institutionalisation of participants with them feeling 'this is it, this is the job'; an almost ideological break down of the social work professional identity within Queensland.

Summary

The first section of this chapter provided an interpretation and analysis of the word 'clinical' and its application to social work knowledge. It was established that this word may represent a frontstage agency in which everyday reality of social work identities in health are constructed. It was also discovered that in terms of social construction, this word may influence the legitimacy of the social work knowledge base within the health context. With regards to social work knowledge of interpersonal relationships, it is evident that the

participants felt this is intrinsic to their everyday knowledge base—although it was expressed by the participants that they felt this knowledge is not valued by the health system. It is further evident that on the basis of employing social work knowledge in interpersonal relationships, challenge of a dialectic of authenticity and inauthenticity is embedded within the problematic reality of identity construction. It was found that the participants experienced a disconnect between terming their knowledge as clinical and what this represents in relation to their backstage desire of employing relationships knowledge in their everyday practice.

The participants' lived experience of how systems thinking and relationships knowledge informs their everyday use and application of psychosocial theory was explored. In considering the previous section on social work relationships knowledge, the problematic nature of incorporating everyday knowledge to formal knowledge was identified. It appears linear within the relationship between participant reports and relevant literature that knowledge of relationships is inherent in systems thinking and psychosocial theory. Interestingly, participants appeared to experience less difficulty in exposition of formal theory pertinent to social work identity, as opposed to the everyday knowledge, despite the interconnected relationship between the both of them. This directed the inquiry to consider what occurs during this process of transferring knowledge to theory for social workers in health settings and, further, what influences disconnect of the two in social work practice in health.

The final section of this chapter explored the transference of the participants' knowledge and theory into their everyday practice. It was identified that participants translated their knowledge and theory guided by the ideological principles embedded within the social work profession. It was interpreted that the participants' exposition of their practising identity was in a consistent conflict with what was either authentic or inauthentic use of problem-solving ability. It was discovered that this caused the participants to experience frustration and helplessness in constructing their desired identity as a professional social worker. It was considered that this ongoing experience hindered their sense of belonging in the health system with the overall result perceived as an institutionalised ideological break down of their social work professional identities.

Chapter Six
Social Work Values and the Ideologies of Health

Introduction

This chapter is aimed at exploring and interpreting the influence of socio-political ideologies of health on participants' professional social work identity. Interpretation of their reported lived experience of the development and maintenance of the values embedded within their identities will be undertaken. This will entail discussion of the participants' asserted value base and how it is developed and maintained by reflective practices. The discussion will go on to explore the various influences and constraints on the participants' values and overall identity development. This will include sections that focus on the influences of paradigms of knowledge and their role in constructing social work knowledge for practice, an examination of neoliberalism's role in guiding health system operation in Queensland, and the participant's experiences of this, and discussion on the dichotomous nature in construction of professional social work identity. In line with the interpretive constructivist research paradigm employed in this research, this chapter will interpose an interpretive presentation of the data alongside a constructivist discussion of findings.

Values in health social work

Freidson (2001, p. 25) asserts that the skill and knowledge of a profession is filtered through a funnel of 'tacit art'. He explains that this is developed through implied experience as opposed to discipline-specific formal theory (Freidson 2001, p. 25). I argue that this explains the process of a professionals' 'know-how' (values and experience base) to 'know-that' (skill and theory application). In applying this to social work, it could be interpreted that the funnel in which skill and knowledge is applied in everyday practice is value-filtered accordingly. The know-how is seemingly more difficult to define as ideas and experience are not part of a formal codification or easily accessed and expressed (Chugh 2015). Freidson (2001, p. 197) relates the concept of tacit art to what he describes as the 'soul of professionalism'. This concept posits that it is difficult to know-that without a founding know-how and that these are inexplicably interconnected. He goes on to explain the influence of socio-political ideology in constructing the paradigms of knowledge influence

on the know-how of professional disciplines in order to establish and maintain control over social capital (Freidson 2001).

Ideology is identified as the system of beliefs that influences thinking, in turn, influencing behaviour (Harms and Connolly 2009, p. 8). Historically, the ideology of social work is founded on values of power-with in their service of clients and patients, influencing the views and beliefs in which social workers approach complex and difficult social issues (Bisman 2004). From here, there is the expectation that this know-how is undertaken within a know-that framework of problem-solving, which is founded in the profession's inception internationally (Boyd 1984; Bartlett 1979; Oliver et al. 2012).

Relational values

One of the participants explains how her values resonate within her everyday tasks:

> *A lot of empowerment, because at the end of the day—'I'm not telling you what to do, I'm just trying to get you to look at things from a different perspective' ... I hate to think this one [patient/client] was going away thinking— 'Awe ... She's told me to do this or do that'—because that's obviously not what I want them to go away with. Rita*

Rita is highlighting the significance of her approach not adopting dogmatic principles. Rita exemplifies this innate drive for patient and client self-direction despite the strain of health system ideology impelling the health professionals' control over treatment (Beddoe & Maidment 2009, p. 117) identified by participants within the previous chapter. Another participant, Sharon, elaborates on this quandary by discussing her similar belief of self-direction:

> *Often you know as health professionals, people are having things thrust upon them, this is what you have to do, this is how it's going to be done. So I like to as a social worker try and just ensure that people are aware that they have choices and what those choices are and I know that often their choices are very limited but that doesn't mean that they're not there to them. So that's something that's really strong to me, people's right to decide and you know people's independence. Sharon*

It was clear within the participants' disclosures of their guiding value base that common value themes surrounded beliefs in self-direction, autonomy and strengths, in order to 'empower' the people they work with. All of which are identified within the AASW's *Code of ethics* (2010). Whilst the participants don't make reference to the word 'values', it is with the understanding of the obscure relationship between know-how to know-that, that it can be interpreted their assertions are related to values. This is inferred in perceiving the participants' beliefs as the disciplinary tacit art which informs the foundation of the know-how of their everyday practice. Overall, this encapsulates the interpretive social work lens that influences the construction of the know-how embedded within their social work identities. I submit that this is the innate drive in which social workers intuitively, rather than deductively, approach the complex nature of their everyday tasks. One of the participants, Anne, provides an explanation of how her views inform her application of counselling skills:

> *I think it would have to be about accepting people where they're at … Respecting and validating their decision … Really listening to what people's concerns are through some of those counselling skills ... Anne*

Anne is identifying her belief of respecting the decisions of the patients and clients she works with. Anne's statement could be considered to share the same meaning as the value of 'Respect for persons', one of the three values embedded within the AASW's *Code of ethics* (2010). The AASW (2010) describe 'Respect for persons' as:

> The social work profession holds that every human being has a unique and inherent equal worth and that each person has a right to wellbeing, self-fulfilment and self-determination, consistent with the rights and culture of others and a sustainable environment. (AASW, 2010 p. 10)

In considering the participant reports that detail the filtering of their views and beliefs in to everyday practice, it is imperative to explore the interpretive lens in which they are incorporated into their social work identities. The desire to foster 'choice' in social work practice within the health context could be attributed to a guiding relational lens. Connolly and Harms (2012, p. 155–7) correlate a relational lens to partnership and participatory practices in social work. It is understood that these practices establish relationships with service users that focus on developing their independence by encouraging autonomous decision-making in an emphasis on self-directed goals. Whilst this interpretive lens appears

to achieve an alignment with the beliefs identified by participants, this leads to the criticisms surrounding the dualism of social work values and the socio-political ideology of the health context in which these are practiced. This is particularly relevant when citing Connolly and Harms (2012, p. 3) who suggest that there is danger in social work operating solely from the relational lens as it poses the risk of '… practice that is deficit focussed and blames people for the very predicament in which they find themselves'.

Conform or leave

Healy (2005) explains the requirement of social workers acquiring relevant skills and knowledge in order to practice within their chosen context. Whilst logical, Healy explains (2005, p. 25) that this focus in isolation could influence the predominate means in which social workers construct their unique professional identity. Healy (2005, p. 19) identifies the need for social workers to critically analyse the knowledge claims that shape their practice contexts. This is understood in considering the previous chapter where it was interpreted that participants' professional set of values may be manipulated by the dominant discourses pertinent to the health system ideologies in which they are employed. The result of this was reported experiences of their value base being what they termed 'devalued' and, in turn, forced to 'conform' to the contextual parameters of the health systems in which they are employed.

In her own words, one of the participants, Leanne, explains this divide between social work values and those of the health systems:

> *I think coming from a different set of values and professional values specifically I think we look totally different at client than the medical model ... that's how I see it actually, is that it's [the medical model] a quick fix, give them some sort of medication and send them on their way and that is ... not so much in the medical hospital setting, normal, but in mental health you see that a lot more where, if you compare that with social work values and our identity as a social worker it's totally the opposite of how we work with people. Leanne*

Leanne, as quoted above, reported alongside other participants, that when faced with the challenge of actuating their own vision of the social work identity against the health systems stratification of this, they felt pressure to either conform to the health system or leave their employment. They explained the difficult nature of this and how it ultimately led to their experience of job dissatisfaction and symptoms of burn-out. It could be postulated that the participants' experiences demonstrate a process in which they are rendered subordinate to the health system through the tacit systemic process outlined above.

Whilst gender was not an intended focus of this study, Willis (1989, p. 123) explains the interrelationship between class and gender in medicine's subordination of health disciplines. It is argued that social work is a predominately female profession with a servitude discourse shaping this gender disparity (Flood 2014). It is interesting to note that all of the participants of this study identified as female. Willis (1989, p. 123) identifies the process of subordination to occur in tandem with socially stratified class and gender appropriations. Whilst Willis (1989, p. 93–124) underpins his discussion on this with the example of midwifery's subordination to medical doctors, it is clear the premise of subordination is the power medicine wields in dictating the functions of health service delivery and how constituents of this system must operate accordingly. With this, it is interpreted that medicine is aligned with positivist socio-political ideology which first excludes the legitimacy of social work because of competing foundational paradigms and goes on to subordinate the social work role by process of institutionalisation. This is supported by the interpretation of what the participants represent as utilisation of a relational lens in their practice and how it is rendered as dichotomous in application. In this application, they feel a sense of congruence to their social work roots although their exposition of this is moulded within the confines of dominant health ideology, namely medical dominance.

Social work and reflection

Chenoweth and McAuliffe (2015, p. 65) define values as standards of behaviour and explain that these constitute principles of rules and beliefs that govern behaviour. They make specific reference to how values inform ethical practice and encourage value congruent skills and knowledge of social work professional frameworks for practice (Chenoweth &

McAuliffe 2015, p. 68–72). They relate these roots of the social work profession being deeply embedded in principles of moral philosophy (Chenoweth & McAuliffe 2015, p. 61).

