Gazing Anew: The Shift From a Clinical Gaze to an Ethnographic Lens

Mary C. Lawlor

The purpose of this paper is to analyze ways of perceiving, knowing, and being with others while engaging in qualitative and ethnographic research. As occupational therapists acquire research expertise and embark on research trajectories, they bring their clinical legacy into the research arena. The ability to conduct qualitative and ethnographic projects may require a reconfiguration of the clinical gaze of occupational therapists. This transformation is complex and also involves acquiring and adopting a stance that alters relational and interpersonal processes and results in new ways of seeing and being. I draw upon experiences in training, mentoring, and supervising therapists who embark on ethnographic research, as well as my own research practices, to illustrate points of intersection and divergence between the clinical gaze and ethnographic lens. Artistic metaphors are also used to highlight aspects of the interactional and intersubjective processes intrinsic to ethnographic practices. I argue that ethnographers are continually evaluating and negotiating their stance in the field. The clinician who becomes an ethnographer faces unique challenges to his or her stance in the midst of moment to moment encounters as well as over time in the course of prolonged engagement.

vision needs to be reconfigured (Webster’s, 1996). I believe the idea of reconfiguration or distortion captures the experiences of some therapists who feel they are looking at the world in a new and different way when they begin to do research. I will focus on aspects of ethnography, a particular theoretical and methodological approach in qualitative research. Where appropriate, I will refer to the broader arena of qualitative research. In discussing ethnography, I will rely primarily on ethnographic theory and methods that are grounded in anthropological traditions, but will attempt to avoid a confounding of ethnographic theory and anthropology.¹

I draw specifically upon experience gained through co-conducting two longitudinal, multisite, federally-funded, interdisciplinary ethnographic studies and on my own experiences negotiating the transition from clinician to researcher. This research, and the pilot work that preceded the current study, have extended over a period of a dozen years in Chicago and Los Angeles.² This paper is informed as well by informal discussions with research team members in the midst of conducting fieldwork, as well as in processing research encounters, and in analyzing and interpreting data.

Implicit in my naming the transition process of moving from clinician to researcher as transformation is my belief that embarking on a research trajectory³ both requires and results in major shifts in identity and ways of understanding human experience. Clinical trajectories and research trajectories intersect, but also diverge in several key areas. The points of intersection indicate ways in which the clinical gaze enhances ethnographic work and points of divergence mark times in which the clinician must abandon or blindfold his or her clinical gaze, or adopt a new lens, in order to allow the ethnographic view to flourish.

¹ Ethnographic approaches are also prevalent in sociology, education, medical humanities, and other social sciences. I am considering here only ethnography that is qualitative, though recognize that some ethnography is quantitative or combines qualitative and quantitative approaches in mixed method designs.

² For additional descriptions of these research projects, see Lawlor and Mattingly (1998, 2001) and Mattingly and Lawlor (2000, 2001).

³ The term trajectory as used here refers to movement into a practice arena (in this case, research) that requires the mastery of certain skills and the acquisition of a new identity and is based on the work of Lave (1997) and Lave and Wenger (1991). These authors, as well as other practice and learning theorists, emphasize the social dimensions of learning a practice and the importance of participation in social communities as part of learning and socialization processes (Wenger, 1998). The concept of trajectory adds possibilities of movement in a desired direction, such as becoming a better qualitative researcher or gaining mastery of ethnography. As Lave (1997) has argued, the concept of trajectory provides for “...the possibilities for going deeper, becoming more of something” (p. 148).

Artistic metaphors also help to frame the arguments presented in this paper. Artistic and aesthetic modes have historically been evoked to convey the art of occupational therapy as well as the art of ethnography (e.g., Lawrence-Lightfoot & Davis, 1997; Rosaldo, 1993; Willis, 2000). The artists who generated the movement that led to the impressionists period exemplified a kind of transformation in practice and identity that might be seen to parallel the transformation process of clinicians who become qualitative researchers. During the impressionist movement, artists left studios and government sponsored venues for selling art for the immediacy of painting from nature and in public social settings. Improvisation and a desire to capture the experiences of the senses motivated the artists (e.g., Kapos, 1991; Tucker, 2000). Perhaps a motivation to study and appreciate lives as lived in sociocultural worlds has prompted occupational therapists to leave institutional settings and participate in community life through qualitative ethnographic projects. A number of art historians and critics comment on the challenge faced by these revolutionary artists in their attempts to forget what they had known, to somehow see the world in a fresh new way, as if for the first time (e.g., Zola, 1991). Occupational therapists with a well-developed clinical eye face challenges as they attempt to gaze anew as researchers.

