A Copernican Revolution in Clinical Ethics: Engagement Versus Disengagement

Ross Van Amburg

Key Words: professional competence • professional–patient relations • role

Spiritual fulfillment in the professional role of occupational therapy practitioner is hindered by the ethical consideration of maintaining an objective client–therapist relationship. Objectivity is a disengaged perspective that depersonalizes human relationships. It operates on the tacitly performed, reductionistic assumption that all truth can be structurally represented and verified. However, to obtain meaning from truth is to adequately interpret experience through dialogue. Meaningful experiences are hermeneutical in nature and require engaged, sympathetic relationships to be spiritually manifested.

One of the confines of disengaged therapeutic relationships is the result of how we as occupational therapy practitioners find meaning and compliance with the scientific principle of objectivity. Our profession honors its social standing by including objectivity in our code of ethics as a standard of practice (American Occupational Therapy Association [AOTA], 1994). As this issue of The American Journal of Occupational Therapy demonstrates, there is a growing movement within the occupational therapy profession to find spiritual meaning in our professional roles. Urbanowski and Vargo (1994) defined spirituality as the ability to find personal meaning in life's experiences, even in the mundane. Yet, how can we constitute spiritually meaningful, professional roles into the disengaged, depersonalized refuge of objectivity?

Enforced Objectivity

As a postmodern culture, Western society continues to use the language of Cartesian dualism, which ties us to an epistemological, or knowledge-based, paradigm of interpreting our experiences by disengaging subject from object. An early example of this dualism, as suggested by Berman (1989), is that in the early history of the Catholic church, the spiritual–subjective aspects of reality were kept, through the authority and enforcement of the church, entirely and solely within the church's influence. The material–objective aspects of reality were allowed to be discussed only outside of the spiritual–subjective domain. Science was forced to disengage self from the material world of objects by considerable threats from the church. Persons who tried to lead spiritual lives by holistically integrating spirit into the corporeal world were branded heretics and became targets of the church's wrath. Likewise, our language has evolved into an epistemological paradigm through which our interpretations of experience have become a self-fulfilling prophecy. Separation of subject from object in reality are only poles of our attention. Our thoughts are tainted, as it were, by the historicity of meaning through the language within which we communicate.

Our socially accepted commitment to dualism is reflected in our appeal to scientific objectivity and its mandate to remove subjective interference from objective observation. This disengaged perspective is believed to remove the contaminating effect of personal influence on scientific experiments. Many professional organizations adopted dualism to enhance their scientific credibility and to protect their clients from intrusive practitioners. The depersonalization of human experience results from this commitment to disengagement.


This article was accepted for publication December 4, 1996.
Disengaged Relationships Harm Clients and Therapists

The effects of disengaged therapeutic relationships harm occupational therapy clients. With attention on client autonomy over the past three decades, clients have been increasingly concerned with the depersonalization of their illness experience. In recent history, the medical community has emphasized the importance of remedying a person's disability while omitting concern for the person's experiences with the disability. Treatment has centered on the dysfunction and not on the person who has the dysfunction. However, clients are concerned that the practitioners who provide for them also care for them. Peloquin (1993) summarized the problem as follows:

When practitioners depersonalize, they are not inclined to care, and their behaviors sap a patient's courage. Helpers rarely listen when patients ask them to attend; patients then reason that practitioners lack the required sensitivity. They despair of being understood. When helpers neglect their patients' heightened sensitivity, they intensify the pain of illness. (p. 835)

Case-Smith and Nastro (1993) found that therapists depersonalize their relationships with mothers of children with cerebral palsy. In their study, collaboration between clients and therapists was clearly missing in an environment rich in family autonomy and human agency. One of the authors' conclusions included the following:

The participants were alienated when professionals did not attend to their concerns, did not believe their reports about their children, and did not take seriously their report about their children's levels of functioning. These responses resulted in feelings of distress rather than a sense of collaboration in determining the child's program. (p. 815)

The problem of disengaged, depersonalized therapeutic relationships is exacerbated by the edict of the AOTA's (1994) Occupational Therapy Code of Ethics, which sanctions depersonalized ethical conduct. Principle 1B states, in part, "Occupational therapy personnel shall avoid those relationships or activities that interfere with professional judgment and objectivity [italics added]" (p. 1037). Objectivity is not a collaborative process. Rather, it is a depersonalizing and distancing practice that interferes with a practitioner's concept of caring and holism. It is an artifact of the medical model and one of the guiding principles for the science of occupational therapy. Objectivity should not be considered a therapeutic or ethical principle because it necessarily distances the client and the therapist from the therapeutic process.