Reflecting sense of self

One participant provides her overview of how her values inform her practice:

> *I feel that I 'listen'. I have 'compassion'. I do believe that everybody has their own answers … we look at the identity of the person, the importance of the person. We do it in a non-judgemental, compassionate way. Definitely not a 'sooky' way where we take their abilities away from them. We build on those abilities and empower them. We do it without 'ego'. Jane*

Jane commences her discussion on values with 'I' statements conveying her beliefs. She then goes on to state her view of how the 'we' (social work) apply this to practice. The participants explained that their identity as a social worker in health is influenced predominately by the tacit nature of a parallel between both their personal and professional value base. It was clear at the point of data saturation that what the participants described as their personal and professional values were integral to their experience of constructing their professional identity:

> *I think my social work studies actually formed me. I think it fits my personal values and even where I am today throughout my career. I think between my values and my social work values … it's the me, it fits who I am and I think that's why I'm staying in my heart a social worker but also, I think I will always love people and working with people as a social worker would. Leanne*

The intersection of the personal and professional value bases of social workers is considered a common source of reflection in considering identity (Dominelli 2010; Connolly & Harms 2012). This brings the understanding that whilst values provide guidance to social work identity articulation, they are inherently reliant and interdependent on the wider scope of an individual social worker's personal and professional beliefs and the various influences that contribute to the construction of these (Beddoe 2010). In drawing on an illustration

provided by Harms and Connolly (2009, p. 9), the diagram in Figure 4 below demonstrates the overlap of influences on professional and personal:

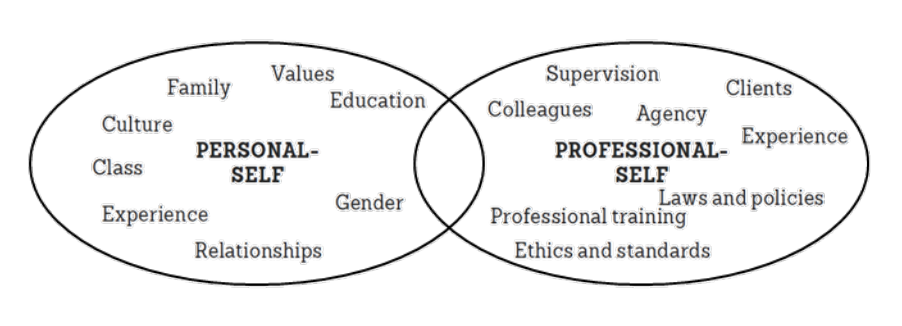

Figure 4: Personal and Professional Influences

Chenoweth and McAuliffe (2015, p. 26) assert that a social worker's early experiences of cultural background, gender, class, education and religious beliefs or spirituality provide the baseline for development of knowledge and skills. They go on to explain that these also provide a means of considering how a social worker's values align to the organisational values in which they are employed. In reviewing the relevant literature, it is understood that social work filters its everyday practice through a funnel of reflection (Harms & Connolly 2009; Beddoe & Maidment 2009; Chenoweth & McAuliffe 2015; Payne 2014).

Trust of reflective practice

Reflection in social work practice embodies varied applications dependent on the context in which it is utilised. In interpreting values and their influence to everyday practice, social workers engage in critical reflection (Harms & Connolly 2009). One of the participants provides her view of reflection as an asset:

> *I think the reflection, the discipline of reflection is a tremendous asset.*
>
> *Jacinta*

Fook (2015) provides two examples of critical reflection. The first is explained to involve the unearthing and examination of deeply held fundamental assumptions for the purpose of change. The second emphasises a focus on power and how it is situated within the scope of everyday exchanges between individuals and society (Fook 2015, p. 441). This exemplifies the transformative foundation of critical reflection, and the necessity of its purpose being embedded in fundamental change of perspective. In drawing on an illustration provided by

Harms and Connolly (2009, p. 8), the diagram in Figure 5 below outlines this transformative process:

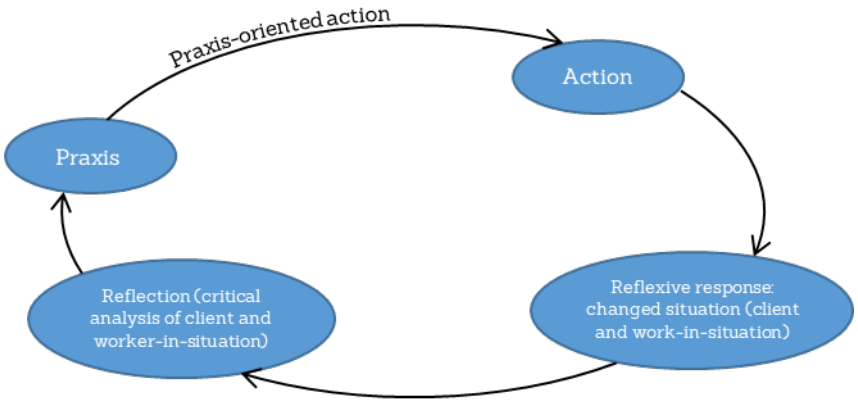

Figure 5: The Development of Praxis-Oriented Practice

In this diagram, they identify that the process of reflection is action-based in its proceeding reflexive response. They identify that this reflexivity in social work is informed by praxis which is defined by Harms and Connolly (2009):

> Praxis is the process of ideologically strengthening our practice through critical reflection and reflexivity, challenging our values, ideology and beliefs, and creative rethinking of issues with a view to facilitating macro change (Harms & Connolly 2009, p. 8).

Participants imparted that their reflective endeavors were usually in consultation with their social work supervisors and peers. Davys and Beddoe (2010) identify professional social work supervision as a platform for critical reflection. They define professional supervision as:

> … a forum for reflection and learning. … an interactive dialogue between at least two people, one of whom is a supervisor. This dialogue shapes a process of review, reflection, critique and replenishment for professional practitioners. Supervision is a professional activity in which practitioners are engaged throughout the duration of their careers regardless of experience or qualification. The participants are accountable to professional standards and defined competencies and to organisational policy and procedures. (Davys & Beddoe 2010, p. 21)

One of the participants, Sally, provides her view that reflection expands beyond the focus of self and that it is a process in which social workers can trust:

> *Because, that's what we see in the interdisciplinary teams, is the lack there-of [critical reflection] in other disciplines. So, that's something really interesting in-we open ourselves up for not just 'self-reflection', but*

> *reflection with our 'peers'. And, we feel that in our-in our profession—social work—that we can trust that. And that's what I see in the everyday, is my decision making is based on my social work 'values', which are very aligned with my personal values. Sally*

In likeness to Jane, Sally identifies the collective in stating 'we'. Like Leanne, Sally identifies the relationship between her personal and professional values and how these inform her decision-making in social work practice. Another participant explained the significance of her social work supervisor in guiding her development as a social worker:

> *So I guess you know in thinking before we got together today, I thought I don't know whether that's unique or not, but I feel I really developed as a social worker under my director and so therefore I think I've really been exposed to her ideas and her values as well and that's been a real guiding force for me … You know, and I feel I'm fortunate because I think her values align with mine so there hasn't been a lot of conflict there which is good, often you know we have very similar values so that's how it is. Sharon*

Challenges to social work reflective practice in health

Interestingly, one of the participants explained that the ability to engage in professional supervision was foiled by workplace process relating to 'performance management' within the health organisation she is employed by:

> *So the performance and development template that we use has been replaced by performance coaching sessions, so even the terminology infers that people are going to be coached to improve their performance. Rather than being, people being able to determine how they want their performance to evolve. You're required to have an interview with your team leader who's a registered nurse, and the team leaders are really suffering overall because they're getting pressure down to squeeze the last of the blood out of the frontline staff. Jacinta*

The reports of the participants identifies an attribution of reflection to development and maintenance of their social work identity. This is conceived in the relevant literature's assertion that value development is derived from critical reflection (Harms & Connolly 2009). In considering Jacinta's response, it appears the health organisation in which she is employed has provided a constraint around the function of supervision. Another participant expressed her thanks at the end of her research interview for prompting reflection on her identity development:

> *No, no I think, I've enjoyed talking to you, thank you, it's always interesting isn't it when you're asked certain questions that perhaps you haven't reflected on before it makes you look at different areas so I really appreciate that. Sally*

It appears within Sally's above statement, that she is perhaps signifying she has not been prompted to reflect on aspects of her professional identity. In light of the identified necessity of critical reflection in identity development relating to values, and the participants reported reliance on this for identity construction, it is questioned whether or not health systems are providing supervision in line with social work requirement.

Paradigms of health and social work

> *A lot of people have trouble defining themselves as a social worker and I suppose how I do define myself, particularly in the multi-disciplinary team and medical model, is that all the other degrees are science based and social work is humanities and I think that is one big distinction. Jacinta*

Health system organisation is an extremely complex human and material infrastructure in industrialised societies (Jamrozik 2009, p. 183). This human and material infrastructure is tasked with the provision of services that foster '… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1948). Jamrozik (2009, p. 181) suggests that this definition is subject to normative interpretation within socio-political structures. Within Western societies, the dominant socio-political interpretation of this is held in the gaze of medicalised ideology (Germov 2013; Jamrozik

2009). When considering the discourses which shape the context of health ideologies, informing knowledge paradigms are explored.

Freidson (2001, p. 153) suggests that paradigms of professional knowledge are a product of a foundation in which professions codify a body of principles in developing and maintaining the social status of their occupation. He goes on to allude that professional values sculpt the dominant means in which a profession develops an overarching and standardised model for practice. He continues that various ideological influences of society co-construct a profession's foundation of informing knowledge, usually in the interest of establishing and maintaining control over social capital (Freidson 2001).

The health system is comprised of multiple influencing paradigms of knowledge informing its delivery of health services. Taylor (2008, p. 17–21) identifies three main paradigms of health: the medical model, the social model and the biopsychosocial model. The medical model is explained as a product of biomedical knowledge, adopting a pathologising view in the treatment of illness and disease (Healy 2005; Taylor 2008). Taylor (2008, p. 17) explains the medical model's approach as 'It is the person's body which has the "problem" or "illness" and it is the responsibility of medical professionals to provide treatment to 'fix' the problem'. The social model, in contrast, is asserted by Taylor (2008, p. 17) to adopt the understanding that health issues are a result of social organisation. In exploring social work in mental health, Bland, Renouf and Tullgren (2009, p. 10–14) explain that the social model often situates social workers in the domain of social context. They term this as a *'critical approach',* which emphasises an understanding and address of social consequences of structural oppressions. Drawing on the World Health Organisation (WHO), Taylor (2008, p. 21) explains the biopsychosocial model to incorporate positive aspects of both the biomedical and social models. This is aimed at developing a more holistic approach to provision of health services (Chenoweth & McAuliffe 2015, p. 171–2).

Humanistic values

The participants identified the influences of a biomedical, social and overall vision of biopsychosocial models within their everyday practice. They identified their acknowledgement of the necessity and place of the medical model, however imparted a view consistent with the social model. In implementing their knowledge of relationships and

social work theory from a social approach to practice, participants described having a significant focus on the social implications of health issues for individuals, communities and society overall. Applying the idea of systems, one participant provided a clever analogy of how a holistic mind, body and social systems thinking is adapted to the challenges within her practice:

> *… you're working with different systems, sub-systems, and if one part changes the rest of the system in terms of homeostasis needs to adapt, and that's where we get resistance and we have to be patient with that because it's hard for other parts of the system to adapt. Jacinta*

Participants attributed this thinking to their focus of addressing health issues that surround social inequity and injustice rooted in the social implications of health. One participant explained how she sees the differences between a social work approach and that of the medical professions:

> *... in a way I think that I see that as ... medical professions look at a person just so totally different, than social workers. We look deeper and see we want to go to the root and give that person a more permanent, possible more permanent change in his [sic] life, in his circumstances. Leanne*

It is interpreted that Leanne is referring to issues beyond the medical diagnosis, such as the comorbidity of depression to diabetes. Comorbidity is a term used to describe the interrelationship of physical, mental, social and emotional diagnoses of health issues (Katon 2008). It is argued that social work is trained in a humanistic, as distinct from a scientific paradigm, with knowledge being broadly drawn from social sciences (Chenoweth & McAuliffe 2015) and without emphasis on study of the biomedical (Barnes, Carpenter & Dickinson 2000).