The Metaphor of Gaze

The use of gaze to indicate ways of knowing and perceiving, a particular stance toward the world, can be found in many fields including medicine, social sciences, and humanities. The term gaze is often used based on the work of Michel Foucault (1973) and often paired with a qualifier such as “clinical” gaze, (Foucault, 1973; Good, 1994), or “medical” gaze (e.g., Good, 1994; Greenhalgh, 2001). Byron Good (1994) described the process of acquiring a medical gaze including learning how to “think anatomically” (p. 73), which enables the clinician to deconstruct the human being into manageable units of focus related to specific elements of the body. The power of the medical or clinical gaze is not merely evident as a form of seeing, but is also expressed in terms of how it works to reconstruct or reconfigure the object of the gaze (Good, 1994; Good & Good, 1993). Mary-Jo Good (1995) examined how students enhanced the focus of their gaze through the socialization processes inherent in medical education including the responses of supervisors to their clinical reasoning processes and their narrative constructions about their observations.

Although comments about the clinical eye or an occupational therapy way of seeing can often be heard in occupational therapy settings, little explicit description of an
occupational therapy gaze is found in the current literature. Fleming and Mattingly (1994) described ways of perceiving as a central dimension of clinical reasoning. Gazing as a particular mode of perceiving, seeing, and knowing is implied in Mattingly's (1994a, 1994b) descriptions of occupational therapy as a two-body practice and in the appreciation of the "reading" of contexts in the clinical reasoning process (Mattingly, 1991). Burke (1997) described eye gaze in a pragmatic rather than metaphorical sense when discussing acts used by therapists to signal parents. Hooper (1997), in a case study of philosophical underpinnings of clinical reasoning, appeared to call on gaze metaphors when concluding: "As therapists are able to trade eyeglasses, there can be tremendous learning across borders" (p. 336).

Visual metaphors permeate the ethnographic and anthropological literature. For example, Clifford (1997), in describing traditional conceptualizations of fieldwork in anthropology says, "The eye is unimpeded, free to roam." (p. 52). Stoller (1989, 1996), Grimshaw (2001), Herzfeld (2001), and others argue that there is a kind of privileging of visual modes of understanding in anthropology or ethnography or both that parallels the centrality of vision in Western discourses. Grimshaw (2001) argues that the use of vision in anthropology serves two purposes; as a methodological aspect of ethnographic practice and as a kind of metaphor for ways of knowing or knowledge. The use of the term "witnessing" is also fairly prevalent in descriptions of ethnography, usually referring to the presence of researchers during key moments or events in participants' lives (e.g., Behar, 1996; Davis, 1997; Green, 1998). In Lawrence-Lightfoot and Davis's (1997) analysis of the relational aspects of ethnographic research, visual metaphors including perspective taking, illumination, witnessing, and lenses are used extensively, though not exclusively.

The metaphor of gaze also captures a particularly salient feature of observation, human interaction, and responsiveness. Byron Good (1994) asserted "Medical knowledge is not only a medium of perception, a 'gaze,' as one might take from Foucault. It is a medium of experience, a mode of engagement with the world" (p. 86). In reflecting on a childhood experience, Sara Lawrence-Lightfoot (2000) stated, "In the process of recording the image, the artist has made me feel 'seen' in a way that I had never felt seen before, fully attended to, wrapped up in an empathetic gaze. I learned that an essential ingredient of creating a portrait was the process of human interaction" (p. 211). Placing engagement as a central dimension to gazing allows this metaphor to be a helpful analytic tool in comparing and contrasting ways of perceiving and knowing that are intrinsic to research practices and clinical practices.

