Recovering Relationships: A Feminist Analysis of Recovery Models

Kate Brown, Diane Gillespie

Two models of recovery based on the concepts of independence and interdependence are contrasted from a feminist perspective. Drawing on social and psychological analyses, the authors critique the overemphasis of independence as the goal of health care and instead advocate a more relational model of therapy that reinforces social and emotional connections between people. Two narratives from occupational therapy are used to illustrate the differing assumptions underlying these models. The authors discuss some of the structural and interactional barriers to the expression of interdependence in health care institutions. They suggest that through purposefully sharing practice experiences and instating collaborative, nonhierarchical models of organization, practitioners can begin to overcome these barriers.

Independence and Connection

In their comparative work with cultures across time and around the world, anthropologists have observed that human beings are social creatures. Our meanings, languages, and even survival as a species are predicated on the ability to relate to each other in interdependent ways. The primacy of the independent person, as articulated in mainstream American culture, is not shared by many people around the world (or by some marginal groups in the United States) who live in more communitarian societies (Shweder & Bourne, 1982). In these societies, networks of reciprocal kinship and community obligations tend to bind persons together in the expectation that more close-knit relationships are right, good, and even necessary. The health beliefs and practices in such societies often reflect this communitarian emphasis. For instance, from the perspective of many Southeast Asians, it would seem cruel and unhealthy for a grandmother to live alone in a retirement home room where she would be responsible for her own care; she would be unnaturally isolated from a meaningful web of mutually caring relationships.

Of course, communitarian relationships are not entirely absent from mainstream American culture or health care, but independent individualism is valued more. A number of cultural analysts have remarked on a growing discontent and alienation in the United States that have resulted from this imbalance between independence and connection in work and other aspects of life (Bellah, Madsen, Sullivan, Swidler, &Tipton, 1985; Brown, 1990; McIntyre, 1984). A call for social structures and policies that
can foster greater equilibrium between these two poles arises from such commentaries.

This call is reinforced by the work of feminist psychologists who have voiced strong objections to independence as an ideal for mental health and especially for women’s development. Miller (1987) and McIntosh (1985, 1989), for example, have argued that the notion of an independent self is a myth perpetuated by the privileged and powerful who have hidden and disguised their dependence on others. The success of such supposedly independent persons is based on the assistance of others whose supportive work (e.g., typing the reports, raising the children, cleaning the homes, cooking the meals, and carrying out the orders of the independent person) is devalued and overlooked.

Gilligan (1982) and Gilligan, Ward, and Taylor (1988) have also questioned the cultural assumption that equates maturity, high self-esteem, and well-being with self-sufficiency and autonomy. In psychological and moral theories that are based on the ideal of the self as separate, dependence on others is viewed as dysfunctional, debilitating, and less worthy. However, feminist psychologists have shown that relationships with others need not be demeaning and that meaningful connections with others help many people to mature and gain self-esteem. To denigrate such relationships is to deny the fruitful realization of a different self-concept, one that is especially valued by women in our society. Surrey (1991) explained that “for women, the primary experience of self is relational, that is, the self is organized and developed in the context of important relationships” (p. 52). This relational matrix of the self emerges from women’s socialization and the cultural expectation that they will take care of people. The difficulty for women caregivers is, as we noted above, that the work of relationship is both invisible and devalued.

Implications for Occupational Therapy

To show their different implications for occupational therapy, we contrast two models of recovery—one based on independence, the other based on interdependence—through stories told from the perspectives of two occupational therapists, Chris and Pat. We have written these descriptions as narratives to illustrate how therapeutic assumptions can be revealed through the words and attitudes of the tellers of these stories.

Chris and Ms. C.

Ms. C. is a 62-year-old widow who is recovering from a stroke under the care of Chris. Chris tells about her as follows:

Ms. C. was a pretty standard case. You know, she was lonely from being widowed recently and still adjusting to living alone. I kept encouraging her . . . that she could do most things on her own at home, that it was important to try to live like she used to. After we rearranged the furniture and discussed such basics as food preparation, bathing, dressing, and grooming, I felt confident that Ms. C.’s capacity to perform self-care tasks was adequate. Her hand was still weak and we went over some exercises that she could do at home to increase her endurance and ability to be independent.

I encouraged her to do things she could still do even though she might be slow. She likes to watch television, and she has a friend come by to take her to play Bingo at the church once a week. It’s hard for older people living alone, but she’s functioning pretty well. She’ll make it. Luckily she has enough money to live comfortably and hire any help she needs. I checked that out first...her financial situation.

Pat and Ms. P.