Both Leanne and Jacinta's approaches could be aligned with the key focus of the social aspect of the biopsychosocial model, which delineates a structural understanding and systemic intervention of health issues (Perriam 2015; Taylor 2008). I explained this difference within a published submission to a Queensland social work newsletter:

> In contrast to the medical model, health social workers are educated to identify the social and environmental causes of illness and sculpt an anti-oppressive, systemic

> and strength-based intervention—empowerment and connection are, in effect, our 'treatment'. (McNamara 2015b)

Leanne went on to discuss her view of the social implications of health issues, to which she provided this example from her experience:

> *… she had to undergo that [hysterectomy] and now um, she won't have children anymore, so how many social implications is there, I mean I see the doctor perfectly do the operation and get her back to proper health but what about the social implication of having a hysterectomy. Leanne*

Leanne is highlighting the social impacting factors from a social model of health approach which encompasses consideration of emotional and social impacts to the patient and their family. The notions of health are argued to be socially constructed and that these social constructions are what constitute the true reality of an individual who adopts a particular notion (Yuil, Crinson & Duncan 2010).

As Leanne was explaining her notion on a social work approach to health during her interview, the volume of her voice raised and her pace of speech quickened. In further explicating meaning from 'detail in the data'[4], it was interpreted that this was a significant point for Leanne; the social implications were of substantial meaning to her and perhaps of more relevance to a social approach than the medical. This prompted Leanne to go on and question whether or not her social work approach was regarded equally as highly as her medical colleagues:

> *A client does have a physical part and I think that's where the medical model fits. But does the medical model really accept and acknowledge our social approach … and more emotional approach, specifically in mental health, and see that equally? Leanne*

[4] Griffiths (2013) provides meanings of participants reported experience within observations of 'vocalisation'; methods other than discourse (e.g. tone and volume of voice), in which a participant conveys their experience.

Asserting social work knowledge

Throughout Barbara's interview, it appeared she opposed dominant health system operation. This was in congruence with the other participants' experiences. However, Barbara provided her perspective on the capacity of social workers to construct their professional identity among medical colleagues:

> *The thing is, social workers will tend to have the 'victim mentality' as in, we are being disadvantaged, we are being disregarded, and we are second-class. And, I don't see it that way. I think we do have, as social workers, the power and the 'clout' to define our identity within a multi-disciplinary team. Barbara*

It is difficult to assume Barbara's intended definition of the word 'clout'. However, in undertaking researcher interpretation and drawing on a conventional definition, it is usually used in reference to wielding significant financial, political and social power in contending an entity's interest (Dines 2012). When considering the subordination and exclusion of social work in health systems within Queensland, it is onerous to consider the clout available to the participants. This is in consideration of the influence of individualism embedded within neoliberal ideology, which has contributed to a disarray of the collective foundation of social work. Further, how this individualist approach limits a collective establishment of resources associated with political, financial and social capital for social workers who interface with the dominant ideology of health and the clout of its governing socio-political influence. Further exploration relating to the above will be discussed in greater depth within the 'Social work and the business of health' section of this chapter.

Whilst Barbara reported similar experiences to other participants, she often shared her perspective that denoted a belief in the power social workers possess in articulation of professional identity. Barbara's above statement is worthy of further analysis, as reports of the other participants within the previous chapter and relevant literature propose social workers are devalued in multidisciplinary settings and experience feeling disempowered in identity development and maintenance ventures. They signify feeling as though their identity is lost in definition amongst the inter-professional nature of multidisciplinary teams. Peck and Norman (1999) assert that social workers experience challenges in constructing a

unique discipline identity due to the context being dominated by a medicalised ideology, resulting in the experience of feeling devalued. In congruence with Peck and Norman's (1999) findings, other participants reported the difficulties they encountered working alongside other disciplines in health settings:

> *I think there were disciplines who didn't value social workers really high. So, that was difficult, that immediately put strain on your work. I still see social work in a setting like that sort of as a secondary level because the main treatment in the illness of schizophrenia is the doctor and medication or whatever medical treatment is needed, but the supportive role of an Allied Health professional, specifically social work, on family issues, all those other impacting issues can make his [sic] job actually so much easier, and if he will just recognise what we can do but I don't think that's recognised. Leanne*

> *The pecking order or the perceived pecking order … I'll give you an example: I've had somebody who's been on leave- a psychologist on leave and they're returning after maternity leave, and not sure if they're coming back. Because, when they left the place, it was run by psychologists, now it's run by social workers. And [now], they're not sure that they'll enjoy it, or would really be helpful for their careers. Sally*

Dual focus of knowledge paradigms

In discussing the influence and impact of the health system on her social work role, one of the participants, Sharon, explained her experience:

> *I think what's really real for me, is some days I feel, because that's another thing of being in that silo and being in that environment, that I have maybe lost or not had the opportunity to develop as strongly some of my social work values that I may have done if I was in a community organisation that's less restrained. I think for me, like the bottom line for me, is I know I can go to work and I can make a difference for people, so even though I may not be in my ideal environment for now I still feel that it's fulfilling enough for me to be able to continue what I'm doing. Sharon*

It was interpreted that Sharon has expressed experiencing difficulties in developing and maintaining dual focus, and commitment, to the demands of the contrasting paradigms of knowledge informing her practice. Sharon expresses concerns that she may not have developed her social work values, and she attributes this to the constraining environment of the health system. Interpreting Sharon's response of making a difference as perhaps part of her established sense of *Dasein*, it was apparent that she felt this was her point of importance within her health employment. Heidegger (1927, p. 38) explicates the importance of interpreting this understanding of *Dasein* in terms of the temporality in which it manifests. In Sharon's case, this constitutes the experience of 'for now' as stated within her above discussion. For now, Sharon expresses feeling she works within the 'silo', or parameters of the health system, as long as she can feel she can semblance making a difference, and that this is 'fulfilling enough'. When discussing the influence of the medical model, Barbara explained that she was aware it is now a part of her framework for practice:

> *I'd say this thing is like… its part of my 'framework' now. I work in an organisation. This organisation employs me- it employs me to do a job. That's how I look at it. Barbara*

From both Sharon and Barbara's statements, it was interpreted that deriving from the competing influencing paradigms, the participants experienced a sense of subjection in mitigating autonomy in their identity development endeavours. Perseverance of this struggle is widely known as the survival of the health social work role in a globalising world (Dominelli 2010). Another participant explained how she was advised by her social work supervisor to put her position in context to adapt to the constraints of the health system:

> *I think you know in my head we work in a medical model and the medical model has restraints thrust upon it and I mean they don't always sit well with social work but you know from day one my supervisor who is now my manager has made it very clear to me that social work is in a medical model and so you need to put your position in context. Sharon*

It is argued that the political discourses informing health service operation often adapt key principles that emphasise those of the medical model (Gomory et al. 2011). In consulting Payne's (2014) understanding of this, it is interpreted that there is an overarching paradigm

of biomedical knowledge embedded within the participants' experiences of the health system within Queensland. In coalescing the previous chapter, it could be interpreted that the health system's expectation of the participants' social work role constitutes a sole paradigm influence of Payne's (2014) ideas on problem-solving focus. It was identified by participants that they feel aligned more with a social approach, whereby problem-solving is anticipated to encourage empowerment. The participants expressed that they felt the medicalised approach dominant within the health system disregarded their more social approach to health issues. This pressure of influencing paradigms has been argued to impact the construction of social work identities within the health context (Coppock & Dunne, 2010). It is contended that resistance to the dominant health paradigm contributes to the discredit of social work, whereas compliance achieves status, warranting the ongoing demand of social work employment in health (McMichael 2000; Clarke 2005). The issue of dissonance in adopting contrasting paradigms for practice is viewed as problematic for participants maintaining a self-determined and solidified professional social work identity.

Social work and the business of health

The overall health system within Queensland is product of the encompassing Australian strategy for health service delivery (Queensland Government 2016). This approach to health service delivery is argued to be increasingly adoptive of principles consistent with neoliberal ideology (Wallace & Pease 2011). For social workers, this elicits the challenge in appeasing a system that is '… increasingly focused on accountability and outcomes, competition and efficiency, risk management, and privatisation of services' (Greenslade, McAuliffe & Chenoweth 2015, p. 423).

Short and sharp

Participants explained that administrations tasks were often underpinned by the daily aim in planning discharge of patients alongside their medical and multidisciplinary teams. The participants explained in Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', that this is often achieved in undertaking psychosocial assessments, facilitating family meetings and other tasks such as patient advocacy and stakeholder liaison that assists patients and their families to navigate the health system.

These tasks were identified as paramount in achieving accountability of the participants' daily practice.

Catherine identified the pace of the health system within the previous chapter. She explained the urgency of discharge was a common undertaking within her experience of health service delivery:

> *I just think we've got this pressure to get a referral, do something with it as quickly as possible. Catherine*

Like Catherine's view, participant Anne explained in the previous chapter how this fast pace of the health system influences 'short, sharp assessments'. Catherine went on to explain the 'backlash' in the previous chapter of not achieving quality when faced with the pressure to quickly quantify the clients/patients accessing the health organisation in which she is employed.

Another participant explains that this pressure comes from aligning practice with Key Performance Indicators (KPIs). She explains her view of this in discussing KPIs as constituting a dilemma for social work:

> *KPIs ... And things like that. And, that is the dilemma of … the social worker, I think, is balancing the 'client-centred' with the 'bang-for-buck' thing. Sally*

A key feature of KPIs is the stringent requirement in documentation of their adherence and achievement (Fenton 2016). A substantial number of the participants commenced their explanation of tasks undertaken in their day with the responsibility of administration. The general consensus among them regarding what constituted administration tasks was often described as record keeping and data entry for the predominate purpose of accountability. Within a framework of neoliberalism, this is increasingly becoming the norm for health system operation in Western societies (Fleit 2008).

More budget led, less about humanistic values

Conversations on administrative tasks quickly resonated in a discussion on what was conceived as bureaucratic informed practices. Participants linked accountability to meeting

standards associated with the various foci of business within their health organisation; KPIs appeared to align their practice with funding allocations. They described the relationship between KPIs and funding allocation as an interconnected endeavour where meeting the criteria and standards of KPIs usually secured more or at least maintained funding, whereas not meeting KPIs usually resulted in a loss of funding:

> *… the client's person is becoming a lower priority and it's really about numbers, so our team leader we need to have, there are funding packages and there are KPIs and if you don't do all your KPIs you don't get your money, and if you don't get your money you get in trouble … Jacinta*

Lawler and Bilson (2010, p. 9–14) argue that human service organisations adopting performance measurement and operationalising this within a business model and focus on cost efficiency practices are taking on key principles of neoliberalism. Participants explained that this approach to their delivery of health services was encompassed by an autocratic and hierarchical style of management within the health systems in which they are employed. In discussing the tenets of health system organisation with one of the participants, it was explained that management approaches were 'punitive':

> *It's more budget led, it's less about humanistic values and more about achieving KPIs and it's quite, my experience of it, it's very punitive, more stick than carrot. Jacinta*

In stating 'more stick than carrot' it can be assumed that Jacinta is referring to the colloquial idiom of 'sticks or carrots' which abstractly explains the punishment (sticks) and rewards (carrot) systems employed within organisations to drive performance of employees (Mirrlees 1997; Chenoweth, Warburton & Buckley 2005). In adapting this to interpretation, it could be perceived that Jacinta views the use of punishment as the driving force to performance within the health organisation where she is employed. The enforcement of punishment through hierarchy and chains of command is commonplace within health systems (Foucault 1976; Turner 1995; Willis 1989) and is characteristically a method of a managerial approach to health service operation (Lawler and Bilson 2010; Rogowski 2011). Rogowski (2011, p. 161) emphasises the desire of social workers to operate from a commitment to human rights and avocation of social citizenship with his desire holding the

belief of full and equal participation in society. As asserted by the participant Jacinta, the emphasis on humanistic values is lost to principles of neoliberalism enforcing managerial top-down approaches in distribution of power. Fenton (2016, p. 32) explains that the approach of neoliberal practices is in opposition to social work values.

