

Pragmatism and Clinical Practices

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Abstract

The increasing preference for technological therapies in healthcare is perceived by many as a serious threat to the future of socially based therapies. While this concern is not without merit there is another more hopeful possibility to be found in recent adaptations in the ethical evolution of medical practices. In particular the inclusion of pragmatism into clinical ethics holds the possibility of a mutually beneficial relationship between clinical social workers and medical professionals.

Keyterms: Pragmatic Social Work, Clinical Pragmatism, Clinical Social Work, Applied Ethics, Professional Ethics

Introduction

Unlike other mental health professions, like medicine and clinical psychology, which gain their professional authority through their expert status as masters of scientifically based techniques of diagnosis and treatment, social work does not produce its own tools and so is not a ‘true’ profession in the classic sense. Social work has attempted to bolster its self- image by investing in academic ventures creating journals and doctoral programs but the standard in academia is still one of scientific knowledge and this leaves social work to imitate sociology and or psychology raising legitimate institutional questions of the value of such duplication. Likewise, in the realm of professional practice, which is now almost exclusively run by corporate health conglomerates, the scientific techniques of medicine and psychology can be measured in terms of outcome equations, relating to statistical norms, which easily translate into the bookkeeping practices of the business sector, leaving social workers to serve these professions or find a new source of professional identity. This essay will offer social work an alternative vision for the future by calling on the resources of pragmatism, not to try and mimic or co-opt the applied sciences by creating an alternative and or inclusive foundation, but more like a work of art which allows one to appreciate a familiar scene in a new way.

The deeply ambivalent relationship between clinicians whose practices depend on using social behaviors (including all aspects of thinking and speaking) as their only tools and those who use the tools of applied science can be traced back to the underlying anxiety diagnosed in Freud’s foundational dream analysis of “Irma’s Injection.” There Freud shares with us a fear that echoes loudly in our times: “I was alarmed at the idea that I had missed an organic illness. This, as well

may be believed is a perpetual source of anxiety to a specialist whose practice is almost limited to neurotic patients and who is in the habit of attributing to hysteria a great number of symptoms that other physicians treat as organic” (Freud, 1950, 21). Lurking doubts of the possible organic causality of psychopathology have continued to haunt all the following generations of lay analysis. But the patients who are properly referred to social workers are those who are suffering their own failures of imagination in so much as their habitual ways of coping are no longer able to meet their changing relationship to their environment. This is absolutely not to say that habits are unnatural and or do not include physical processes, but it is to deny that the social realm can be reduced to the organic. Practitioners of this clinical social work who are seeking a more cooperative relationship with medicine may find hope in the recent development of clinical pragmatism in medical ethics.

Clinical pragmatism addresses moral problem solving in a context of reciprocity consisting of a series of interconnected steps:

1. Assess the patient’s medical condition.
2. Determine and clarify the clinical diagnosis.
3. Assess the patient’s decision-making capacity, beliefs, values, preferences, and needs.
4. Consider family dynamics and the impact of care on family members and others intimately concerned with the patient’s well-being.
5. Consider institutional arrangements and broader social norms that may influence patient care.
6. Identify the range of moral considerations relevant to the case in a manner analogous to the clinical process of differential diagnosis.
7. suggest provisional goals of care and offer a plan of action including plausible treatment and care options.
8. Negotiate an ethically acceptable plan of action.
9. Implement the agreed upon plan.
10. evaluate the results of the intervention.
11. undertake periodic review and modify the course of action as the case evolves (Fins, Bacchetta, & Miller 1999, 32).

By creating clinical pragmatism, the medical community has begun to reform its procedures and values to better reflect the democracy which supports it. Intersubjective systems minded clinicians who practice social work, are in a unique place to benefit from this medical change of heart.

Pragmatism, values and ethics

Both clinical pragmatism and pragmatic social work are inspired by the writings of the American philosopher John Dewey who argued that:

The problem of restoring integration and cooperation between man's beliefs about the world in which he lives and his beliefs about the values and purposes that should direct his conduct is the deepest problem of modern life. It is the problem of any philosophy that is not isolated from life (Dewey 1929, 255).