Like Ms. C., Ms. P. is recovering from a mild stroke; she is in her 70s and recently widowed. Pat describes the experience with Ms. P. as follows:

The first thing I heard from Ms. P. when I interviewed her was her concern about feeling cut off from people since her husband died, and then even more cut off after the stroke. She’s very lonely. And I thought to myself that there must be 50 other widows in Omaha in this situation, and I wanted to get them all together so that they could meet each other and help each other out. I kept thinking about my experience in the Peace Corps in West Africa and how this woman sitting in front of me— if she were in Senegal—would never be left alone with no one to look after her. So I asked my colleagues about support groups—we try to help each other find resources—and I found some groups thought she might want to participate in. She used to play bridge before her husband died and she thinks that it would be interesting to join a card club through her church. Last week, we concentrated on hand exercises that will allow her to shuffle cards. Her son feels pressured and maybe guilty that he’s not here. But I told him that his mother just needs to hear his voice every other day. He doesn’t have to spend a long time on the phone with her—just check in and share some of his life and ask about her. And then what about any neighbors? I still worry about her and I guess I worry about being able to try to link older people to other people. There are so many barriers, transportation not the least. It can get depressing and sometimes I wonder if it’s even part of my job to care...maybe that’s the most depressing thought.

Chris’s story illustrates the themes that inform the model of recovery based on independent functioning. From a distanced position in relation to Ms. C., Chris is an objective and neutral observer of her situation. Chris assumes that Ms. C. must learn to handle frustration and adversity on her own and that the professional’s role is to manage her case through identifying strategies that will allow her to adjust to her situation. Caretaking of Ms. C. is impersonal, without specific response to the particulars in her life; Chris treats her as she would any other stroke survivor. Concentrating on Ms. C.’s ability to regain her strength in physical terms, Chris has focused on the problems of self-care and daily maintenance. Self-sufficiency and autonomy, then, rivet Chris’s thinking about the recovery process.

In contrast, Pat’s description of Ms. P.’s situation reveals a different way of thinking about recovery, one that we identify as relational because it is based on interdependence and connectedness. Pat imagines for Ms. P. what women-centered psychologists such as Belenky, Clinchy, Goldberger, and Tarule (1986) called a holding environment, a safe relational context (see also Fedele &
Harrington, 1990). Such an environment allows care to be particularized; that is, Pat situates a plan for Ms. P.’s recovery in the context of her real social experiences. Through listening to and understanding Ms. P.’s concerns, Pat then imagines new arrangements that would connect and integrate Ms. P. with others. For Pat, recovery is a process of reconnecting and re-engaging with others given the new set of circumstances that resulted from Ms. P.’s stroke. Further, Pat responds to Ms. P.’s vulnerability to loneliness and links it to her motivation to recover.

The core psychological ingredients of a relational model of recovery are attentiveness, empathy, and mutuality (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Attentiveness to others and a motivation to understand their situations, for example, create the climate for relational growth and recovery. In her work on the relational self, Jordan (1991) noted that empathy is both affective and cognitive. One tries out another’s experience as if it were one’s own: “one places oneself in the other’s shoes or looks through the other’s eyes” (p. 29). Accurate empathy allows us to see the other in the fullest possible context. However, empathy does not imply that one lives solely in or through the other. Instead, as for an anthropologist working in another culture, the goals of empathy are not only greater sensitivity to the circumstances and orientations of others, but also better understanding of one’s own experience (Marcus & Fischer, 1986). In this way, empathy contributes to mutuality. Through mutuality, we not only accept the similarities of our experiences with the other, but also come to respect the uniqueness of our experiences and the differences in our situations.

Pat demonstrates this cycle of attention-empathy-mutuality in the narrative presented above. Pat actively imagines what it would be like in Ms. P.’s situation but balances this identification with the recognition of their different roles in her recovery. Pat’s ability to empathize with Ms. P. allows Pat to discover already meaningful connections in Ms. P.’s life. With this subjective knowledge, Pat can foster Ms. P.’s integration back into her relational context. In contrast to Chris’s more detached, objective, or cross-situational approach with Ms. C., Pat’s approach is engaged, personal, and focused on the particulars of Ms. P.’s recovery. Empathic sharing must be coupled with mutuality in relationship if both persons involved in the caretaking process are to be empowered. Pat moves toward Ms. P. in an empathic exploration of her circumstances and as a result Pat understands her anew; similarly, because she feels heard and attended to, Ms. P. is able to move toward Pat by sharing more details about her illness and living situation. In mutual relationships, each person affects the other. “Mutual empathy occurs when two people relate to each other in a context of interest in the other, emotional availability and responsiveness, cognitive appreciation of the wholeness of the other; the intent is to understand” (Jordan, 1991, p. 89).

Pat also recognizes the difference in their situations and their unequal roles, and this knowledge leads her to recommend that Ms. P. join support groups where she can relate to others on common and equal ground. If the group can validate Ms. P.’s experiences, she can better develop her own sense of agency as a recovering person. Without such validation and empathy, Ms. P. may learn to see herself as a burden on others who must care for her. Pat demonstrates the concept of mutuality not only in relation to Ms. P. but also through her interaction with her colleagues. Their support heightens Pat’s capacity for caregiving.

Pat’s capacity to care is not limitless, however. As she says, the work as conceived within a relational model can be depressing. Financial, transportation, and prejudicial barriers can and do circumvent the efforts of professionals and patients who frame their concept of recovery on such notions as interdependence, connection, and community. Patients’ circumstances may be so alienated and community linkages so attenuated that building networks of relationship for recovery seems impossible. Patients who are secure in relationships only if they are the givers may resist the basic interactional skills involved in asking for assistance from others (Snow & Rogers, 1985). Additionally, patients who for psychological or cultural reasons are more comfortable as loners may resist these rehabilitative efforts. Furthermore, the work that Pat was trying to do may not be appreciated by supervisors or the agencies that reimburse for such services because they are likely to reward the more dominant model of independent recovery.