The dilemma explained by Jacinta, of balancing a social work approach and that of the socio-political ideology of the health system, highlights the competing influences on social work identity construction. Lawler and Bilson (2010, p. 14) go on to explain that in the case of social workers, aligning with these principles requires an increased amount of their time in undertaking administrative tasks. One of the participants, Jane, explained that this was difficult to manage and encroached on her capacity to apply her social work skills:

> *Well, you have so many people to see at a 'red dot', the red dot on the chart, you have to see a certain number of patients in the day, so you can't spend much time with the patient, because, there is so many others that you have to see to do things like—things, more 'administrative' with them. I think, not I'm not using my social work skills in doing this—specifically. Jane*

One of the participants, Barbara, explains that neoliberalism contests her 'core':

> *I do feel there are tensions within my core … professional values, because the hospital system; it's very much neoliberalised. And, you tend to sort-of, like, hang-on a second ... this is just too fast. Like... we averaged ten discharges per week for a thirty-two (32) bed ward. Barbara*

Another of the participants, Catherine, explains her experience of the processes she views as 'not in place' for dealing with the walk-in clients at the health service she is employed within:

> *I think I'm always questioning that cynicism, I think maybe all that jadedness you see in a lot of areas, I think I'm always questioning when I hear my internal, my thinking kind of goes that way. And I think I instantly question it and go why am I thinking that way, why am I getting angry at this woman for turning up distressed and I'm thinking that's ridiculous, I'm*

feeling that because the processes aren't in place to deal with this, it's not that person's fault and I think that's where it comes in maybe being new as well you know that I am still kind of checking myself constantly. Catherine

It is argued that health services that adopt neoliberal principles are established by dominant budget focus (Lawler & Bilson 2010) and that they secure contracts to provide service by developing their service within a framework of economic rationalism. Catherine concedes that she initially felt 'angry' because a woman arrived at the health service distressed. She explains that she considered this further, and recognised in 'checking' herself that her frustration was with the system which did not provide adequate process for her situation. It is interesting to consider the impact of this frustration on social work identity development. It would seem that the poorly resourced systems play a role in service users becoming perceived as the 'problem'. Whereas with reflecting on the situation, Catherine identified that this was more what Mills (1959) would conceive as a public issue as opposed to a private trouble of the service user in this scenario. It is interpreted that with the resource of reflection Catherine delineated this response.

Economising health

Jacinta explained within her interview that the health organisation she was employed by operated with a focus on 'economising' their health service. She explained how this resonated in the consistently changing dynamic of funding:

… it's kind of epitomised a lot of the implicit expectation with these funding cuts, so it's gone up to seven percent, and this year it's ten percent or nine point six. So two years ago we had to spend seven percent less than we'd been budgeted for. And then the following year we had to cut an additional seven percent. And then it was raised to nine point six percent. - Jacinta

When Jacinta was asked if this affected her social work role, she replied:

Absolutely. It's squeezing therapies out. Jacinta

Another participant discussed how socio-political change within the health organisation where she is employed resulted in a professional and personal impact on her:

> *And then and I think that is about to change again I suppose, there's been money given in to the [blank] area so there's going to be a position recruited which will change my job again so I actually don't know what my job will be by the end of the year. I guess it's been very much a feeling of if you don't like it then get out, which is quite harsh but that is pretty much what comes across, you know there's so much change across so many areas, I think there's very little empathy for change or how change processes affect people on like a personal or professional note. Catherine*

The influence of neoliberalism is argued to have contributed to an increasingly casualised workforce (Chenoweth 2008). This is resultant of the increasing privatisation of the once-core health services, causing a rise in competition and market drive, which renders health services to compete for tenure of contracts to survive (Wallace & Pease 2011). When Catherine was asked how her predicament of job uncertainty impacted her, she replied:

> *I would say that I feel very powerless, a personal powerlessness to change, it's going to happen to me, it's not going to happen with me, it's going to happen whether I like it or not, I guess in that I've pretty much gone well I need to decide if I'm going to stay here then I think there's a part of me that you do start to go, you do start to think a bit smaller. Catherine*

Interpreting this, it appears this is a significant cost of resources to be faced with job uncertainty. This is not an isolated incident, with multiple studies highlighting the impact of a casualised workforce on the maintained role of social work and other human service workers (Beddoe 2010; Chenoweth 2008; McMichael 2000). It could be argued that neoliberalism's founding tenet of individualism in society, not the collective (Dines 2012), embeds the market drive and consequent competition component in the consistent change of employment conditions in health, rendering the focus on feelings of concern and powerlessness of the self, distracting from the collective of social work values (Ife 2012). In conceiving the clout of the health system's dominance in the paradigm of knowledge and sociopolitical influence, it could be interpreted that the resource of the social work collective is first dismantled and later reorganised as, in Willis' (1989) terms, subordinate. The process in which this occurs can be understood in drawing on Lukes' (2005) analysis of

power. Lukes' concept of manipulation, which was discussed in the previous chapter, identifies the means by which the health system first manipulates social work values. It can be seen within the first two sections of this chapter that the dominant paradigm of health reorganises the way in which social work reflective practices occur. This influences the praxis, or ideological influences, that inform the participants' practice activities and, ultimately, how they embody this as part of their professional social work identity. When considering Lukes' (2005) concept of force, it can be interpreted that neoliberalism forces the participants to adhere to the tenets of an ever increasingly privatised, market-driven, casualised workforce, causing experiences of powerlessness and focus on survival.

The value struggle

> … And when you stare for a long time into an abyss, the abyss stares back into you—
> Friedrich Nietzsche cited in Horstmann and Norman (2002, p. 69)

The literature from which this epigram is sourced is an English translated version of Nietzsche's *Beyond good and evil*. It is clear that Nietzsche imparts an alternative view to the mainstream black and white conception of what constitutes a 'good' and 'evil' stance. In this, it is depicted that what is 'good' changes invariably over time, the same for what is considered 'evil'. That reality is a multifaceted truth, taking on various forms over time. It is hoped that this epigram imparts the dialectical nature relating to ongoing exposure to an environment an individual is in opposition to, and how this poses the possibility of convergence and compromise over time due to a change of conception in values.

The Nietzsche quote gives credence to the theme of contextualising social work values within medicalised and dominant socio-political ideology, which will be explored within this section. The concept of social workers contextualising their overall identities is not new. In fact, the very concept of human beings integrating their identities within stratified social norms has long been a fixation of philosophical inquiry through the ages (Hiedegger 1927; Berger & Luckmann 1966). The results of these explorations and investigations have provided discourses as opposed to answers to this phenomena. This section will present the participants' discourses on the experience of incorporating social work values in to their everyday practice within the context of dominant health ideology.

Social work resistance

One of the participants, Barbara, highlights her view in not accepting dichotomous identity development as the status quo. She provided the metaphor of prostitution to highlight her views on the troubling aspects of dichotomous identity embodiment which will be explored in this section:

There's no point in prostituting yourself and going through that. Barbara

During analysis of the data, Barbara's metaphor of prostitution was difficult to sensitively deconstruct. It could be interpreted that she is identifying a view that social work surrenders its value base to the dominant social expectations set by the health system. Willis (1989, p. 217) asserts that 'Illness mediates social relations in all society' and this is the context in which the following discussion will be interpreted.

As it was highlighted in the previous chapter, discourse in health ideology permeates the social relationships of health service bureaucracy. In considering Barbara's analogy in further depth, it could be considered in likeness to what Foucault (1976, p. 13) describes as the discretion of the medical gaze to separate a human being from the flesh that forms its holistic entity. He explains that this is embedded in socio-political influence, which constructs the ulterior right in health system consensus in its treatment of patients (Foucault 1976). This is the understanding that the health system views an individual accessing health services in a dehumanised manner, supporting a doctor's right to perform the necessary treatment. This is because the medical doctor is socially constructed in likeness to a sage (Willis 1989). Returning to the point on how health ideology sculpts social relationships in health bureaucracy, it could be considered this same view of humans accessing health services is applied to the expectation of the social work role. Willis (1989, p. 2) explains that 'Not only has medicine gained the right to deny the legitimacy of evaluation by others, but it has also gained control over the work of other health occupations'. This approach is void of considering the potential of consequence that may impact the multifaceted and complex nature of the human being attached to it (Turner 1995). Coalescing this to Barbara's analogy, it could be interpreted that she is identifying that she disagrees with the notion of social workers operating as mere functionaries. Ife

(2012, p. 218) alludes to functionary work as without 'passion'[5]. Goffman (1956, p. 47) provides an explanation of this in line with a frontstage exposition of identity: '… it often happens that the performance serves mainly to express the characteristics of the task that is performed and not the characteristics of the performer.' In applying this understanding, it could be interpreted that the concept Barbara puts forth is a place in which social workers are forced to exposit an inauthentic sense of professional self. In her own words, another one of the participants highlights how her desire to impart authentic values is stymied by the influence of the health system:

> *There's lots of troubling times. I've got a student on 'prac' [social work field education placement] at the moment; she's got her fourth (4) year prac. And, this morning I said to her—one of the biggest problems I still experience on a day-to-day basis—about the [organisations] is. I just have to 'swallow' it and I don't like it, is the 'pathologisation' of clients. In-that we ask them to go and get a [name of plan] treatment plan from a doctor. I'm really opposed to it in my 'values', because most of these kids don't need a [name of plan] treatment plan. For moral reasons just pathologising these clients, it's also the future it could impact on. We don't think about it at the time, but I've had clients who come back and say—'I want to join the military, and those records might ruin my chances'. Insurance companies can actually refuse a person when they're older, because they've had a [name of plan] treatment plan. Because it's still really 'stigmatised' in legal terms. [Practice context] is still really stigmatised. Even though we think we've come a long way. Not in the aspect of the community have we come along way. And those are the reasons, so that's why I get so upset about it; we could also ruin somebody's future. Sally*

In discussing the future of social work in relation to her values, Barbara provides her view on the importance of social work taking ownership and leadership of their role in social change:

[5] Ife (2012, p. 218) explains that social work is not only driven by careful analysis, but a passion to make the world a better place.

> *Social work is being innovative, being leaders, being a part of the force in social change. This is what we are, and if we lose that identity, if we lose that drive, what is there for us? Barbara*

Barbara exemplifies the need for social change to be a focus of the profession. It was interesting that throughout Barbara's interview, she often provided examples of her practice experiences in which she felt she had asserted her social work position. Barbara was compelling in the sense that she acknowledged the influence of the health system on her identity as well as her role in enforcing the health system's vision of the social work role. However, Barbara explained that she would often assert herself within multidisciplinary meetings and undertake social work projects in her attempt to better articulate and convey the social work identity in her health employ.

'Passion'

Barbara provides an explanation of why she feels she conveys a strong sense of her professional identity by 'boiling it down' to this statement:

> *I don't know … maybe it's just me, I think it boils down to knowing I have a good understanding of my role, and how important my role is. Barbara*

The difference between Barbara's experience and those of the other participants is conceived in relation to how social work becomes constructed over time. In consultation with Berger and Luckmann's (1966, p. 195) concept of the dialectical nature of identity, it is demonstrated that the intricate nature of dual narratives constructs how individuals subjectively appropriate their identities to the objective reality of the social world. Whilst the authors believe identity to be socially constructed, they acknowledge the significant role of the self and how this entity conceptualises its own subjective reality for application to the various social institutions in which they are involved. Analysis of this subjective reality is, in part, inevitably a matter of philosophy in interpreting sense of self.

When considering Barbara's approach to the dual narratives influencing her social work identity, it is interpreted that despite her demonstrated critical insight and consistent awareness of her position between the struggles of influence on her identity, she continues to seek out avenues to continue asserting her professional identity. Barbara appeared to not

relay the same conjecture of 'this is it, this is the job' as other participants did. A factor that could be attributed to her point of difference to the other participants is her experience level. Barbara disclosed that she had below five years of social work experience at the time of her interview. This could support the notion that social work passion, or value, fades as the organisational demands on the social work role exhaust the available energy resource in maintaining it (Ife 2012).