Gazing also conveys the interrelatedness of theory and practice. In both clinical practice and ethnography, the eye is directed by an agenda that incorporates theoretical sensitivities toward where one might look, what one should see, what is foregrounded, where attention should go, and how long attention should linger. Gaze is theory driven, even when in a particular research mode the theory orienting the eye is one of attempting to free the mind from a particular theoretical stance or preconceived notions.

The metaphor of gazing also connotes a physical act that does not solely reside in the eyes. It is also evident in the gazer's body. Embodied knowledge contributes to ways of being in the world. Hasselkus (1997), drawing on the work of Heidegger, described the researcher's subjectivity as incorporating their mode of "being-in-the-world." She contrasts this with the calls of others for an "objective eye," a researcher stance that she considers antithetical to qualitative inquiry. As Laderman (1994) argues, "Anthropologists use their own bodies and minds as primary tools for the investigation of cultures. They participate as deeply as possible in the lives of those they study, at the same time maintaining sufficient distance to observe the workings of culture. They become insiders-outsiders, observing with cool eyes and participating with a warm heart" (p. 192). The way of being a therapist in a health care encounter is a different way of being than an ethnographer. One doesn't just think differently or perceive differently. One also acts differently and this mode of action reflects the reality that one is also being different in these sometimes complementary and sometimes contradictory arenas.

Perceived Affinity Between Qualitative Methods and Occupational Therapy

Arguments about the perceived affinity between qualitative research and occupational therapy or occupational science are often based on perceptions of shared domains of concern (Kielhofner, 1982; Larson & Fanchiang, 1996; Yerxa, 1991; Yerxa, et al., 1990). The apparent coherence of occupational therapy and qualitative methods has also been noted related to ethnography. For example, occupational therapists have been described as “ethnographers” of their own practice (Mattingly & Gillette, 1991). Ethnography is about the everyday (e.g., Hammersley & Atkinson, 1995; Willis, 2000) and directed toward understanding how people live their lives in their sociocultural worlds. Occupational therapists address activities of daily life and are increasingly attentive to sociocultural influences on meaning and lived experience.

Improvisation as a critical element of practice has been described for both occupational therapy (Mattingly, 1998)
and ethnography (Holland, Lachiotte, Skinner, & Cain, 1998; Willis, 2000). Occupational therapy practices and ethnographic work are often narratively organized and grounded in both narrative reasoning and narrative theory (Mattingly, 1998; Mattingly & Lawlor, 2001; Jackson J., 1998). Narrative often forms the basis for social action in both practices. This social action is grounded in intersubjectivity (Carrithers, 1992) and in interpersonal processes involving establishing connectedness, a central feature of both practices. However, the relational and intersubjective nature of ethnography draws upon different conceptual foundations than practitioner–patient relationships (Aunger, 1995; Jackson M., 1998; Lawlor & Mattingly, 2001). For therapists and patients and their families, the driving question is, “How can we come to know enough about each other that we can effectively partner up?” The objective is one of collaboration and the extent to which practitioners and their clients need to know each other is limited by the extent to which the knowledge is relevant to the intervention and recovery process. The relational work and intersubjective challenges in ethnography differ in terms of intensity, degree of intimacy, and the nature of the interpersonal processes (Lawlor & Mattingly, 2001).

A review of the literature reveals many instances in which qualitative or ethnographic methods are incorporated into clinical practice or are recommended as techniques to be imported into clinical practice (e.g., Clark, 1993; Clark, Ennevar, & Richardson, 1996; Gitlin, Corcoran, & Leinmiller-Eckhardt, 1995; Frank, 1996; Hasselkus, 1990; Price-Lackey & Cashman, 1996). Ethnographic and other qualitative techniques have been used in studies of occupational therapy practice (e.g., Burke, 1997; Crepeau, 1991; Mattingly, 1998; Mattingly & Fleming, 1994; Niehaus, Bundy, Mattingly, & Lawlor, 1991; Rosa & Hasselkus, 1996; Townsend, 1996). Occupational therapy researchers and anthropologists associated with the profession have conducted qualitative and ethnographic studies related to illness or disability experiences (e.g., Farber, 2000; Frank, 2000; Kretting, 1989); caregiving practices (e.g., Hasselkus, 1991; Scoggin, 1999); and occupation (e.g., Clark, 1993; Dickie, 1996; Larson, 2000; Mee & Sumson, 2001).