Taking the lead of the experimental psychologist and pragmatist philosopher William James, Dewey insisted on the primary ethical roles of practice, purpose, and plurality in his philosophy. Dewey emphasized the practical outcomes and the ethical consequences of beliefs rather than the authority of any theoretical reasoning that might be created in advance of results. This pragmatic reasoning allows for clinical hospitality to presenting individual differences, rather than a theory based clinical stance which assumes to know better before the actual case is at hand. Pragmatic reasoning is always willing to test and retest its interpretations against the lived experience of the involved parties. Pragmatic resolutions are understood to have only instrumental, rather than a priori, value so is to be considered 'true' only to the degree that they can help us into a satisfactory relationship with the other parts of our experience.

This conscious attention to the process of selection, choices to attend to some things and ignoring others, leads to an epistemological humility, and a respect for democratic solutions to moral dilemmas. Pragmatism does not deny the knowledge and experience of clinical experts but does recognize both the limits of knowledge and the differences in lived experiences which can lead to differing understandings. Clinical pragmatism and pragmatic social work are focused on helping to clarify and meet, not to prescribe, the patient's life choices and so are process oriented. The role of the clinician is to help facilitate a moral problem-solving process of individuation, testing preconceptions against the particulars of a given patient narrative. While the clinical process should not force a clinician to violate his or her own ethical stance, therapy does not impact the clinician and the patient equally and the ending resolution must reflect the instrumental desire of the patient whose life will be shaped by it.

In so much as it reflects a more open ended, reciprocal, and contextualized ethics of care clinical pragmatism represents a shift in medicine towards the pragmatic concerns of post-modern systems minded social therapy. While its democratic intentions are to be applauded clinical pragmatism is clearly limited in the amount of time available for physicians and patients to establish the kind of in-depth relationship that the cares of complex dilemmas evoke. These principles of pragmatic medical care of patients by physicians may be logically extended to include

the care provided by a similarly pragmatic social work. Social therapy can both aid in the initial care, by helping clinicians and patients to imaginatively investigate the systemic implications of changes, and to help patient systems to extend their adaptations to include life from beyond the medical system.

Clinical Orientation

The orientation of pragmatism; practice, purpose, and pluralism, may seem almost unreflectively natural to American psychotherapists. But the majority of American schools of therapy are Humanist in their orientation. Much like the country's legendary founding fathers they believe in certain unalienable and self-evident human rights. Underlying this sense of human rights is a Kantian post-enlightenment logic of a universal human nature, which when properly nurtured will exhibit culturally acceptable ethical values. This transcendental universalistic view of human nature is not shared by pragmatic social work. Dewey learned from Hegel that human subjectivity is thoroughly historicized. Dewey reads Hegel to teach us that human individuality is not a natural given state of being but rather a social process of interactions in participation with social systems. But unlike Hegel, who held that history had a Spirit revealed direction of progress; Dewey learned from Darwin's *Origin of Species* that life is an ever-changing adaptation to contingency. Darwin's theory of the evolution of species overturned the ancient Greek metaphysics of eternal forms for species, including the human branch of the biosphere. The pragmatic approach to moral dilemmas is then rooted in experimentalist coping strategies formed through an understanding of developmental origins (Rorty, 1995). These experimentalist coping strategies may be turned for clinical purposes into patient owned reflective relationships to previously unimagined and or unconsciously acquired social habits.

In his own work Dewey developed the social and political implications of the understanding of our evolutionary capacity for habitual responses, and their relationship to imagination, which he gained from the works of Charles S. Peirce and William James. Dewey teaches us that "The more numerous our habits the wider the field of possible observation and foretelling. The more flexible they are, the more refined is perception in its discrimination and the more delicate the presentation evoked by imagination" (Dewey 1922, 175-6). Dewey brought an added element of ethical socialization to this habitual adaptation in his descriptions of our capacity for imaginative, conscious and 'internal' (not otherwise acted upon), deliberation and experimentation called dramatic rehearsal. In imagining different choices and their possible

consequences, by remembering like events and by gathering data from trusted sources, we can begin to narrow down our choices without suffering the consequences of otherwise acting out. The parallels between dramatic rehearsal and clinical social work will be obvious to experienced clinicians who should recognize the example provided by Dewey scholar and ecosystems advocate Steven Fesmire in his clarification that:

Dramatic rehearsal is the reflective phase of the process of reconstructing frustrated habits. For example, in a close relationship another's objective presence has been woven into the fabric of one's habits. Loss of the relationship throws these habits out of equilibrium with changed surroundings. The prior habits cannot just be willed to change; rather, they ground, motivate, and structure ensuing adjustments, as when an unmet need for companionship provokes imagination of viable prospects for reestablishing stability: say the strengthening old friendships or actively pursuing new ones (Fesmire 2003, 78).

Pragmatic Social Work

A pragmatic social work would be led by Dewey in a "Faith in the power of intelligence to imagine a future which is a projection of the desirable in the present and to invent the instrumentalities of its realization, is our salvation" (Dewey 1917, 69). In practical terms the adoption of a pragmatic clinical posture would be a fairly straightforward affair to embody. In his book *How We Think*, Dewey outlines a method of inquiry for us to begin with: "[i] a felt difficulty; [ii] its location and definition; [iii] suggestion of a possible solution; [iv] development by reasoning of the bearings of the suggestion; [v] further observation and experiment leading to its acceptance or rejection" (Dewey 1910, 72).

When reading this outline it is vital here to remember that this a matter of mutual reflection on the choices and desires represented in the patient's narrative. The role of the clinician is to help client pay attention to the habits which they display so as to make them conscious of the ways in which their behaviors have been shaped in relation to previous choices and idealized future possibilities. By bringing the therapeutic relationship to bear on these displayed habits the individual client can then choose to either continue in these behaviors, now fully conscious of and so socially responsible for them, and or to imagine and experiment with alternative practices. The client does not become more like 'themselves', as there is no such predetermined identity, but rather is freed to identify themselves through practiced trials with appealing social choices. This

is a truly systemic psychology which while recognizing the capacity for individual choice understands these choices to be between various relationships as competing goods.

As identity results from socialization, including the language acquisition necessary to self-consciousness, we are always already in relationships. All human consciousness is a reflective function of memory, imagined and interpreted. We even see, smell, taste, and hear, with our brains and not with our sense organs. So even in absolute isolation or the depths of dreaming we exist only in relation to others, ethically defined by our very being.

The clinician who introduces their patients to a logic of contingency can provide an existential freedom of choice from a previously fatalistic logic of determinism. Clinical ethical choices become existential in nature as they bring the client's focus to bear on actual differences, versus ideal, possibilities and limitations. This shift of attention from the timeless unlimited possibilities of the transcendental to the contingent a-moral impositions of the reality principle is often met by both clients and clinicians with reactions of grief and mourning. Professionally this had led to a psychological denial of pathology as witnessed by the attempts of humanistic psychology to reduce religious beliefs into psychotherapeutic techniques. This self-aggrandizing anti-medical scientific confusion of psyche and soma has recreated the backwards looking logic of sickness as a symptom of a failed moral nature. It is not the trained expertise of social therapies to diagnose or to treat the suffering directly caused by physical corruption. Rather the role of the social therapist is to help reduce the suffering related to the anxiety invested in taking the responsibility for making the agonizing ethical choices presented by a medical diagnosis. Medical practitioners may be able to tell patients what their physical ailment is and how various treatments may impact their lives but the work of deciding what choices to make and what this change means to the life of the patient system is left to the care of the interpersonal therapeutic relationship. The following clinical narrative caricature will serve as a case in point.

Illustrational Case

Every Wednesday morning, I would check my mail and phone messages at my office in a state mental health clinic and then hit the road as part of a rural outreach effort. I would meet patients in the offices of a family medical practice served by two part-time nurses and one internist. Many of my referrals came through this practice and so I was not entirely surprised to be met at the door by an unscheduled but tearfully distressed middle-aged woman. She was still in her sweat clothes and curlers, not an unusual state of attire at the local diner, but her total lack of make-up

was suspicious given the huge dark circles under her eyes and the prevailing local fashion trends. While the doctor was generally considered to be a fellow “townie” by these people I was a relative stranger and they often put on their best face to see me, suspicious of an outsider’s judgment.