Perhaps the process of experience in health social work could be likened to Berger and Luckmann's (1966) concept of institutionalisation which was deconstructed in the previous chapter. This presents itself as a significant finding, in that it directs an understanding of how the social work value base is denigrated by the health system's ongoing objectively assigned role of social work to the participants ongoing habitualised and subjective internalisation of 'this is it, this is the job'.

Within the previous chapter, Heidegger's (1927) concepts relating to *Being* were utilised to interpret the participants' lived experience of their everyday social work role. It was conclusively discovered within Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', that participants formed their most authentic sense of *Being* in the foundation of what they envisioned to be their values in practice of knowledge and theory. In review of the participants' reported subjective value base in this chapter, it appears that within the scope of a relational lens, each participant described similarity in guiding values and how these are applied to their practice contexts. As it was discovered in the previous chapter, however, the participants identified a dual exposition of their relationships knowledge; that of their own vision and that of the health system. It could be understood that in the case of the participants' use of a guiding relational lens, it is again a complex frontstage incorporation into their social work professional identity. Applying Goffman's (1956, p. 61) dramaturgical symbiosis of a theatrical performance, it could be interpreted that the participants make up what is considered a performing 'team'[6] and the health

[6] Goffman (1956, p. 50) defines a 'team' in the context of his theory as a set of performers who cooperate a presenting single performance. Whilst variable in their underlying exposition of the self in the performance, they are directed by a director to perform a single performance.

system is the 'director'[7] of the performance. And that the process in which social work exclusion and subordination occurs is in the context of a frontstage performance. The audience in this instance could be perceived as the public, those accessing the health services. This suggests that the frontstage representation of the relational lens could be likened to the participants' sustained definition of the health system's trajectory of the social work role. As well as this, there is the potential of subtle incorporation of their backstage ideals, identified in Barbara's experience. This creates the illusion of compliance to what the health system's chosen reality is, but allows for the participants' self-direction in subtle conveyance of a more authentic felt sense of self to the frontstage (Goffman 1956).

Drawing on Goffman's (1956) theory further, it could be fair to assume the frontstage representation of the two realities becomes complex and resource costing. It is perceived this impacts the participants' mediation of their ideals in allegiance to adopting an authentic sense of the relational lens in their everyday practice. The participants identify that whilst this authentic aspect of their identity is somewhat stymied by the health system, they are still able to actuate a semblance of their beliefs and knowledge of relationships within their everyday practice. This was evident in Sharon's reports outlined within the first section of this chapter, highlighting her struggle in maintaining focus of her belief of making a difference.

It could be derived that that this ongoing performance underpins their construction of identity as a social worker. As it was identified within the previous chapter, the knowledge of relationships is highly regarded by participants. They warrant this as the core knowledge they draw on in their everyday social work endeavours within the health system in Queensland. This returns the interpretation to Connolly and Harms' (2012) concerns around the secular adaption of the relational view. It appears that when considering the potential that the health system exercises Lukes' (2005) concept of manipulation, the participants'

[7] Goffman (1956, p. 60) defines a 'director' as the entity that exercises direction and control over the performance.

know-how and know-that of relationships is appropriated by sociopolitical ideologies' interest in ownership and distribution of social capital (Foucault 1968; Friedson 2001).

Summary

The previous chapter provides a guiding interpretation of what has been discovered in the participants' dichotomous adaption of the guiding relational lens identified within this chapter. Within the previous chapter, the participants identified that they and their social work colleagues come to accept this dichotomy as part and parcel of social work identity development in health. It was identified in this chapter that the relational lens is integral to the values that are foundational to the participants' vision of this. It is further identified that these values correspond to the chosen knowledge, skill and theory application as outlined within Chapter Five. This chapter has provided an understanding of how the relational lens establishes the social work know-how and how this informs the know-that of their practice endeavours. It is clear within the participants' reports and the interpretation of these within this section that concepts relating to the ideological underpinnings of the exposition of values have emerged. In this, the participants made reference to the ideological challenges the health system poses in the application of their intended relational lens in adopting knowledge for practice. This warranted exploration of the reflective process in which participants consider the influences on their value base, and how these inform their social work identity construction within the health system.

The role of reflection, reflexivity and praxis in professional social work identity construction was defined and applied to the participants' experiences within this chapter. The role of these have been explored in relation to the participants' development and maintenance of values as part of their professional social work identity. It was discovered that the participants highly regard reflective practice as the cornerstone in which their value base and overall identity is conceptualised. They identified the purpose of supervision as a platform for reflecting on their social work identity. It was, however, discovered that the health system may have a different vision to the participants on the role of supervision. This lead the inquiry to exploration of social work and the health system's paradigms of knowledge.

It was evident that knowledge paradigms significantly influence social work identity in health. The participants identified their alignment with a social model and, further, that this was in contrast to the prevailing medical model. The participants identified that they felt devalued by their more medicalised colleagues and that these experiences often strained their work, stymied their development of values and encouraged them to compromise so as to feel 'fulfilled enough' to continue working in health. The continued theme of the participants' dissonance between the dual health and social work influences on their identity was evident within this section. The participants' view of beliefs appeared to be central to their adaption of knowledge paradigms. The role of socio-political influence on knowledge paradigms was relative in their discussion. This ensued an exploration of the socio-political underpinning of the operation of health services and how this influences and impacts the participants' social work identity construction.

The final section of this chapter signified an important relationship with the previous chapter. It was clear that this section demonstrates the same quandary of the participants constructing their identity inside the constraint of competing ideologies relating to the actuation of a relational lens to their practice. Within the previous chapter, the participants identified the use of psychosocial theory and systems perspectives, which infers drawing on a lens of social justice and social change. It was, however, discovered in the previous chapter, that these were significantly more difficult for the participants to utilise in their daily practice. This was due to the value foundation of these demonstrating a stark contrast to the health system's stratified position of social work. The use of relationships knowledge, however, was interpreted to be more easily adapted by the participants under the guise of a 'clinical' approach. The last section of this chapter explored the foundation of relationships knowledge further in correlating the values of a relational interpretive lens. In this, it was discovered that whilst the participants' feel this is an exposition of their social work identity, it resonates a deeper struggle of competing ideological influences based on the question of authenticity in expending resources to remain true to social work values.

Chapter Seven
Concluding and Reflecting on the Research

Summary of thesis

This thesis commenced with the impetus of research which discussed my desire to interpret how the professional identity of social work is constructed in health. This developed an aim of exploring lived experience of this and a question of how it is socially constructed. The thesis shared the stories of nine participants and conveyed their experiences of constructing their own professional identities. I respected these experiences for uniqueness and nuance, but also explored these conceptually, to explicate the meaning and process which underpins the story of identity construction for health social workers in Queensland.

Whilst the relevant literature highlighted the influences on social work identity construction, it seldom deconstructed how this process occurs. This thesis discovered how the participants experienced their own development of professional identity, alongside the social construction of this within the health context. In this, the challenges they face in establishing and maintaining their desired professional identity within the health context in Queensland were explored. During this exploratory process, the requirement to understand how social work identity construction is influenced by not only the individual, but the systems they interface, was recognised. This directed the research in adopting an eclectic theoretical framework, which accommodated the multidimensional representation of identity construction embedded within this thesis.

The provision of better understanding the social work identity in health settings, discovering the unique building blocks that construct this identity, and a developed means for interpreting the multidimensional intricacy of this, is anticipated as the overarching contribution of this research to the knowledge base in respective areas of inquiry.

Theoretical development

After completing the research, I engaged in what could be considered the process of epistemological reflexivity (Charmaz 2017). Before providing this reflection, it is noted that it wasn't my lack of education on the relationship between the personal and professional self in social work. It was, rather, an ignorance that formed some of my narrow views on the

sheer importance of the 'personal' upon entering this research. Over the duration of the research, I critically reflected upon my own personal and deeply seeded beliefs on the importance of the concept of 'personal', or 'self', as I went on to describe it. This prompted a consideration of how my views both compelled and mired the progress of this research.

I commenced this research with the narrow view that social work was a profession, and that this was the most important consideration. I ensued the focus of this research on the basis of discovering that, which I later found to be primarily a frontstage representation of the profession. In the process of speaking with participants, my secular view of who we are and what we represent in a professional representation was significantly challenged. My bias was that of proving the place of social work in the *professional* realm, which at times derailed my focus on the participants' lived experiences. Underpinning this was the desire to prove social work as a *valid* profession, worthy of respect from the health system. I felt the need to professionalise the *who* of what social work *is* in health. And therein I discovered the overarching dialect, that what and who social workers are as professional is deeply entrenched in who they are as their personal self. I suggest that these concepts cannot be separated, they appear to be one in the same, an interconnected entity. The *who* of what social workers are shouldn't be measured for its validity as a 'professional'—especially seeing as aspirations of identity validation for the social work profession is moulded within the gaze of what constitutes the social construction of a social worker in health.

Social work is deeply rooted in philosophies of morality and quests of emancipation. The identity of the profession is rooted in values. I was ignorant in believing the values social workers are taught and socialised into are somehow entirely 'new learning'. Whilst the jargon used and ongoing application of values in practice presents itself as the basis of transformative new learning, the intrinsic nature of these values appeared to be interwoven into the fabric of the social work self. I found that this professional sense of self relies on congruence with the personal self. I found that social workers of this study relied on their personal sense of self to articulate who they are as a professional and that the connection between the concepts of self and professional can become a contrived venture for social workers in health. I can now see that social work is not just a professional occupation, but perhaps a way of life. This does not appear to be totally respected in health, a system that encourages detached objectivity and functionary mechanisms for social work practice.

The participants of this study presented a dual narrative of what constructs both the ideal and the reality of who they are as a health social worker. They identified that this dual narrative comprised the ideological influences of both social work and that of the health system. For the participants, they often expressed feeling their social work contribution was devalued by the health system. This was a theme that emerged consistently in each substantive chapter. In Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', the experience of incorporating knowledge of relationships and systems theory into their ideal of practice was contrived by the reality of the health system's vision of the social work role. It was established that the participants' knowledge and theory of practice aligned within a framework of the social model of health, whereas the health system was explained by participants to align more with the medical model. The participants recounted experiences in which they felt they either needed to conform to the health system's proposed social work role, or find other employment. They elaborated that when endeavouring to actuate their ideal social work identity, they were often left feeling devalued, sick and burnt out. For the participants who did not as overtly resist these influences to their social work identity, they were tasked with the ongoing agency of a contrived frontstage performance that required the appearance of adapting the health system's prescribed social work role. They too, expressed this keeping up of appearances drained resources of the self and resulted in experiences operating as mere functionaries and feelings of powerlessness and helplessness. This supported the finding that the process of praxis underpinning the participants' application of knowledge and theory is manipulated by the socio-political clout of the health system, then institutionalised by the dominant ideological parameters of the health context.

The same theme of ideal versus reality emerged within Chapter Six, 'Social Work Values and the Ideologies of Health'. This chapter built on the foundation of relationships knowledge and how this correlated to the participants' reported relational interpretive lens as guiding their value base. It was discovered that there was an intersection between the participants' sense of self and their application of values to their everyday practice. The participants reported experiences of their incorporation of social work values to their vision of social work health service delivery. In this, they correlated the influence of their values to the humanist knowledge paradigm intrinsic to their identity as a social worker. They reported

experiences of a contrived actuation of their values, attributing this to the contrast between their intrinsic humanist paradigm and the more scientific paradigm of health systems. The participants recounted experiences of having the reflective means in which they conceptualise their values stymied by a neoliberal approach to the health system's performance management processes. It was also explored at depth that what the participants felt was their own 'problem solving' approach to their practice was manipulated by the health system in adhering to its principles of neoliberal service delivery. Again, the participants expressed an overall sense of their professional social work identity being devalued, and that they experienced significant self-resource expenditure to continue the contrived frontstage appearance of a social worker working within the constraints of the health system. This supported the finding that the participants' implementation of their values resonates with a deeper struggle of competing ideological influences based on the question of authenticity in expending resources to remain true to social work values.