Reflections on the influence of an occupational therapy perspective on the conduct of research are briefly discussed in some qualitative papers. Townsend (1996) introduces her study of occupational therapy mental health practice by describing her research stance as one of being an “occupational therapist, adult educator, and sociologist” (p. 180) and subsequently describes drawing upon her occupational therapy knowledge in this research. Niehaus, Bundy, Mattingly, and Lawlor (1991) mention the necessity of reflexive analysis related to the principal investigator’s prior history of school system practice in her qualitative study of school-based occupational therapists. Crepeau (1997) presents an essay of reflections on her social biography and how her experiences informed her qualitative projects. Frank, Huecker, Segal, Forwell, and Bagatell (1991) describe a case example of applying ethnographic methods to an analysis of occupational therapy in which one member of the ethnographic analytic group also served as both the practicing occupational therapist and the narrator of the case history. These pairings of occupational therapists and ethnography are not unproblematic. In an article written by McCuaig and Frank (1991), Frank describes a propensity of an occupational therapist researcher to attempt to normalize and perhaps romanticize her view of her subject and her experiences in such a way that struggles, difficulties, and complexities in daily life were obscured. Blanche (1996) laments that she was unable to retain an “unattached role of researcher” (p. 269) as she felt compelled to address clinical concerns and assume an advocacy role in her ethnography of a mother involved in cross cultural health care encounters.

Much of the literature and current dialogue in the profession emphasizes the ways in which occupational therapy and qualitative or ethnographic methods share characteristics. This assumption of commonalities glosses over ways in which these practices are dissimilar or have contradictory or incompatible features and diminishes the extent to which careful attention is paid to the processes involved in acquiring the theoretical knowledge and practical expertise necessary to conduct qualitative or ethnographic research. Examples drawn from the qualitative and ethnographic experiences of occupational therapists which are provided below problematize the assumptions of affinity and reveal the complexities involved in the transformation from clinician to researcher.

In the following sections, I present an argument about perceiving, knowing, and being with others that illustrates the transformation of a clinical gaze into an ethnographic lens.

There is obviously not a standard or universal way of being an occupational therapist or being a qualitative researcher or ethnographer, nor would I argue that occupational therapists all see the world in the same way. Therefore, operationalizing these different modes of seeing and being with others is highly problematic. The extent to which the way of being a clinician and the way of being an ethnographer differ depends on many situational, interpersonal, cultural, and personal factors. For example, a clinician who adheres to a predominantly biomedical view of practice accentuating an authoritarian, positivistic, and objectivist stance would markedly contrast with an ethnographer whose subjectivist stance guides his or her mode of
being with participants. The contrast is less immediately apparent in situations in which health care interventions are constructed through collaborative models. Ways of being with another that emphasize the abandonment of typical hierarchical formations of practitioner–patient relationships are often described in terms of desired characteristics found in collaborative, mutually respectful relationships (e.g., Cunningham & Davis, 1985; Lawrence-Lightfoot, 2000; Trostle, 1988). Clinical relationships have also been seen to provide parallels to anthropological relationships (Chrisman & Johnson, 1996) and issues of relationships between clinicians-turned-ethnographers and their participants have been raised in other health fields including nursing (e.g., Cartwright & Limandri, 1997).

Transformation From Clinical Gaze to Ethnographic Lens

When I reflect on the processes inherent in moving from clinician to ethnographic researcher, four aspects of ways of being and perceiving surface. These aspects are vulnerability, being present, human sociality and social graces, and self-consciousness and reflexivity.

Vulnerability

Ethnographic relationships demand a vulnerability that permeates the way of being a researcher (e.g., Behar, 1996; Lawlor & Mattingly, 2001). This can be particularly evident when the ethnographic project deals with human suffering, marginalization, contested cultures, and stigmatization (e.g., Bourgois, 2002; Frank, 2000). Vulnerability is not merely a form of emotional fragility, but is a way of participating in aspects of informants’ lives that enhances understanding. It is a vehicle for participation and an essential ingredient to building relationships. “Making oneself vulnerable is an act of trust and respect, as is receiving and honoring the vulnerability of another” (Lawrence-Lightfoot, 2000, p. 93).