I introduced myself and opened the door. She sat down and thanked me for the tissue that I handed her and told me that the “doc” had sent her down here after their appointment earlier this morning. She said that he was mad at her for refusing to give up her part-time waitress job at a local bar even though she had suffered a nearly fatal stroke last year and shouldn’t be driving car long distances or pushing her body so hard. I asked her if she had talked with him about why she had made these choices and she said no. She explained that he had said that he didn’t want to hear any excuses and that he knew what was best for her and if she was “too crazy to listen to reason” then she should go down and wait for the “head-doctor” (her words) to set her straight.

This is the kind of unfortunate doctor-patient interaction that the ethical practice of clinical pragmatism would help to avoid. This doctor showed no interest in serving the various social needs of his patient; rather he was serving his own mechanically minded job description. He was clear that he saw this patient as having broken or malfunctioning parts which it was his job to fix. This doctor showed no professional interest in the emotionally charged hopes, dreams, fears, and obligations that made up the patient’s embodied value system. Had this doctor taken more time to talk with his patient he could have saved her this emotional grief, she and I the several sessions we spent adjusting her attitude towards our work from his referral as punishment, and she may have complied with the more physically compelling parts of his treatment program sooner than she did. As it was it took her and I several months to even begin to develop the trusting desire that would motivate her to seek regular health care

While I could and did provide her with counseling relating to relaxation techniques the work of therapy was focused on her ethical responsiveness to this life altering change in her health. The specter of death had served to heighten her sense of responsibility to an almost paralyzing level of anxiety. Like many people who suffer unimaginable tragedies she was feeling lost in a kind of timeless limbo separated from the largely unreflected flow of her past common-sensical identity and equally unable to respond creatively to the present she had also lost her sense of having a future. The fact that the rest of the world did not seem to have changed with her but was apparently going on with its business as usual, especially her husband and children, only further served to reinforce a sense the of loss of the temporal dimension of her life and the resulting spatial

disruption being translated into existential feelings of non-being. The client's past choices had not properly prepared her for this trauma and now all of her previous modes of adaptation were called into doubt. Not surprisingly, given her depressing state of affairs, this client was unable, or unwilling, to engage in a constructive practice of dramatic rehearsal, choosing instead to present largely fatalistic and often morbid images of her future in which her projected habits brought about only more pain and suffering.

Faced with this paradigm of destruction and discontinuity the social worker is left to adopt an ironic style of bricolage. Like the subjects of Levi-Strauss' writings, we are left to refashion to our own clinical use tools (in this case the client's presentation of past habits) which were designed for other purposes (Stout 2001, 74-7). What was called for now was a therapeutic reconstruction of the past. By engaging the client in an account of her life story a process of comparison can begin by using the various imaginal personae encountered therein, and the inevitable differences that come with repetition. The clinician becomes the collector of memories for the client, comparing and contrasting the various selves and others previously represented in the client's narrative.

Not having been previously taught to communicate even one coherent life story the client is now faced with a chorus of narrative voices. Under these terms therapy becomes a theatre of ethical performances. The client is encouraged to imagine and act out different social styles in relation to her own shared memories of past ideals, expectations, experiences, and fears, and in response to questions of choices and outcomes from the clinician. The rules of engagement in this game theory are modeled by the professional ethical standards of the social worker. The pragmatist philosopher Michael Eldridge provides us with an outline of the "formal properties" required of social practitioners who would seek to serve as examples of Dewey's democratic ideals; "in order to use causes meaningfully and pervasively one needs beliefs, such as the belief that ideas are responses to difficulties, or that directed change is possible. One also needs attitudes such as open-mindedness, wholeheartedness, and responsibility" (Eldridge 1998, 17). The imaginal possibilities entertained by the client are focused by the clinician's choice of questions (which are informed by the social worker's intuition, educated awareness of the various plots that we have received from history, and her imaginative intelligence) to compare choices made by the client outside of the 'clinical hour' to statements of purposeful identity made in the presence of the clinician

Having survived this conscience raising therapy of habits the client's once rigid and largely reactive reflexes eventually come to be less threatened by the appearance of difference. Through

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this self-reflexive process of experimentation, the client's defenses are eased enough to include a practiced identification with the social habits of moral inquiry, imagination, conscious choice, and thoughtful attention to others. In the current tyranny of the means, represented by the endless flow of detached images promoting our commercialized culture, personal style may be more of an oxymoron than a subject of discriminating taste, but this is a bid for life that clinical social work may find worth taking an educated bet on. Pragmatic social work becomes an act of faith in the continuing American democratic experiment with the pursuit of individual freedom and happiness.