Passion and professional identity

It is clear that there are unique ingredients that make up the participants' identities, in terms of their frameworks for practice in health (relationships knowledge and systems thinking). However, the central aspect of relational values by which these practice frameworks are reflected are stymied by the health system that denigrates social work passion.

The data tells the story of social workers who, with experience in health over time, have been socialised into socio-political norms of dominant health service delivery. This is achieved by the health system in use of manipulative and coercive power modes. It tells the story of these participants' construction of their professional identities being faced with the choices of compliance with, survival of, or exiting social work employment within the health system in Queensland. In theorisation of the participants' stories, it is clear that the health social work identity is developed and then sustained with 'Passion', a concept coined by Ife (2012). It is even clearer that when passion cannot be sustained, this is when the participants were at risk of forfeiting their identity and assuming a functionary role for the purpose of survival—with little capacity to maintain focus on what they perceived as the values of their social work identity.

In the diagram illustrated over page, the substantive theory is presented. This diagram illustrates the socially constructed role of a health social work bureaucrat—a frontstage social work role formalised by the health system's clout of power modes, such as coercion and manipulation, to ensure the social work role meets their economic, social and political agenda. This role is then, in part, institutionalised by social workers themselves. This is argued as a result of the exhaustion of social work passion for capacity to resist this process and remain authentic to their backstage sense of self.

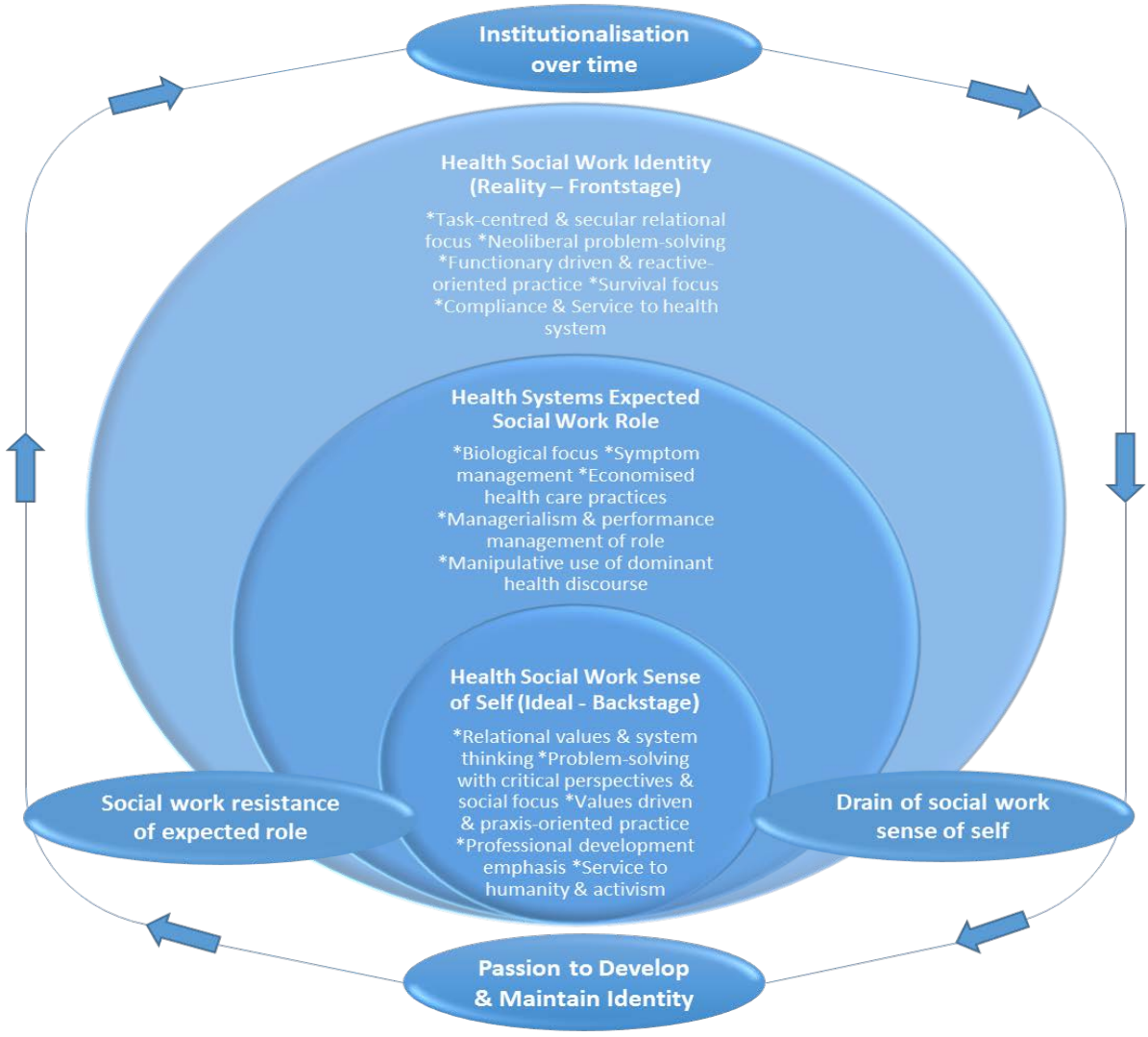

Figure 6: Passion and the health social work identity

Evaluating the research

It is important to reflect on a completed study for its strengths, limitations and soundness in meeting criteria of its overarching research design (Alberta 2006). This section will unpack considerations of Charmaz's (2006, p. 177–183) guidelines for reflecting on grounded theory research, as well as provide insights and recommendations based on the implications of the study and an evaluation of the strengths and limitations presented.

Meeting criteria as a grounded theory study

Charmaz (2006, p. 182–3) identifies four separate guidelines for meeting the criteria for grounded theory study—credibility, originality, resonance and usefulness. It is suggested that demonstrating strength in the combination of originality and credibility increases the resonance and usefulness of the contribution (Charmaz 2006, p. 183). Charmaz (2006, p. 183) signifies that this guideline emphasises a criteria to account for the study and development of theory, however it seldom evaluates the narrative of data and what makes it compelling. A focus on the narrative evaluates a constructivist contribution to this more traditional grounded theory evaluative guideline. Charmaz (2006, p. 183) exemplifies the intuitive act of writing alongside the inventive and interpretive nature of a constructivist approach to grounded theory. It is considered that Charmaz's (2006) stance better acknowledges the reflexive position of the researcher which looks beyond the naming of facts and emphasis on the soundness of mechanics of grounded theory methods. Charmaz (2006, p. 178) overviews what to consider in a constructivist grounded theory study in explaining the emphasis on data interaction that is fluid and open-ended, as well as explicit instruction that the researcher is part of, not separate from, the study. In reflecting on this research, I acknowledge the open nature of a semi-structure interview style I employed as well as the layered coding processes and the reflexive stance I have adopted in my interactions with the research. I argue that this approach has been in adherence to Charmaz's (2006) position on meeting criteria for constructivist grounded theory research.

When considering this research against the methodological processes of grounded theory, Charmaz (2006, p. 182) explains that in achieving credibility, a study must first demonstrate it has achieved an intimate familiarity with the setting or topic explored. This research has

explored the lived experiences of nine participants who identified as social workers employed within the health sector in Queensland. The dissemination of the participants' stories has culminated in a substantive theory which respects the nuance and uniqueness of multiple truths in each of their experiences. This was achieved by providing each of the participants' unique perspectives in categories that were discussed within Chapter Five, 'The Everyday Lived Experience of Health Social Workers in Queensland', and Chapter Six, 'Social Work Values and the Ideologies of Health'. This was credit to the relativist ontology that guided this research, and is argued to have demonstrated an intimate familiarity in the depth of analysis achieved by using in-depth interviews as a method of data collection.

In the positivist tradition, the onus of absolute truths is demonstrated in vast quantities of predetermined sample sizes (Hood 2007, p. 161). By contrast, constructivist grounded theory does not qualify merit on numerical value, rather it considers the range, number and depth of observations gleaned from the data. In considering the achieved depth of the participants' accounts of their lived experience, this research could also be considered to address Charmaz's (2006, p. 182) credibility guideline of sufficiency in meriting the claims of the resulting substantive theory. This was achieved in a rigorous process of theoretical sorting that occurred during the coding and categorising of the data which is explained within Chapter Four, 'Designing Research to Explore Lived Experiencer'.

The requirement to demonstrate a strong link between the data and the final analyses is argued by Charmaz (2006, p. 182) to warrant credibility in constructivist grounded theory studies. This thesis captures the unwavering opinions, understandings and lived reality of the participants of this study. This is evident in the majority of overarching categories discussed in this thesis, which were carefully constructed in using the participants' own words, encompassing codes that provided a narrative of their reported values and beliefs about their social work identities.

When considering the originality (Charmaz 2006, p. 183) of a grounded theory study, this research contributes to existing knowledge on identity construction for social work and new knowledge on a once anecdotal take on the construction of social work identity in health settings within Queensland. It offers new ideas in terms of providing a means of interpreting the social work identity in context and has provided a highly collaborative and unique

analytical framework for extracting the meanings and processes involved in identity development experiences. This interpretive framework is argued to be unique in its ability to provide interpretation, and analyse concepts of existence and social construction. Whilst achieving originality, this design for interpretive-constructivist research could be considered as meeting the criteria for usefulness in its applicability to social sciences' explorations of lived experience, particularly on the topic of identity construction. It is argued that the analytical framework was well justified and demonstrated success in its address of the research aim and question of this study.

In providing the narratives of the lived experiences of the nine participants, the overall nature of this study focussed on portraying the uniqueness and nuance that characterises the truth of individual realities. The richness of the narratives that were yielded by use of in-depth interviews allowed for an ontological focus in consultation of philosophy that interprets the meaning of existence and how it becomes socially constructed (Heidegger 1927; Goffman 1956; Berger & Luckmann 1966). This has demonstrated the sheer depth of insight captured, and how this greatly assisted in fleshing out categories that aimed at portraying the fullness of the multitude of different truths of reality in studied lived experience. This offers participants, and people who share their experience, deeper insights on their lives and worlds which are key to achieving resonance of a grounded theory study according to Charmaz (2006, p. 183). Further to this, the overall analytical framework adapted to this research culminated in an exploration of the hidden nature of macro power-relations. This has successfully distinguished these for what they are and mean. This was achieved in analysis of taken-for-granted language such as the word 'clinical' and provided insights on the insidious meanings embedded within day-to-day discourse. These understandings were established in exploring the participants' everyday social work practice and how it interfaced with the health system as a whole. Charmaz (2006, p. 183) indicates that providing an analytical link between the micro of individuals and macro of collectives and institutes by deconstructing and illuminating the liminal and taken-for-granted meanings associated with these groups meets criteria for achieving resonance in a grounded theory study.

Implications of the study

The ‘so what’ of grounded theory research isn’t easily measured. This is because its overarching aim is to offer an explanation of its focus of inquiry as opposed to testing an existing hypothesis (Birks & Mills 2015). This warrants methods that exclude the potential of preliminary consultation of literature that pose risks in constraining the emergent process. This ensues an inductive process, where the theory grounded in the data is ensured as a bottom-up product that is emergent and not forced. Within Charmaz’s (2006; 2014) constructivist grounded theory, theoretical sensitivity is achieved in part, with the review of relevant literature which is only undertaken during preliminary stages of the study and analysis of the data. Therefore, the implications of this study are, as intended, by a research design that incorporates grounded theory strategies.