Participant observation, interviewing and listening, coordinated action, and relationship building are dimensions of both clinical practice and ethnography. However, the ways in which they are experienced may differ significantly and expose the researcher to new and different vulnerabilities. The ethnographer must learn to be open to vulnerability and to negotiate the often ambiguous implications of a vulnerable stance. The clinician must often mask vulnerability and managing the significant emotional burden of many practices generates adaptive strategies that may serve to delimit or minimize vulnerability. This is not to say that occupational therapists do not assume vulnerable stances or ever appear vulnerable. However, when and if they do, there is often a deep tension evident between vulnerability and the perceived more desirable stance of retaining professionalism (Mattingly & Lawlor, 1998).

The jointly coordinated action sequences that propel occupational therapy sessions differ from the participant observation of researchers in informants’ lives. While practitioners often work to engage patients or clients in participating in therapeutically designed activities and occupations, ethnographers are often challenged by the need to gain entry into the lives of their informants in such a way that they will be allowed to participate in the activities and occupations of the people they are studying. This desire to gain entry into participants’ lives and worlds and the pragmatic steps undertaken to achieve this engender considerable vulnerability. Unlike the clinical arena where the therapist is often in a familiar context with a repertoire of somewhat routine actions and functions, the ethnographer is often in an unfamiliar world where there may be an acute awareness of being on someone else’s turf.

Being Present

A second dimension of the transformation from clinician to researcher involves being present, a mode of engagement in ethnography that conveys absorption in the events, words, and daily lives of informants. It is a way of being that embodies heightened attention and deep respect. It is a demanding way of being that is difficult to sustain over long periods, yet being present is a critical dimension of ethnographic research. Lapses in researcher attentiveness are readily identified by participants either explicitly (e.g., “Do you need to go?”) or evident through review of transcripts or videotapes in which waning interest directly impacts on the quantity and quality of data collected.

I have witnessed times when participants modify their behavior in such a way as to promote a more present stance in a researcher. Signs of this dynamic are evident in changes in voice, physically altering the distance between the researcher and the participant, often by leaning in, and embellishing the dramatic or performative aspects of narrating that serve to compel the audience to be more intensely present. Considerable animation may also occur not unlike descriptions of reanimators provided by Daniel Stern (1994) in his studies of infants who had depressed mothers and their modes of interaction, or in Stern’s terms, schemas-of-being-with. In longitudinal ethnography,4 this stance of being present is highly consequential in situations of pro-

4The term longitudinal ethnography is used here to describe research that extends over a lengthy time period and focuses on changes over time. Also see Weisner (1996).
Horned engagement where maintaining relationships over time requires ongoing evidence of not only continued, but also deepening, presence of the researcher.

**Human Sociality and Social Graces**

Expression of human sociality and social graces marks a third dimension of difference in ways of being. The ethnographic relationship requires a level of social connectedness and responsiveness that exceeds the traditional characteristics of practitioner–patient relationships in health care settings. Boundary and relational work in ethnographic relationships is complex and warrants careful attention to the ethical, moral, and pragmatic aspects (Lawlor & Mattingly, 2001; Lawrence-Lightfoot, 1997). However, this ethnographic way of being with another that is socially framed allows a kind of freedom to interact and relate that is simultaneously more challenging and less constrained than afforded in clinical relationships. Accepted ways of managing the nuances of social exchanges in the clinical world might appear to be violations of relationships in the research world and vice versa. Even such pragmatic functions as turn taking in conversations, interrupting, or changing the subject have different implications in the ethnographic arena as compared with the clinical world.

The social aspects of ethnography are also fueled by the ways in which research participants and researchers develop a shared repertoire of experiences. “Hanging out” generates many social situations such as giving rides, going to restaurants, grocery shopping, participating in celebrations such as birthdays, and helping to clean up—all of which are less frequent and less familiar in clinical situations. These experiences routinely involve the exchange of social graces and often forms of symbolic or actual gift exchanges. This is certainly not to say that occupational therapy practice doesn’t contain small acts of kindness (Mattingly, 1998). However, the nature and extent of these social exchanges differ markedly.