The effects of disengaged therapeutic relationships harm therapists. Sachs and Labovitz (1994) found that all of the therapists they studied had difficulty delineating the boundaries of their role. These difficulties stemmed from three factors: (a) their interpretation of the holistic philosophy in their every activity as occupational therapists, (b) the nature of their caring work as broadening their activities beyond the strict occupational therapy role definition, and (c) the characteristics of organizational settings in which their work took place. (p. 1002)

Successful role performance is a function of self-efficacy. However, expectations of self must be realistic within a “dynamic interplay between thought, emotion, and action” (Bandura, 1982, p. 122).

Jacobs (1994) studied declining job satisfaction of 90 physical rehabilitation occupational therapists from a concern for an increasing professional attrition rate. She used Csikszentmihalyi's (1990) concept of flow as a job satisfaction index. Flow is a person's positive mental state that results from his or her subjective evaluation of the relationship between personal challenge and skill level (competence). Jacobs found that flow experience occurred only 2.4% of the time during caregiving intervention activities (only vocational intervention activities had lower flow results). Boredom was found to exceed flow experience for every subject. These numbers highlight the numbing effects of disengagement on therapists.

Paradigm Shift: A Copernican Revolution

To define professional role boundaries in a spiritually meaningful, professional code of ethics for occupational therapy, a paradigm shift is required. A holistic perspective must engage therapists in caring relationships with their clients regardless of the work setting. Helfrich and Kielhofner (1994) and Dreier (1992) have identified the perspective an engaged, holistic paradigm should have:

The disproportionate emphasis on meaning as a feature of either therapeutic media or therapeutic process reflects a view implicit to occupational therapy research—a view that the patient is coming into therapy. An alternative way of viewing how meaning is experienced in therapy is to consider therapy as an event coming into the life of the patient. (Helfrich & Kielhofner, 1994, p. 320)

Such an egocentric shift is a Copernican revolution. Copernicus, a 16th century astronomer, was regarded by history as the person responsible for changing the widely held, egocentric view that the universe revolved around the earth. Rather, the earth was found to be merely a component of the universe that influenced the behavior of objects only in an environment of mutual time and space because of its relatively weak gravitational attraction.

Understanding the Client–Therapist Relationship

Mattingly (1991) and many others have directed much of their research into developing a narrative-based therapeutic understanding of client care that emphasizes a phenomenological approach. These researchers have suggested that clinical reasoning is narrative in nature. According to Mattingly:
In each new clinical situation, then, the therapist must answer the question, What story am I in? To answer this question, the therapist must make some initial sense of the situation and then act on it. The process of treatment encourages, perhaps even compels, therapists to reason in a narrative mode. They must reason about how to guide their therapy with particular patients by imagining where the patient is now and where this patient might be at some future point after discharge. (p. 100)

Outcomes are measured by the efficacy of the narrative process: What is the meaning of the story for client and therapist? Rehabilitation may be the stated reason for a client’s treatment, but renewal (transformation) is the desired outcome that has meaning for all participants in the process. The members of the rehabilitation team (i.e., family members, the client, professionals) will create new chapters in their life stories because of their illness experience. Renewal is the positive outcome of a narrative-based ethic. It is necessary for each participant to be proactive in order for collaboration to occur. Collaboration will result in renewal for all participants if it becomes an enabling experience. Zaner (1993) confirmed this premise by illustrating how we learn self-worth from an enabling experience:

We are enabled to be what we are only within these complex and mutual relationships with others, relationships which voice that complex and often troubled imperative [self-worth]. We need and want other people to know that each of us is important, and we need and want to know that we matter to them. It has been noted often enough that when we are born, we are old enough to die. But, when we are born, we surely will die unless we are nurtured and tended by others, most obviously our parents. We owe our very lives to other people, and from birth on we exist within multiple and complex relationships, bonds, and ties. (p. 145)

Foundations for Narrative Truth

A Copernican revolution is being called for in the principles of occupational therapy's code of ethics. Objectivity is a valid prescription for applying many assessment protocols, but it should be recognized as being a disengaging therapeutic practice. Because the only knowledge we can have of the material universe is that of its structure, science assumes that truth can only be structurally represented. However, this paradigm is challenged by the hermeneutical (interpretive) perspective. Sherwood (1969) explored the hermeneutical requirements of a satisfactory psychoanalytic narrative. He found that two criteria were necessary to establish a satisfactory interpretation: adequacy and accuracy. These criteria formed the basis for Spence's (1982) delineation of truth into narrative truth and historical truth.