As with most social work research, the inception of this study was founded on the desire to provide a voice for those who may be marginalised or oppressed (Volter 2008). The relevant literature that substantiates a discount of health social workers, and now the voices of these nine participants sharing their experiences of this, presents itself as an aspect of reflection in considering the future of social workers in health.

This study has improved and nuanced a better understanding of the social work identity in health. Within Queensland, there has been an absence of qualitative study that explores the construction of professional social work identity within the health context. As it is identified within the beginning chapters of this thesis, social workers make up a significant number of health professionals employed within the health sector in Queensland. Further, it is demonstrated that social workers provide integral health services surrounding the social aspects of health issues. Therefore, the findings of this research welcome enquiry of the various private and public health organisations and departments which comprise the health system in Queensland. It is hoped that these findings establish a dialogue in underpinning the advancement and progression of the social work position in health.

The same ideological principles of health systems found within this study are argued to influence health service delivery across international contexts (Beddoe 2014; Yalli & Cooper 2008; Yip 2004; Zittel, Lawrence & Wodarski 2002). Therefore, the implications of this study may inform an understanding of social work health identity internationally. This improved

understanding is anticipated to materialise any practical means by which social workers and social work leaders can advocate for a more articulate and robust professional identity through various social and political avenues.

Alongside these new insights, this study presents a unique approach in exploring identity as a theoretical and methodological contribution to both social work and qualitative research inquiry. The grounded theory strategies to inquiry and eclectic theoretical framework complimented the overall interpretive-constructivist research design. This design allowed for the participants' lived experience to be explored not only for its meaning, but accommodated an interpretive inquiry of how the meaning of participants' identity is then constructed in context. The strength of this approach to research is evident within the richness of exploration and interpretation of the data that resulted in robust findings on an area relatively unchartered. It is anticipated that the demonstrated value in this unique approach to qualitative research may present itself as a useful design to drawn on for future research undertaken in the area of identity exploration.

To summarise, the implications of study contribute to the ongoing and evolving knowledge base on social work identity in health. They also demonstrate a means by which future action can be undertaken to underpin advancement and progression of the social work identity in health settings. As well as this, the research design implemented in this study offers the potential to be replicated or drawn on in other inquiries of identity development.

Strengths and limitations of the study

As with all research, this research posed both strengths and limitations; there is never 'perfect' research (Taylor 2008, p. 148). Research is often comprised of political imperative (Alston & Bowles 2012) with the presence of researcher bias in qualitative research difficult to mitigate. In qualitative research, it is often the case that bias is sought out for its necessity in conceptual direction of the research, ensuring data is focussed and relevant to the studies' inquiry (Luce 2010). This comprised the reflexive approach adapted to this research, which required the researcher to co-direct understandings with participants by practice of critical reflection in memoing and consultation of the supervisory team. This was ensured as balanced within the scope of researcher reflexivity guidelines (Charmaz 2017), aimed at remaining cognisant of my own 'researcher baggage' and how this had potential to

both benefit or hinder the research process. I achieved this by frequent reflective discussion on my value-laden positions with the supervisory team of this research.

The interpretive-constructivist paradigm of this research demonstrated strength in its outcome of yielding data rich with meaning to address the exploratory research aim and analytical research question. It is reflected that this meaningfully portrayed the narratives of participants and provided a thorough representation of their values. However, representativeness is often considered a limit of qualitative research (Denzin & Lincoln 2005). In the case of this research, it is highlighted that whilst providing a snapshot of nine participants' experiences, it does not represent the entirety of the health employed social work population in Queensland. It was however explained within Chapter Four, 'Designing Research to Explore Lived Experience', that a qualitative design best met the needs of this research focus and boasted strength in its capacity to meet the philosophical basis of social work research endeavours.

Consideration of gender was highlighted toward the end of this research process. The entire participant population in this research identified as female. This could be perceived as a strength in its provision of the female lived experience, particularly with regards to this study's critical focus on power-relations in a society where the question of equality for women is still at the forefront of global debate (Alston & Bowles 2012). However, it is conceded that potential for a richer understanding of the concept of identity may have been achieved in interviewing male social workers. It is noted that male participant expression of interest was received for this research. This was, however, at the point of saturating out the findings at the completion of analysis of the ninth participants' interview. It was collaboratively decided by myself and my supervisory team at this point that no further participants would be interviewed as theoretical saturation had been reached. This was also compounded by the pressing time constraints of the Masters by Research timeline.

Finally, this research portrays a deficit focus in the narratives from the participants. Traditionally, social workers adapt strengths-based approaches to qualitative research (Rubin & Babbie 2015). Whilst the deficit focus I have presented is at odds with an aspect of traditional social work research paradigm, it is emphasised that this research entered an area with a known significant problem-base. I have reflected, alongside my supervisory

team, that the end result of this research, whilst providing the deficits, has achieved in identifying the current challenges to social work identity in the context of health in Queensland. With identification established, this has elucidated topics that present the potential of future research ideas that adopt a strength-based paradigm. This is anticipated to employ qualitative, action-based methods to address identity challenges for social workers in the health context within Queensland, and perhaps Australia-wide.

Future research

Throughout the research journey, there have been important findings and subsequent considerations that direct a focus on future research. This is by no means an exhaustive list of the prospects for future research in this area, but will conceptualise two key areas in which the focus of this study highlighted.

The first potential is derived from the findings of the research presented in this thesis—that a need presents itself to better articulate and assert the social work professional identity in health settings. This would consist of a qualitative action-based research aimed at developing a framework for professional social workers to drawn on, in assertively developing and maintaining their identity in the health system. The grassroots tenets of this approach would be informed by theory relating to both Westoby & Dowling's (2009) *Dialogical Community Development* model as well as Scharmer's *Theory U* (2016). This has the potential of re-engaging with the participants of this study, alongside other health employed social workers in Queensland, or a widened geographical scope of Australia, to co-construct a framework alongside them.

The second surrounds a qualitative inquiry into the preliminary experiences of health social workers in Queensland. This would entail exploring the lived experience of both social work students undertaking their field education placements and new graduate social workers in health settings. In likeness to the research presented within this thesis, this experience would then be considered in terms of how the students and new graduates commence a beginning articulation of the social work role in health. It would be interesting to apply a different mode of data collection, in perhaps including focus groups and an undertaking of multiple interviews with participants over a period of time, similar to that of a longitudinal study.

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Appendix A
Academic Space Article - QSW Summer Edition 2015

Hi, my name is Jacqueline McNamara and I am new graduate social worker working in regional Queensland. I'd like to take this opportunity to share some of my experiences while on my final placement and how this led to my decision to undertake further research through a Masters of Research.

My final social work practicum was at a youth mental health organisation in a regional setting. This organisation operates within the parameters of a consortium business model and is funded to provide psychological interventions related to four key target areas of mental health, physical health, drug and alcohol and vocational support.

This placement was an experience that encompassed the transformation and emergence of my professional identity, from student social worker to a new graduate social worker with a desire for a mental health career path. I seamlessly transitioned from student to employee within the organisation and stepped in to a role carefully constructed by my supervisor and myself. This role was aimed at amalgamating both discipline specific and role specific performance indicators/objectives with an emphasis on anti-expert frameworks whilst encompassing social justice and person-centred beliefs.

The role I have explained above would be argued by Weiss-Gal and Welbourne (p. 282, 2008) to be the quintessential post-modern ideation of social work professionalization and matched my own perception of social work professionalization in that it provided me with identity, integrity and autonomy. I felt as though I had reached congruence with self, organisation and my professional code. I felt proud, accomplished and professionally recognised and this was significant, as I always feared I would struggle for this congruence.

It wasn't long, however, before my role's anti-expert foundation and social work underpinning was examined by managerial staff with a clinical governance lens. As well as this, it underwent informal speculation by my communities' mental health professional network and non social work colleagues within the organisation. It was considered by these groups as a superfluous role within the organisation, and that overall, a social worker was not suited to such a "technical" field. This criticism occurred despite the organisations'

overarching values and objectives of delivering contemporary youth friendly service, underpinned by an anti-expert framework and humanistic practice philosophy.

“What is a social workers professional role in mental health?” I asked myself, as I began to struggle to articulate my identity and purpose within the organisation. I felt like a mere functionary, without a professional identity to guide and construct the uniqueness of my practice. Was this related to the concept of de-professionalisation?

Whilst the term “de-professionalisation” can hold multiple meanings, Clarke (p. 189, 2005) explains that deprofessionalisation of social work is a result of economic/social policy shift, pushing for mechanised and managerial frameworks of practice for the purpose of rationalisation and increased accountability of social services. Ferguson, Lavalette and Whitmore (p. 70, 2005) go on to submit that these mechanised managerial type social services are more inclined to align their service delivery with professions that are characterised by medicalised ideologies such as law, medicine and psychology.

Comprehending this definition, I felt as though my profession and my role were characterised by this concept of de-professionalisation. This led to contemplation of my professional competence and confidence.

Over the duration of my practicum, supervision became critical to my professional growth and development. So I knew it was important that I sought out guidance from my supervisor, to ensure I continued to be reflexive in both my interpretation of these responses and approach to them.

Basically, I needed some help to unpack what had recently transpired.

During supervision, we reflected collaboratively, asking each other some very challenging questions about the existential nature of social work as a profession. My supervisor, an AASW mental health accredited social worker of 25+ years post graduate experience and a Masters in supervision, divulged her own experiences of feeling de-professionalised and devalued and how this similarly invoked in her what it did for me – consideration of professional confidence and competence.

Hearing my experienced supervisor share this with me helped me understand how the de-professionalisation of our role and identity can seriously impact on our own perceptions of our identity. I was already keen to undertake further study and immediately knew that this notion of how our professional identity is constructed, deconstructed and professionalised was going to be part of my research goals.

I am now at the beginning of the next stage of my academic journey, a postgraduate Master's degree in Research, and, this will be my topic of research. I have eager research supervisors, supportive family and friends and a desire to develop a depth of understanding of deprofessionalisation and secondly, a commitment to do something about it.

This research will be informed by a grounded theory approach. I am looking forward to gathering qualitative data, and presenting a narrative of social worker's professional identity in this context. I thank my supervisor for having those conversations with me as a student social worker and hope to hear other's perspectives on this as part of my research project.

I hope to follow up with this research progress in the upcoming Queensland Social Work winter edition and if this topic resonates with you, I hope you will consider participating in the future.

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Jacqueline McNamara – B Soc Wk (CQ University)
Source: https://www.aasw.asn.au/document/item/7039

Appendix B
Academic Space Article—QSW Winter Edition 2015

Hi All. My name is Jac and I am a new graduate social worker working and studying in Central Queensland. You last heard from me in the 'Academic Space' of the QLD AASW Summer Edition, 2015 where I shared some critical reflection on my final field education placement and how I wanted to do research on the development of professional identity of social workers in the health sector. My experience in my recent three-month secondment as a mental health intake officer has helped shape my own professional identity. It has been a challenging journey, but these challenges only provided more insight and convinced me that this is the right research area.

My first week involved observing the various members of the team; psychologists, nurses and social workers, carrying out their daily tasks as mental health clinicians. Each member added a flavour of discipline specific knowledge, skills and values to their delivery of the service. Initially, it seemed as though these various disciplines were worked in a kind of uniform harmony of shared roles. It resembled a healthy transdisciplinary model, with appropriate overlap of disciplinary boundaries, all with the focus of best practice and good outcomes. The psychologists and nurses collectively boasted over 70 years of experience! So it was safe to say that I felt that adhering to their feedback would be beneficial to my development as a mental health clinician and as a social work professional.