I have both personally experienced and witnessed many instances in which the clinician-turned-ethnographer is caught in conflicting modes of being while engaged in seemingly social acts. For example, can the pediatric therapist hold an infant for a mother without their clinical and bodily ways of knowing transposing this social kindness into an intuitively clinical act? Should she or he just cuddle the baby or should they take this spontaneous opportunity given in this moment to position the child or help the mother with her ways of handling the child? How does the ethnographer help an elderly woman reposition herself in bed to make her more comfortable in a gesture of kindness without worrying about whether she should be encouraging this woman to turn herself as part of a rehabilitation agen-

da? When I play with children as an ethnographer, am I also playing as an occupational therapist?

**Self-Consciousness and Reflexivity**

The fourth aspect of this analysis of ways of being is self-consciousness and reflexivity. Recent ethnographic and anthropological literature is marked with increased attention to issues of reflexivity (e.g., Davies, 1999; Frank, 2000; Krefting, 1991). A kind of self-consciousness is necessary in ethnography as the researcher is the research instrument (Hammersley & Atkinson, 1995). For the clinician-turned-ethnographer, a self-consciousness of stance is often palpable. The ethnographer who is conducting research in environments that replicate or resemble settings he or she worked in as a clinician is facing several issues related to getting situated. In order to do ethnography, one must feel and act like an ethnographer. For relatively novice researchers, particularly when working autonomously, this may engender much self-consciousness about how to be, what to say, where to look, and such pragmatic and common concerns as how do I know when to end this interview? Considerable energy is also directed towards how not to be. For the clinician-turned-ethnographer, self-consciousness may often entail how to stifle clinical instincts and directives to enable events to unfold.

The need to be self-conscious about the researcher stance continues and deepens with prolonged engagement. Changes in participation in clinical practices and research practices lead to changes in how people do things which contribute to both how individuals are perceived by others and how they perceive their identity (Wenger, 1998). The complexities extend beyond the researcher to the transactions that occur between researchers and participants, as evidenced by the negotiating processes inherent in relational work. As Agar (1996) has argued, who you are as an ethnographer is in part predicated on how your informants choose to identify or categorize you. Issues of situatedness are under constant renegotiation. Even when researchers feel firmly situated in their stance, the transactional nature of ethnographic research ensures that upheavals can and will still occur. These disruptions to one’s stance can be experienced as dislocations from one identity to another. Although sometimes subtle, these dislocations may also be marked and jarring and accompanied by an awareness of having participated in highly charged transactions. How does the ethnographer manage the many solicitations by others for them to resume their clinical stance or turn a clinical eye? There are times when participants in research projects want the researcher to respond more like a clinician. In my experience, both practitioners and family members may exert pressure for a shift into a more clinical stance.
Tales from the Field

The following example is illustrative of the conceptual issues identified above and is summarized here based on fieldnotes written by Karen, a member of a research team. The encounter described below included a series of brief exchanges between several people, including the researcher and the mother of a child in the research study, the researcher and the grandmother, the researcher and a social worker, and the researcher, mother, and grandmother. The researcher, who I will refer to as Karen, is a highly experienced occupational therapist, as well as an experienced researcher with a doctoral degree. Her recent work and study have involved ethnography. She was attending an interdisciplinary clinic for the afternoon in order to observe and videotape health care encounters, and conduct research interviews. As is fairly typical in ethnography, much of Karen’s afternoon involved hanging out both in the clinic and in other public spaces such as waiting rooms.

Briefly, Karen began interviewing the grandmother in the waiting room while the mother was in another part of the clinic with her young daughter who was undergoing a procedure. As the interview evolved, the grandmother began to share her concerns regarding the relationship between her daughter and her son-in-law. As the grandmother continued, Karen also became concerned about aspects of the family situation. In her engaged stance as an active listener, Karen began to provide suggestions such as “You know what you can do? There’s a social worker here.” Karen subsequently offered to introduce the grandmother or the mother to the social worker. (I would like to be clear that in this example the stories told by the grandmother did not involve events that would necessitate reporting to authorities as required by law [e.g., evidence of physical abuse to a child], nor did they reveal current dangers in the home.)

