The Casson Memorial Lecture 2004, given on 11 June at the 28th Annual Conference of the College of Occupational Therapists, held at the Harrogate International Centre, Harrogate. The conference theme was 'Occupation Matters'.

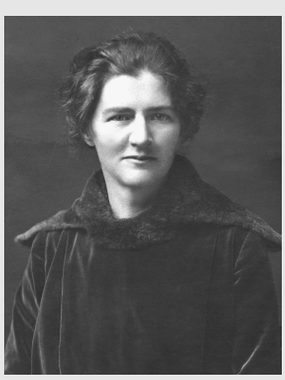
The Casson Memorial Lecture 2004: The Fascination of the Difficult

Professor Jenny Butler

Introduction

Your Royal Highness, ladies and gentlemen: I am delighted to be here today and, of course, very honoured to be giving this Casson Memorial Lecture in the 50th anniversary year of Dr Casson's death. It has even more resonance for me personally because this year marks the end of my seconded 5-year post as the Elizabeth Casson Trust Reader in Occupational Therapy at Oxford Brookes University. I would like, at this point, to thank the Elizabeth Casson Trust for the Readership because it has given me so many wonderful opportunities.

Elizabeth Casson (1881-1954)



This lecture is entitled 'The Fascination of the Difficult' and will last about 40 minutes. Now, at the end of an exciting, but tiring, week for us at the annual conference, that is a long time for you to sit and listen. Generally, people cannot listen and take in what is being said to them for much more than 20 minutes; attention levels slip (you start to wonder whether you will be in time to get the half past four train or will have to wait for the quarter past five) and the ability to recall what was said is severely reduced.

So I need to do something if you are to listen, enjoy and remember anything of this afternoon's lecture. I have a cunning plan…

Teaching and learning theory helps us out: if you have a 2 or 3 minute break after 20 minutes, then you can return to (almost) the first high levels of attention that you started with and can sustain that attention reasonably well for the *next* 20 minutes. What I am going to do, therefore, is to give you a break after 20 minutes: just 2-3 minutes to stand up, have a chat, stretch or whatever you would like to do. I am even going to play you a bit of music so that you can dance around if you wish to! I will then ask you to sit down again and listen to the second part of the lecture.

Learning theory also tells us that from any lecture, listeners will be able to remember only three key things and will need reinforcement to do that. So the three main things I am going to talk about this afternoon are:

- Complexity
- Thinking
- Ethics.

I will keep reminding you of those three things and then, at the end of the 40 minutes, I will tell you three main points from the talk that you can take home and remember. Then when you go back to your places of work throughout the United Kingdom (and even around the world) and people ask, 'So what did Jenny Butler talk about then?', you will be able to say confidently, 'Oh it was great – she talked about complexity, thinking and ethics', and everyone will be very impressed at your ability to recall. So let me now get started.

Complexity

Last year saw the publication of *Occupational Therapy defined as a Complex Intervention* (Creek 2003). I think this document marks a watershed in our profession's history in that it makes overt the complexity of occupational therapy practice.

To me, thinking about complex and difficult things is fascinating. It is compulsive and ultimately satisfying. As Dr Elizabeth Casson stated (1955, p99, reprinted from 1936):

> One of the most powerful motives we have is curiosity.

At different times, as we all know, different people send our thinking off in all kinds of unexpected directions. A casual conversation can rebound into wonderful avenues of thought that somehow we could not have managed on our own, without that trigger. Such was the case with me: talking with Jennifer Creek one morning at the College of Occupational Therapists, she stated that she was becoming really interested in complexity and how near it was to chaos.

Dr Casson

'One of the most powerful motives we have is curiosity.'

(1955, p99, reprinted from 1936)

What a wonderful notion. It started me thinking. I began to think about complexity and about things that are difficult. I remember that on many occasions during my research studies on adult-onset apraxia, I would wonder why on earth I was doing the topic. It was so difficult to understand. Why hadn't I chosen something much easier? Therein lay my answer: just because it *was* difficult. Because within its difficulty lay the challenge. To have chosen something easy or simple would have been to miss the point.

Was this a pattern of behaviour for me? Further back in time, I remember during my undergraduate psychology degree really struggling to understand some of the content of the 3-year programme of philosophy, yet hanging on in there and persevering with its difficulty because it was fascinating. I was determined to make some sense of it.