Organizational Constraints

Too often the source of discouragement for an occupational therapist working within a relational model of recovery comes from a lack of institutional support for this perspective. The independence model of treatment and recovery depicted in Chris’s narrative often dominates the orientations of the most powerful professionals and administrators in health care organizations. Organized bureaucratically, institutions expect occupational therapists, as caregivers, to conform to prescribed roles and definitions set forth objectively for standards of care. Chris is likely to gain power in the institution by fitting into these already established institutional formulations. Assuming the agreed-on way to be natural and right, administrators and practitioners become blind to alternative ways of providing care. From the orientation of independent functioning, Pat’s approach seems subjective, emotional: Pat may seem overly involved in the case. As a result of such criticism, Pat may feel silenced and depressed. The health care system’s inability to hear what Pat knows about recovery is paradoxical for an institution with the word care in its name.
Ferguson (1984) observed that such a criticism is inevitable from within the hierarchical structures that organize human services in the United States. She argued that the goals of health and welfare institutions have become bureaucratically defined to meet more of the organization's needs for efficiency and accountability and less of the patients' needs for care. Decision makers with authority in such institutions seldom create the means for knowledge from practitioners in the organization's lower echelons to influence their policies. It follows then that upward mobility within the organization would not be as likely for professionals whose goals do not match those of their employers. Professionals who work with colleagues and patients from a more connected, less competitive model may be directly and negatively sanctioned, or they may find themselves indirectly affected (e.g., passed over for promotion).

Add the increasing commercialization of health care to these organizational priorities and a relational model for patient care and recovery becomes even more problematic. As reimbursement becomes more tied to technical procedures, the cognitive and affective work involved in forming relationships with patients and fostering community around them is further devalued because these activities are not billable units of interaction.

**Toward a Feminist Model of Occupational Therapy**

We have sketched out some of the theoretical dimensions of what a relational model of recovery might entail in contrast with the prevailing recovery goals of independence and self-care. In addition, we have suggested that an interdependence model often stands in opposition to current institutional arrangements that control health care practices. The barriers notwithstanding, occupational therapists like Pat who practice an interdependent model of recovery are at the vanguard of a growing feminist movement that espouses the importance of human connection as essential to our nation's health into the next century (Gilligan, 1987). Two approaches that occupational therapists are using with other practitioners to promote interdependence, connection, and community in recovery are discussed below.

**Conscious Reflection About Practice**

Even such a simple act as telling a story about one's work—its complexities, contradictions, successes, and frustrations—can be empowering to both the teller and the listener (for a discussion of epistemology and narrative, see Bruner, 1986). Our hypothetical informants, Chris and Pat, would no doubt be prompted to think about the basis of their therapeutic assumptions because someone called forth their stories. Grumet (1988) observed that people, especially women, who work in male-dominated professions rarely have the opportunity for supportive reflection about their practice, especially if their work challenges institutionally prescribed methods or formulas. Her arguments concerned teachers but apply to service professions: "We need to re-create safe places" she argued, "where practitioners such as Pat can concentrate, can attend to their experience of [helping people recover], and we need to create community spaces where the forms that express that experience are shared" (p. 90). Without such places, there is the danger that sharing troubles at work or expressing longings for more meaningful connections will degenerate into complaint sessions, group commiseration, or defensiveness.

Yet in our experience with health care and social service professionals, the process of sharing often germinates the seeds for alternatives to the instrumental, personalized, and competitive values of a hierarchical, rule-governed workplace. This buried knowledge can then be used to create organizational spaces and structures more conducive to a relational model of care.

**New Structures for Relational Recovery**

Ferguson (1984) suggested that we need to restructure existing service agencies or form new ones before we can express and be rewarded for the work that we call relational recovery. She favored a collective model of authority where, for instance, patients, providers, and administrators are partners, each responsible for mutual support, each valuing her or his interdependence. Helgesen (1990) wrote about accomplishing such collaboration through a web-like organizational structure as opposed to a hierarchical pyramid in which authority flows from the top down. The web structure results in multidimensional connections that allow more information to flow through the system. To support these new organizational models, the skills of interdependence will have to be learned by all agents in the recovery process so that attentiveness, empathy, and mutuality can flourish in a healthy, sustaining cycle. Health care agencies must also be community-based, creating or building on the existing social, financial, and political means to foster recovery through such programs as barrier-free architecture.

Conscious reflection and organizational restructuring in health care are not dreams, but are being used now by committed feminists and health providers in many parts of the country, as can be seen in the rise of half-way houses, hospices, support groups for people living with diseases and disabilities, free clinics, and disability advocacy groups. Challenges certainly remain, but those who struggle to recover relationships can bring new meaning, empowerment, and connection to their communities and reap these same benefits for themselves in the process.
References