A little bit later, Karen saw the mother leaving the social worker’s office and heard the grandmother asking the social worker for information about other resources, including legal aid. Karen, who still was concerned about her earlier interview with the grandmother, approached the social worker and asked her if the mother had told her the story that the grandmother had shared with Karen. The social worker replied that she hadn’t heard about these events, but suggested that Karen could tell the grandmother where the local legal aid office was located. Karen told the grandmother the information and her daughter indicated that she didn’t want to go to legal aid.

As Karen reflected on these exchanges, she recognized that she needed to process this further, reflect on her participation, and determine if any further action was needed. This example was discussed extensively within a supervisory process and within the research team as a kind of collective reflexiveness. Karen identified that she had inadvertently breached the confidentiality conditions of the research by sharing events described by the grandmother about her daughter’s behavior with a clinician, the social worker. She subsequently discussed the sequence of events with the social worker who had not taken any action and talked about her need to retain a researcher stance.

Karen expressed that she had felt particularly vulnerable in this situation because of the nature of the information she was hearing and her sense of being unclear about how to respond. Quite naturally, she assumed a clinician mode of being in which she provided suggestions and facilitated communication by discussing the case with the social worker. In essence, she intervened. The desire to act, to do something, in part as a way of managing the discomfort of vulnerability, caused a slippage from researcher stance to clinician stance that was highly problematic. Because Karen was not engaged with this family as a clinician, her attempt to act from a clinical perspective was not well informed. Subsequent reflexiveness about this case revealed additional information about family dynamics that significantly altered her interpretation of the information shared by the grandmother. She also jeopardized her hard-earned trust with this family and potentially their continued involvement in the research. The acceptance by the practitioners in the clinic of Karen in her observational role could also have been threatened. Her movement into an interventionist mode also potentially obscured her ability to retain an ethnographic lens on these family dynamics and this family’s ways of partnering up with practitioners to address pressing family issues. In acting, she forfeited the opportunity to learn, or be taught by this family, about their ways of negotiating both multiple perspectives on issues and managing the nuances of institutional practices.

Although this slippage was potentially highly problematic, it is completely understandable. These moments in which the clinician-turned-ethnographer is establishing his or her perspective, coming to know the circumstances of their informants, and enacting an engaged stance are pervasive and tricky. In this case, the “clinical gaze” provided a kind of clarity that enabled Karen to see the situation in a particular way. Getting to know new and potentially troubling things about this family propelled Karen into a sense of feeling vulnerable that was both unfamiliar and uncomfortable. The desire to act, and an available familiar and conditioned mode of action from the clinical world, were a catalyst for engaging as a clinician. Karen was motivated in part by a desire to help and to share what she knows. She also found the ethnographic stance of not acting or inter-
vening to be uncomfortable, fraught with ambiguity, and resulting in an exacerbation of her feelings of vulnerability.

These challenges to one's stance often emerge in the moment to moment exchanges that permeate participant observation. How these moments are negotiated have many consequences for both the nature of the research relationship and the quality of the data collected. If the researcher is perceived as withholding sound and needed clinical judgments, feelings of betrayal or suspicions about the failure to disclose can be generated. If the ethnographer is perceived as adopting a clinical eye or more dangerously assuming a clinical way of being, clinicians who are participating in the study may feel dislocated. For the ethnographer with roots in a clinical world, locating oneself and managing dislocations become major components of both boundary work and relationship work. The ethnographic lens provides opportunities for understanding human experience unavailable to the clinical eye. In some ways, the clinician may not only need to manage multiple possible gazes, but also suppress their “glance,” which according to Foucault (1973) is a way of perceiving that is targeted and precise, one that goes immediately to the core of a problem that lies beneath the surface of the immediately observable. These highly directed ways of seeing are particularly problematic because they remove the unfolding scene and the perspectives of the other social actors from the ethnographic lens. The precision and immediacy of the clinical glance can disrupt and obscure the needed gazing of the ethnographer.

**Concluding Remarks**

Karen, like several of the other researchers whose experiences are described here, found herself in a new arena where research or become qualitative researchers or ethnographers. There is currently a dearth of information on this topic available in the literature and probably insufficient discussion about the intersections of clinical practices and research practices.