So, in these reflections, I then had to acknowledge that maybe thinking about difficult things is what I like to do. And also realising that I am not alone in that.

Dr Elizabeth Casson, from all that we know about her life and works (and this year we have learnt so much more about her character and life, mainly through her family and their recollections), would seem to have enjoyed what was difficult. She certainly held a deep religious faith and had a moral and social conscience that meant that, although she did not have to leave her home in Wales and work among the poor in London, this is what she did. In her work with Octavia Hill in a London housing project, she excelled. More than that, though, she saw beyond the 'easy' to the 'difficult'. She looked for and saw what lay behind the poverty and disease.

Elizabeth Casson could have remained working in social housing. By all accounts, she was very skilled at it. Even this would not have been an easy path, but she went further into 'difficulty' by training as a doctor and that also was by no means an easy path for women in those days. Again, even when qualified – she was a gifted surgeon by all accounts – she chose not to go down the easy path, moving away from surgery and into psychiatry (arguably one of the most difficult areas of practice). I think that all these moves and twists in the path that she chose for herself indicate a person who was fascinated by the difficult.

I think today's occupational therapists are also fascinated by what is difficult. If we had wanted an easy option, a mechanical process, a routine method of working, we would have chosen something infinitely less complex than occupational therapy! So the notion of complexity should fascinate us all.

What is complexity?

How can an understanding of the notion of complexity help us in occupational therapy?

Lewin (1993) posed the question: chaos and complexity – are they the same or different? He postulated that complexity lay somewhere between total order and the totally random. The linear part of our world is characterised by repetition and predictability. Mathematics and science help us to know and understand that linear, predictable world which forms an important part of our existence. For example, the launch of a spacecraft to meet with a comet, or landing the Beagle on Mars (or not), relies on the predictability of the linear world. However, not our entire world is linear. Non-linear aspects of our world have complex dynamics that defy mathematical analysis.

In non-linear systems, small inputs can lead to dramatically large consequences on one occasion but not on the next occasion. They are not necessarily repeatable or predictable. Complexity theory states that very slight differences in initial conditions produce very different outcomes. You will have heard of the 'butterfly effect': a butterfly flapping its wings in the Amazon rain forest (a small change) leads to a disproportionate change (a tornado in another part of the world) on one occasion. The next time the butterfly flaps its wings, though, nothing of meteorological consequence happens. This begins to describe the notion of complexity. Complexity is *not* a property of the *number* of component parts or even the direction of their relationships. Complexity is concerned with the *variety of interactions* of component parts and thus with the possibility of aligning into many different configurations. Put another way, Lewin (1993) suggested that complexity has to do with the interrelatedness and interdependence of components as well as their *freedom* to interact, align and organise into related configurations. 'Freedom to act' is important here.

Eve et al (1997) stated that complexity theory gives us a new set of intellectual tools or concepts to think with. They suggested that 'freedom' does not mean disordered or random but, rather, implies discoverable meaning in an act: a free act may be unpredictable, but does make sense after it has occurred. And don't forget, unpredictable does not mean unintelligible or inaccessible to knowledge and understanding.

How do such ideas of complexity help in relation to occupational therapy? Creek (2003) described the complexity of the occupational therapy process in terms of a dynamic interaction with the client within a multifaceted context, where the occupational therapist shifts her or his focus or perspective many times during the intervention. Thus Creek (2003) described the interrelatedness and interdependence of the components of the process, with the freedom to interact and align into different but related

configurations. She has described a complex process. The essential element in any unpredictable (therefore complex) process is feedback. The experience of the freedom to act (as in therapeutic situations) relies on a fantastically complex feedback system with iterative richness and difficulty. Creek (2003), in describing the complexity of the occupational therapy process, talked about feedback, reflection and iteration.

In my reading and thinking about this topic I came across a lovely phrase by Lewin (1993), 'surface complexity arising out of deep simplicity'. This phrase resonated in my mind in relation to occupational therapy. I have always considered, through all the lumps and bumps of my career, there to be something very *right* about occupational therapy. At its most simple, at its core, it is a practical process of enablement. Enabling people to do what they are able to do and what they wish to do. So much is simple. The complexity lies in exactly how an occupational therapist thinks and acts with each individual within each unique and complex context.