It is vital for the clinician to be aware that this process is one of imaginative play, not a factual re-presentation. Clinical genealogy imitates the natural development of the self, as a social process in which the individual experiments with the practice of acting out various roles and learning from the resulting responses. The goal, and indeed the epistemic logic, of narrative therapy is one of novel creations of possible livelihoods, not ontological certainty, and certainly not legal facts. If the clinician can avoid taking this play personally then therapy can serve as a safe place to try new things without the often less forgiving consequences of personal relationships. The ethical social worker who respects the developing individuality represented in the client's narrative should work to bear the anxiety of not knowing (both their own and the client's) and refrain from trying to replace the experiential goods of the client with clinician's ideals. The client will only be able to learn to think ethically for herself if she is given a chance to weigh out the consequences of her own previous experiences as a basis for future decisions. In this way the client is returned to her own stream of consciousness, back into the social play of reflected identity, safe to again imagine fruitful future plans of action

In this case the doctor had failed to anticipate that before this patient could meaningfully engage in her medical care, she would in fact have to decide if she still wanted to live. This was by no means a self-evident choice for her, as it had apparently been for her doctor, long before she could work up to trusting her decision-making capacity in such a serious manner, we had to work through the earlier life decisions that had preceded this momentous task. We started with the very taxing but mundane demands of her daily routine. Her stroke had put her in the position of starting over in terms of learning how to approach the tasks of her everyday life. Though her thinking processes were largely intact she was now physically limited in both endurance and structural stability. While we occasionally joked about the living death of housework, (mutual laughter being a good sign that a healing spirit has been engaged in the therapeutic play) she could in fact now

possibly work herself to death. Over the next few months, she began to grow in her trust of our relationship and her own ability to make meaningful decisions. We then began the long hard work of re-viewing many of the major previous decisions in her life; to leave her parent's home early, to begin to drink heavily and revolve her life around various bars, to keep her children and be a single mom, to marry her husband and have more children with him, to stay in this marriage even though she was often desperately lonely.

As she reconstructed the telling decisions in her life therapy began to include a challenge for her to now make choices which reflected her current understanding of her life's value. She started to ask for more of what she wanted from her relationships and compared the results of these experiments with her own efforts. In this way she began to incorporate her own style of pragmatic ethics into her decision-making process. Over the course of therapy, she took care of her dying parents, got two of her children into counseling, forced the local high school to better educate her previously undiagnosed learning-disabled daughter, first left her husband and then renegotiated their marriage and moved back in with him, and ultimately sought a new physician whom she felt that she could work closely with. She had learned the value to her life of a more mutually respectful and inclusive decision-making process for her relationships. She learned that to receive a certain level of care she would have to give a certain level of care and that this required from all parties involved some degree of self-sacrifice, reflection, and intentional communication.

Concluding Remarks

While this case could be read as a therapeutic success story, as the patient lived it, and as this paper now represents it, it was unfortunately a failure at the professional interdisciplinary level. The patient's referring physician was unwilling to participate in the therapeutic process when it became clear that the patient's decision-making process would lead the healing process. Historically this kind of mechanical paternalistic certainty has often been an accepted modus operandi for medical ethics and practice but it must continue to change to fit the evolving ethical standards of the community. Clinical pragmatism not only supports the integration of a community-minded systems perspective into its own decision-making process, but its guiding ethos is born of the humility that comes from a deep respect and appreciation for the complexity and value of the individual. Socially minded clinicians of all differing kinds should rally together to support this revolution in medical ethics and see in its values the call of care demanded by our own.

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