A unique blend of factors may contribute to identity issues for occupational therapists who either conduct research or become qualitative researchers or ethnographers. Ethnography has traditionally, though certainly not exclusively, been closely tied to anthropology. Occupational therapists who receive their research training and are socialized in doctoral programs such as anthropology or education may be simultaneously situated on the periphery of several fields or communities of practice (Wenger, 1998). This positioning has many pragmatic implications including how one establishes a network of colleagues, determines where to publish, and implements a research agenda. A discussion of academic preparation related to qualitative and ethnographic projects also deserves careful attention. I have concentrated here on the aspects of learning the practice of ethnography that come in part from doing ethnography in real world settings.

I have presented one interpretation of the issues inherent in transforming the clinical gaze to an ethnographic lens. There are potentially multiple interpretations of these issues. I have argued that the reconfiguration of the clinical gaze into an ethnographic lens involves major transformations in terms of ways of being in participants’ worlds. I have alluded to both the importance of participation in learning opportunities and the power of reflective processing of events and dilemmas in the successful negotiation of this critical transition. I have many vivid and occasionally disturbing images of novice researchers expressing angst related to their management of their clinical and research identities. I have equally compelling images of the growth in competence and confidence of researchers that were generated by reflective discussions and opportunities to participate in the field with seasoned ethnographers. Perhaps occupational therapists venturing into the public spaces of ethnography are not so unlike the early impressionists who deliberately set out to gaze upon the world in a new more naturalistic way. This metaphorical kinship might extend to the revolutionary spirit that the artists embodied and, to a similar extent, clinicians who become ethnographers, exemplify. The artists collected in small networks to support each other in this rather dramatic movement in the arts. Researchers in occupational therapy need to continue to design and nurture communities of practice that promote participation, learning, and facilitated reflection.

**Acknowledgments**

This paper draws on research experiences gained through two interdisciplinary federally funded ethnographic research projects: 1) a Maternal and Child Health Bureau-funded research project entitled Crossing Cultural Boundaries; An Ethnographic Study, MCJ # 060745; and 2) a National Institutes of Health (NIH)-supported research project entitled, Boundary Crossing: An Ethnographic and Longitudinal Study, National Center for Medical Rehabilitation Research, National Institute of Child Health and Human Development, National Institutes of Health, #R01 HD 38878. I would also like to express appreciation to the many children, families, therapists, and practitioners.
who have participated in this research effort and who have willingly shared their experiences, perspectives, and expertise. I would like to acknowledge Dr. Cheryl Mattingly, a cultural and medical anthropologist, and research collaborator in the ethnographic projects described above. I would also like to thank Dr. Lanita Jacobs-Huey, Dr. Ann Neville-Jan, Erica Angert, Nancy Bagatell, Jeanine Blanchard, Jeanne Gaines, Susan Stouffer, and Amy Buffington for their insights during interpretation discussions related to this research and to this paper.

References


---

**Flexibility, value, and a superlative resource for students and practitioners!**

Introducing an innovative product…AOTA’s Self-Paced Clinical Course, *Work: Principles and Practice*, is now available as a **CoursePack**, presenting comprehensive and practical material, references, and resources.

**Work: Principles and Practice—CoursePack**

Barbara L. Kornblau, JD, OT/L, FAOTA, DAAPM, ABDA, CCM, CDMS, and Karen Jacobs, EdD, OTR/L, CPE, FAOTA, Editors

Eighteen in-depth lessons by some of the foremost experts in the field are now available as **stand-alone course material**. This excellent package provides a solid foundation to understand the potential for occupational therapy as it relates to work as meaningful occupation. The material adds a practical perspective on how to develop and expand occupational therapy’s role in practice related to work.

For further details and a **list of the 18 lessons**, visit AOTA’s Online Store at www.aota.org.

**Order # 3016A-J**

- $92 AOTA members
- $129 nonmembers
  (Shipping flat fee $9.50)

**Also available…**

**Work: Principles and Practice—ExamPack**

Earn 2.2 CEUs (22 contact hours) in the future, simply by purchasing and completing the examination.

**Order # 3016E-J**

- $248 AOTA members
- $311 nonmembers
  (Shipping flat fee $5.00)