Historical truth relates to the accuracy of events. Questions pertaining to person, place, thing, time, and so forth can be validated by corroboration on the basis of whether these concepts were in fact aspects of the experience: Either they were present, or they were not. Historical truth is a reduction of the experience into its component parts or structure.

Narrative truth, on the other hand, cannot be validated with the same fact-finding reasoning of historical truth. Its measure of truth is determined by the appeal to adequacy: Does this account make sense? Narrative truth is the meaning of the experience, which exceeds the sum of its parts. It is a categorical mistake to attempt to reduce meaning to a component part of an experience because the meaning of any given event changes within the context of its interpretation.

Sympathy Versus Empathy

This distinction between historical truth and narrative truth is revealed through an examination of the difference between empathy and sympathy. The therapeutic use of empathy as a form of relationship that can be used in a narrative-based treatment approach can be misleading. A common definition of empathy relates to the ability of persons to project themselves into another's disposition (i.e., walk in someone else's shoes). This particular understanding of empathy can actually be an attempt for a therapist to find meaning in a disengaged and possibly imaginary relationship. Emotional understanding is congruent when it is experienced in the context of a mutually engaged relationship. In sympathy, a person enters into a relationship that is based on sharing of an emotional experience. For instance, although a person cannot feel another's pain, he or she can share the suffering experience. Suffering is an emotional experience that cannot be separated from the relationship therapy practitioners have with clients, it can only be ignored.

Transference in empathic understanding assumes that meaning is an independent object to capture and analyze. The empathizer attempts to find meaning by reducing another person's experience into component parts (historical truth) to find meaning for that person. However, there are no "externally fixed meanings independent of the interpreter" (Stenger, 1991, p. 33). Meaning is not a transferable commodity. Rather, it is an actively experienced inquiry of interpretation into the textual nature of dialogue (narrative truth). Stenger (1991) argued that "the interpreter cannot step out of his own horizon of intelligibility and adopt the author's [client's]. He can only try to assimilate the author's text into his own horizon, by widening his own conceptions of meaningfulness" (p. 33). Books, or any texts, that include conversation are not vessels of meaning that readers or interpreters reach outside of themselves, grasp, and then pull into themselves. Instead, they are potential creative experiences that result in meaningful relationships through continuous personal interpretation and dialogue with the text itself.
In dialogue, the conversationalist formulates his or her experiences of past events into words. According to Gadamer (1977), "As dialogue, language is not the possession of one partner or the other, but the medium of understanding that lies between them" (p. xxxii). Meaning is not a static quality. It is a dynamic relationship that involves the continuous interpretation of text within the changing field of narrative upon which it is presented. As Foucault (1993) argued:

It is not that words are imperfect, or that, when confronted by the visible, they prove insuperably inadequate. Neither can be reduced to the other's terms: it is in vain that we attempt to show, by the use of images, metaphors, or similes, what we are saying; the space where they achieve their splendor is not that deployed by our eyes but that defined by the sequential elements of syntax. (p. 9)

**Interpretation in Human Agency**

The capacity to construct (not reconstruct) interpretations of past events allows the person to achieve several important goals. First, it allows the person to understand his or her experience, possibly in a new way. The person makes sense of the past experience in his or her current context where he or she is able to take action and adapt to lessons offered by the past. Second, it can provide coherence to a person's greater organization or reason. Coherence involves the elimination of irrelevant information in a comprehensive presentation; therefore, the information is more accessible because of its improved clarity. Third, construction of past experiences also subjects the interpreter to personal responsibility for his or her actions. Taylor's (1993) concept of second order desires (self-reflection) provides us with an understanding of how we evaluate our personal preferences. We are responsible human agents because we are capable of interpreting and reflecting on our first order desires (personal preferences). The desire itself is a text through which we interpret our internal process of self-reflection. We use strong evaluation to understand the "quality of our motivation" (p. 16). Strong evaluation allows us to become engaged in the self-reflective, dialogical process of understanding our preferences through the language of "qualitative contrasts" (p. 21) (e.g., Is this activity more meaningful than another?). We are responsible human agents because we have the capacity to change our behavior on the basis of our self-reflective capacity.