If we come, therefore, to accept the argument that occupational therapy is, indeed, a complex process with all that that implies (non-linearity, freedom to act and feedback process), with such an understanding, how can we best research and look for evidence of effectiveness in a way that will have real meaning? If we look solely for linear, mathematical approaches, might we be ignoring the nature of occupational therapy which is, by definition, complex?

We have as a profession, perhaps, been aiming for research involving controlled experiment or observation. We have sought to ascribe to the best practice argument of randomised controlled trials (RCTs). This method, with its mathematical and logical coherence together with reasonable margins of random variation, *can* describe our world in statistical terms. It provides some good evidence, but this aspect of science does have limitations, as Hyde (2004) has argued. I would suggest that in current research, therefore, we should aim to embrace methodologies that take in more complex and open systems. Complexity theory should enable us no longer to be afraid of the unpredictable, particularly in research. We should not, indeed we *cannot*, control all the variables. Occupational therapy as a complex intervention does not fit the linear paradigm.

So, how can a dynamic, non-linear complex process be researched? I rather like the following quote from Aristotle, which may help us:

> It is the mark of an instructed mind to rest satisfied with the degree of precision which the nature of the subject permits – and not seek an exactness where only an approximation of the truth is possible (Aristotle, cited in Eve et al 1997, p125).

For research into complex interventions, two things should be borne in mind: the data must be longitudinal and the environment or context must be measured as well as the outcomes. I would suggest that time series analysis as a rigorous experimental methodology might fit our requirements: more than one measure taken over time (longitudinal data), with reliable quantitative measures being supported by qualitative data (stories) for explanations both for the changes in the context and environment and for the quantitative results. Not only is occupational therapy a complex process (as Professor Derick Wade – one of the College of Occupational Therapists' Honorary Fellows – pointed out in an editorial in 2001), it operates within a complex system (a multiprofessional team of two or more people) and this complex system acts upon another complex system (the patient or client in his or her context). Research paradigms that take complexity theory into account should be seen as elucidating whole classes of phenomena that traditional methods and theories have been inadequate to describe. The descriptions and information will *supplement* our ideas and scientific knowledge.

Break time!

Elizabeth Casson as a young woman

A piece of music

Now it is about 20 minutes through the lecture and you need a short break. I would ask you all to stand up so that your brain and the rest of your nervous system get re-fired. You could chat, do some exercises, even dance to the music that's coming on…

> Song played: Nina Simone, *Ain't got no (I got life)* (Ragni et al 1968).

I would ask you all to sit down now. I like that piece of music. It seems to encapsulate the occupational therapist's philosophy: look for, and celebrate, whatever abilities and attributes an individual has. In addition, it was exactly 2 minutes long, so suited my purposes precisely!

You should now feel newly alert and awake and able to take in the second part of the lecture:

So far I've talked about complexity;
I will now go on to talk about thinking
And then lead into ethics.

So how does an understanding of complexity help us to consider *thinking*?

Thinking

Thinking about things is more than reflection; it is a creative process which needs an allocation of time to accomplish. Barnitt (1990), as usual, was very helpful in her still-pertinent paper, 'Knowledge, skills and attitudes: what happened to

thinking?' She described three types of thinkers needed in the profession of occupational therapy:

1. Creative, innovative thinkers at the level of theory (innovators)
2. Creative thinkers who can pick up the emergent new theory and turn it into new applications (developers)
3. Clinical reasoners – those who can understand and use the new applications and frameworks to direct their professional practice.

Barnitt (1990, p452) quoted Bertrand Russell:

> Many people would sooner die than think. In fact, they do.

As a profession, we must value thinking for its own sake. We must allocate time for thinking. We must not be afraid to think, nor always be *doing*. We must have time to 'be' and time to think. Nixon (2003) made a link between thinking and practice. He suggested that the process of theorising, the development of theory, was in *thoughtful* practice. Professional practice needs thinking (but then thinking also needs practice…) The question arises as to whether we can teach people to think. Nixon (2003) noted that everybody thinks; it is a part of our humanness. But can we learn to think *better*? Can, indeed, we teach students to think better?

Thinking is not easy; it can be a painful process that involves challenge, upset and uncertainty. It is much easier to act in a procedural, treadmill manner than to think about what could and should be done differently; or to think about the *reasoning* behind our normal practice; or to think of the *consequences* of one's normal practice; or to consider the efficacy of one's role within the normal daily routine or procedure. Thinking takes time and it has consequences. It may lead to change, to the abandonment of certain procedures, all of which takes more time.