My role within the service was the intake of new "consumers" and to triage them accordingly. I was excited at the prospect of weaving my social work identity into this team. My external social work supervisor helped me think through how to develop my knowledge and skills, as well as how my social work values could be operationalized in this context (or not, as it turned out). My love of mental health work only encouraged my desire to be quickly inducted into my role. The senior intake officer had a nursing background and being an infant in terms of my professional growth I welcomed her guidance. She provided lots of constructive feedback and necessary supervision.

As social workers, we seldom knock back the opportunity to critically reflect on our experiences and are open to constructive feedback but it was here that - amidst this array of

skilled professionals – that their feedback and guidance began to create some cognitive dissonance for me. I was often told, amongst other things, that my approach is “too warm and empathic” as well as “you need to be quicker!” (I always needed to be quicker!). It was suggested that these should be areas for my professional development.

Despite some kind of intuitive feeling of resistance, I tried to weave their feedback into my approach to service delivery. As time went on, I found myself getting 'quicker' i.e. turning over larger amounts of “consumers” - soon I could revise a risk assessment almost without any critical thought and formulate a "management" plan instantaneously. Despite my social work training, I, like the other professions, began perceiving the high demand on the service as a private trouble rather than a public issue. The quick return of “consumers” to the service seen, not as a limit to the medical model, but just as an effect of their mental illness - or as the patient's failure - certainly not ours.

And the feedback was positive - I even started picking up medical jargon and scientific terminology in exchange for higher status as a professional within the service. But when I was told that I “focussed too much on validating the consumers’ experience” I knew it was time to take this up with my external social work supervisor. During supervision, my supervisor and I explored our interpretation of the social work role within mental health. We both agreed that as social workers within Australia, we are trained in a humanistic, as distinct from a scientific paradigm, with our knowledge being broadly drawn from social sciences and with no requirement to study the biomedical side of things (Barnes, Carpenter & Dickinson, 2000).

As I had learned during my social work studies, being not only reflective but also reflexive in my approach was essential for professional growth, so I went to the literature and found the concept of medical dominance. Willis (p. 4, 1989) explains medical dominance as doctor’s economic, political, intellectual and social domination over the health sector. It is manifested in the medical professions ability to control the knowledge in which healing is based. Within my own experience, I could see how my coding and labelling the people who accessed the service using medical jargon was adopting a "power-over" perspective - at odds with the values I tried to embody as a part of my professional identity.

In contrast to the medical model, health social workers are educated to identify the social and environmental causes of illness and sculpt an anti-oppressive, systemic and strength-based intervention - empowerment and connection are, in effect, our 'treatment'. Like nurses before us there is a need to think through how as a profession our identities can reshape this environment – lest we be shaped by it.

My attempt to weave the unique social work approach into my work was stymied – and this was not just due to my lack of experience. My emerging identity took on key aspects of the medical dominance model. This helped me to see that health social work professional identity presently faces a huge challenge in finding a way to resist medical dominance in accord with our set of values, ethics and practice standards (Coppock & Dunne, 2010). And it has to do this in a vastly changing health service landscape, characterised by an increase in privatisation, marketization and managerialism of the health sector (Gomory et al., 2011).

My challenge now, is to further explore these experiences with other social workers working within the practice area of health. By year's end I'll have completed my confirmation of candidature and hope to provide an update in the QLD AASW Summer Edition.

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Source: https://www.aasw.asn.au/document/item/7773

Appendix C
Recruitment Notice

Recruitment Notice

Research Participants Wanted

Participants are needed for a research project that seeks to explore the construction of social work professional identities in health settings within Queensland, Australia.

A willingness to undertake a private multi-media (phone, skype etc.) interview in which you share your experience of constructing your social work professional identity within the health setting you are employed is required. It is anticipated that each interview will last 60–90 minutes. Interviews will be held by at a time and location mutually agreeable to participants and researcher.

The research is being completed as a Master of Health Science (Research) at Central Queensland University. This research has been approved by Central Queensland University Human Research Ethics Committee–approval number: H16/02-033

If you are a qualified social worker, currently working in a health setting within Queensland, and would like to participate in this research, or would like further information, please contact:

Jacqueline McNamara

Phone: (07) 4923 2125 (Dr Wendy Hillman)

Email: j.l.mcnamara@cqumail.edu.au

Your input into this study would be greatly appreciated.

Appendix D
AASW Advertisement

TITLE: "An exploration of social workers' professional identities within health settings in Queensland."

Key dates	***19th March 2016 – 30th December 2016***
Participants sought	*Participants for this proposed study will be social workers at varying experience levels who, at the time of data collection, are employed full-time, part-time or on a casual basis, in social work specific or generic roles within any health setting in Queensland.*
About	*The purpose of this research is to gain an understanding of how social workers construct their professional identities in health settings within Queensland.*
What is involved	*A willingness to undertake a private multi-media (phone, skype etc.) interview in which you share your experience of constructing your social work professional identity within the health setting you are employed in. It is anticipated that each interview will last 60 – 90 minutes. Interviews will be held by at a time mutually agreeable to participants and researcher.*
How to get involved	*Please e-mail the researcher and express your interest in participating or if you have any queries regarding participation. An information sheet will be provided for your perusal.*
Institution and investigator contact	***Researcher:*** *Jacqueline McNamara* *e-mail: j.l.mcnamara@cqumail.com* ***Principal Supervisor:*** *Dr. Wendy Hillman* *e-mail: w.hillman@cqu.edu.au*

Appendix E
Information Sheet

15/08/2016

Dear,

Thank you for expressing an interest in my research project titled: “An exploration of social workers’ professional identities within health settings in Queensland.”

Please find attached, an Information Sheet that provides further information about the research and a Consent Form. If after reading the Information Sheet, you are willing to participate in the study please peruse the Consent Form, as during your interview with the researcher, you will be requested to provide verbal consent to the conditions outlined within the Consent Form.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Jacqueline McNamara

Email: j.l.mcnamara@cqumail.edu.au

Project Title: "An exploration of social workers' professional identities within health settings in Queensland."

Researcher: Jacqueline McNamara

Supervisors: Dr. Wendy Hillman
Senior Lecturer – School of Nursing & Midwifery
Central Queensland University, Rockhampton

Dr. Darren De Warren
Senior Lecturer – School of Human, Health & Social Sciences
Central Queensland University, Rockhampton

Ms. Davina Taylor
Lecturer – School of Human, Health & Social Sciences
Central Queensland University, Rockhampton

Contact Details:

Dr Wendy Hillman
CQUniversity
Bruce Highway
North Rockhampton
Queensland 4701
Email: w.hillman@cqu.edu.au
Phone: (07) 4923 2125

Appendix F
Introductory Letter

Dear,

The purpose of this research is to gain an understanding of how social workers construct their professional identities in health settings within Queensland.

Participation is open to anyone who is a qualified social worker, employed or self-employed in any health setting within Queensland. This includes participants of varying levels of experience, who are employed on full time, part time, or a casual basis in either social work identified or generic positions.

As a participant in this research, you will be asked to take part in an interview where you will be asked about your experiences of constructing your social work professional identity within the Queensland health setting you are employed in. The interview will be conducted by phone or multi-media program (skype, zoom etc), between you and the researcher in a mutually agreed private location. It is anticipated that the interview will take approximately 60 to 90 minutes. The interview will be held at a time convenient to you.

The interview will be recorded onto audiotape, to be later transcribed into a manuscript for analysis. Recording of the interview is to assist the researcher in having an accurate account of your experience for analysis.

You will not receive any monetary compensation for participating in this research.

During research projects where personal information is being discussed, issues can arise that may be confronting or upsetting to participants. The following contact is provided in the event that you need further support:

Lifeline Australia: 13 11 44 www.lifeline.org.au

The safeguarding of your privacy will be ensured by adherence and accordance to the Central Queensland University's Code of Conduct for Research Policy (CQUCCRP). Your name and any identifying information will not appear on any of the transcripts, thesis or

other publications. The consent form and any other identifying informaton and research data will be stored for 5 years in a secure and locked location, in accordance with CQUCCRP.

The research findings will be included in the researcher's Master of Health Science (Research) thesis, and may also be included in journal articles, conferences, and any other publications that may result from the research.

You are free to withdraw from the research at any time up to the point of data analysis with no explanation, and without prejudice or consequences as a result of your withdrawal.

I am happy to discuss any concerns you may have about how this study will be conducted. I can be contacted by emailing: j.l.mcnamara@cqumail.com

Should you wish to contact any of my supervisors to discuss any concerns you may have about how this study will be conducted, their contact details are located above.

Should there be any concerns about the nature and/or conduct of this research project, please contact:

Office of Research Services (Bldg 32 Level 2)
CQUniversity Australia
Bruce Highway
North Rockhampton QLD 4701
Australia
Ph: (07) 4923 2672
Email: rhd-admin@cqu.edu.au

Yours sincerely,

Jacqueline McNamara

Appendix G
Informed Consent Form

Project Title: *"An exploration of social workers' professional identities within health settings in Queensland."*

Researcher: **Jacqueline McNamara**

Supervisor/s: **Dr Wendy Hillman, Dr Darren De Warren & Ms. Davina Taylor**

Contact Details:

Jacqueline McNamara

Phone: (07) 4923 2125 Email: j.l.mcnamara@cqumail.edu.au

Dr Wendy Hillman

Phone: (07) 4923 2125 Email: w.hillman@cqu.edu.au

I consent to participation in this research project and agree that:

1) I have received an Information Sheet that I have read and understood.
2) I understand that participation in the research involves approximately a 60 to 90 minute individual phone interview and that additional information may be required at a later date.
3) I understand that this interview will be recorded onto audiotape and will be transcribed.
4) I understand that being a participant in this research is voluntary.
5) I understand that I can withdraw from this research at any time up to the point of data analysis with no consequences as a result of this course of action.
6) I understand that to preserve anonymity and maintain confidentiality of participants, that fictitious names may be used in publication(s).
7) I understand the research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet

8) I am aware that a Plain English statement of results will be available.

9) I agree that I am providing my consent to participate in the study.

Name:.....

Signature:.....

Date:.....

☐ Yes, I wish to have a Plain English statement of results posted to me at the postal address I provide below (please tick box)

Address: .....

.....

.....

Appendix H
Interview Questions

- Please tell me about the role you are currently employed in.
- Is this a social work specific role, or a generic role?
- What do you enjoy about your role?
- What are aspects of your role that you don't enjoy?
- Please tell me about your identity as a social worker in the role you are employed in.
- Please tell me about how you fit your social work professional identity within the role you are employed.
- Please tell me about how you fit your social work professional identity within the health setting as a whole.
- Is there anything further you would like to add?

Appendix I
Grounded Theory Memo

27/10/2017

I, and many other social workers, often pride ourselves in our capacity to critically reflect. However, I didn't require the participants to provide a described meaning of the word clinical. Instead, as a social worker myself, discussing the word clinical with the social work participants was non-eventful and did not warrant an on-the-spot critical consideration. Why is this? I feel as though it is a word we throw around in social work ad lib. Perhaps it's embedded in our strive to professionalise? To use language consistent with positivist knowledge paradigms? For me, the word clinical resonates as a term to warrant authority, sterility and professionalism. A kind of 'power over' concept. Historically, I know from the literature that in Australian social work, the use of the word clinical became prevalent during the 1970's. This was as the profession moved toward accreditation, benchmarked values and a shift to "postmodern" informing knowledge. Perhaps at this point, the consistent attribution of this word to social work identity has persisted to shape our everyday being in the health context. Perhaps to the point it's application is no longer questioned, and rather, a given. And perhaps, in the case of social work applying this word to our identity, we render ourselves compliant with the various socio-political facets (medical dominance, neoliberalism and managerialism) of dominant health ideology. In reflection of this, I could have accessed a more explicit meaning and application of the word. In order to explicate more rigorous and rich data. But it seems as though I entered this research socialised in to this discourse, and a party to the process of legitimising it through the social process of interviewing with participants.