The consequences of an increased utilitarian emphasis on outcomes as measures of worth will be to reduce practical reason and responsibility to mere calculation. Utilitarians will only concede to empower human agency with weak evaluations of personal preferences, which are based on tacitly interpreted self-reflection that is influenced more by quantitative concern for outcome (e.g., Is this activity purposeful?). Yet, all decisions between possible alternatives are not derivable from calculation. Weak evaluations are shallow because they do not completely engage the full capacity of the therapy practitioner to interpret and find meaning in the treatment relationship. Our capacity to achieve emotional understanding through interpretation can only be achieved through strong evaluation of our own shared, personal narrative.

**Hermeneutical Experience**

The extent to which engagement occurs is a reflection of the meaningful involvement that is experienced in the therapeutic relationship. The therapeutic relationship merges the personal experiences (life stories) of each participant into one narrative, much like the area defined by overlapping circles. We share a common experience with our clients—the therapeutic experience. Practitioners do not leave their own context to engage in this shared experience. Rather, they use their context (professional judgment, personal understanding) to influence the experience. This treatment narrative is interpreted as a form of text by each participant through the continuing dialogue required of his or her engaged participation. The shared goal of treatment (i.e., renewal) becomes the narrative's focus and the constitution of the relationship.

How the treatment narrative is experienced is determined not by the regulation of objective calculations but by the participants' meaningful engagement. The participants' approach to the experience influences its direction and scope. The dialogue is ongoing and never finalized because all participants are continuously interpreting their own experience. "The task of the translator, therefore," according to Gadamer (1977), "must never be to copy what is said, but to place himself in the direction of what is said" (p. 68). Gadamer called this mode of human experience, hermeneutical experience.

In a disengaged relationship, the therapist must sell his or her authority to the client. The disengaged therapist helps to elicit anticipated behavioral responses from clients, using reductionistic techniques that often do not involve the client's own desires and motivations. Therapy is then aimed at purposeful (functional), but not necessarily meaningful, activities, using only functional outcomes as measures of client worth. The client-therapist dialogue becomes centered on the control of the therapist:

The ideal of disengagement defines a certain—typically modern—notion of freedom, as the ability to act on one's own, without outside interference or subordination to outside authority. It defines its own peculiar notion of human dignity, closely connected to freedom. And these in turn are linked to ideals of efficacy, power, unperturbability, which for all their links with earlier ideals are original with modern culture. (Taylor, 1993, p. 5)

In an engaged relationship, the client-therapist dialogue is centered not on the control of the therapist but...
on the sympathetic engagement of its participants to find personal meaning in their relationship. We use language to communicate our desires and motivations because as Steiner (1975) observed:

"no two human beings share an identical associative context. Because such a context is made up of the totality of an individual existence, because it comprehends not only the sum of personal memory and experience but also the reservoir of the particular subconscious, it will differ from person to person. There are no facsimiles of sensibility, no twin psyches. All speech forms and notations, therefore, entail a latent or realized element of individual specificity. (p. 170)"

Conclusion

Language is the medium through which we express and interpret our experiences cognitively. Our ability to interpret our experiences is the result of our understanding of our presence of being in the world. There can be no other interpretation and scientific objectivity as a coerced methodology that has relied merely on the quantitative accuracy of historical truth to the exclusion of narrative truth, then our profession is well on its way to a hermeneutical understanding of itself and its role in society. The profession has dwelled within the box of disengaged objectivity, but it still exists within the sphere of interpretation. We as a profession need to climb out of that box into the sunshine of human experience.

Acknowledgments

I thank Dawson Schultz, Ph.D. for guiding me through hermeneutics and the cutting edge of medical ethics; Anita Bundy, ScD, OTR, FAOTA, for encouraging me to publish; and Lois Hickman, MS, OTR, for emphasizing that ambience is a fundamental aspect of dialogue.

References


Dreier, O. (1992, September). Narrative and patient’s life worlds: How the stories patients tell in therapeutic settings relate to what goes on in their everyday life. Colloquium conducted at the Center for Research, Department of Occupational Therapy, University of Illinois at Chicago.