Thinking about and understanding the complexity of practice also depends on the individual: the novice is more likely to see things as simple and straightforward. The expert practitioner and the experienced thinker are more likely to see the nuances and complexities of the person and the context and have a greater depth of thinking, clinical reasoning and reflection. I repeat, though, that thinking about and challenging the norm takes time; it also takes courage.

Thinking is a complex, creative and dynamic process where the butterfly effect can have its most momentous outcomes. I reflect again on the life of Elizabeth Casson and on what wonderful outcomes arose from her thinking. She certainly, in Barnitt's (1990) words, was an innovative thinker. Casson observed people engaged in making Christmas decorations on a ward and saw how different they appeared from when they were not so engaged. How many people, I wonder, had walked through, watched, participated in and noticed people 'doing things' on the wards – with no change to their thinking? Elizabeth Casson did think and orchestrated change. The start of occupational therapy in the United Kingdom is the legacy of that thinking.

At the memorial service for Dr Elizabeth Casson in 1955, the Reverend Canon Grensted spoke of three characteristics that went into the making of the Dorset House School of Occupational Therapy and the profession of occupational therapy in the United Kingdom:

Elizabeth Casson Memorial 1955

Reverend Canon Grensted:

3 characteristics:

- **Wisdom**
- **Understanding**
- **Knowledge**

- **THINKING**

1. Wisdom: which is more than learning
2. Understanding
3. Knowledge.

I would suggest that now, nearly 50 years later, we might add at the *start* of the list:

- Thinking.

Perhaps thinking should be part of the professional programme curriculum at all levels? Philosophy, especially moral philosophy, is a discipline that helps us to think. Here, then, is our link to the last part of this talk, which concerns ethics and the complexity of thinking deeply about ethical issues.

Ethics

Another publication from the College of Occupational Therapists in 2003 was the *Research Ethics Guidelines*. I am so proud to be associated with that piece of work and to have had the privilege of working with the core team that comprised Viv Lindow, Jennifer Creek and Sue Rugg, as well as all the occupational therapists around the country who contributed and helped to produce that document.

I am fascinated by research ethics and, certainly, thinking *deeply* about ethical issues in research can be difficult. My experiences as Chair of one of Oxford's local research ethics committees (LRECs) over the past 5 or so years has indicated that many applicants show no deep thought into the potential experience of research participation from the perspective of the individual. Again, the question might be posed: can deep ethical thinking be taught? I also ask: what is the relationship between personal morality and professional ethics?

I think that some of the difficulties that arise with research applications may be because institutional ethics (by that I mean professional codes of ethics, codes of practice, research ethics guidelines and similar documents) may be understood simply as a guide to behaviour that conforms to the relevant code and not be embraced within the individual's personal beliefs or philosophy. In other words, the codes may be considered only in a rather mechanistic way as hoops to be jumped through, whereas *personal* ethics

is about integrity and morality. I believe that researchers must embrace and confront their personal ethics, which is about what you would do if no one could see you and no one could find you out.

In thinking about honesty and integrity, O'Neill (2002) helps us tremendously. She is clear that relations of trust require us to reject deception, to be honest and to have integrity. Taken at its simplistic face value, of course, most people would say that deception is 'not good', yet surprisingly large numbers of past research projects have involved the deception of participants and deception is still proposed even today.

So what does it mean to reject deception? O'Neill (2002) suggested that it means to refrain from lying, from false promising, from misrepresentation, from manipulation and from any other ways of misleading. O'Neill also suggested that rejecting deception can be more positively expressed through ideas about truthful communication, through care not to mislead, through avoidance of exaggeration, through simplicity and explicitness, through honesty in dealing with others, that is, through *trustworthiness*. Many research proposals do not adhere to such principles (at least before the research ethics committees challenge them).

At this juncture, I return again to reflect on the life of Elizabeth Casson and the concept of trust within her practice. Dorset House in Bristol was the first school of occupational therapy in the United Kingdom, which moved to Bromsgrove during the war and then most famously to Oxford, where it remains as an integral part of the School of Health and Social Care at Oxford Brookes University (although we are moving from the current site in August to a new integrated school site nearby).

Elizabeth Casson – and trust

Dorset House in Bristol

- **Mental health unit for women**
- **School of occupational therapy**

Oxford

At this point, I would like to digress slightly and announce that the Dorset House archives are now, through the generous financial support of the Elizabeth Casson Trust, available on the Oxford Brookes University website. A link from the College of Occupational Therapists' website is also planned. There are many very wonderful images, videos and documents on the website. In the archive itself, there are drawings, songs and plays written by past staff and students, as well as documents of the history of the school and Elizabeth Casson's own textbooks from her time as a medical student (among many other items) available to researchers and others to look at in the Oxford Brookes University library (*www.brookes.ac.uk/services/library*). Look in the 'special collections' section.

To return to Elizabeth Casson and the notion of trust, the first Dorset House in Bristol was linked to one of first *open* mental health units for women. This unit was run as a community, a therapeutic community, where staff, students and patients all lived together and had their part and roles to play. It was a community based on *trust* with no locked doors, which was unusual at that time. Elizabeth Casson clearly believed in trust.

If we accept that trust and trustworthiness are important, why then when it comes to research do aspects of deception still present? How can we understand the notion of deception more deeply? Mead (1969), probably one of the most influential anthropologists of the 20th century, considered deception to be concerned with taking advantage of the helplessness of another (for example, a patient dependent on care or a student fearful of not getting a good grade). Taking advantage is, Mead suggested, a violation of trust. When this happens in research, the effect of falsification (misrepresentation, misleading or manipulation) on the individual is to denigrate the individual as a person and not afford him or her the full status of a being able to judge for himself or herself. Mead (1969) went on to state that such practices led to the individual's dignity being abused and affronted. These are very strong words but they provide appropriate messages to understand in research practice, especially when attempting to do research in the same place as you work (Butler 2003).

Mead (1969) has suggested that deception in research – not being honest or wholly truthful or not giving simple communications – also has an effect on the investigator. Researchers in such circumstances become accustomed to trickery, to deceiving and manipulating others or to denigrating participants' humanity. They become arrogant. They show contempt for other human beings by such practices, even though they attempt to justify the research deception in terms of the greater good (utilitarianism). Fortunately, the *Research Governance Framework for Health and Social Care* (Department of Health 2001) reiterates the *Declaration of Helsinki* (World Medical Association General Assembly 1964) in that the welfare of the person taking part in the research must prevail above all else, above the interests of science and society.

Health care research is particularly problematic in considering how to enable people to participate in research in a fully free and open manner. When we are ill or injured or distressed, we are highly vulnerable, highly dependent on others and their actions. In such circumstances, we often lack the skills, energy and cognitive capacity to listen, think and understand. Our highest priority is to get the help that we need from those people with relevant skills and knowledge. When we are also asked to participate in research by the very people that we are dependent upon, we are not functioning in our usual manner. Therefore, the process of giving consent to take part in research is severely compromised.

In giving consent, I am agreeing to a description of a proposal of action (treatment or research). O'Neill (2002) observed that in giving consent, I may see no further than the specific description. I may agree to something if the description is presented in an agreeable way, but may not consent to the same action if it is presented in a more forthright way (for example, a 'slight discomfort' versus the more honest description of 'sandpapering the skin, stinging sensation when lotion applied, some increase in back pain for an hour or so').

O'Neill (2002) also highlighted the case where I might agree to taking part in research yet might truthfully claim that I did not consent to anything that would have *this* effect. Any individual, especially when ill, distressed or injured, is likely to fail to grasp the consequences of what he or she has agreed to participate in. In such a way, consent can be a superficial focusing on phrases and descriptions and not really understanding much that is entailed by those phrases and descriptions (that is, not knowing or understanding the true reality of what the consequences of participation might be). Certainly, it has been noted that a rather functionalist approach is often adopted in busy wards, clinics or departments, where consent is treated as a simple or tedious formality; for example, 'I must go and consent the patient.'

What, it seems to me, is essential is that not just *time* be given to explaining participation in research, but that the individual should be able to express his or her own story within the context of that potential participation in order to make sense of it. As O'Neill (2002) suggested, the consent *process* may involve an intellectual and emotional journey of growing understanding. Individuals need to be able to relate their story, understand more about the processes involved in the situation, think about their understanding, and consider and reframe their concepts of altruism, autonomy, responsibility and risk in the potential participation in research. Only in such a way may full consent be said to be given.

Thus, thinking deeply about ethics needs time; I have illustrated how the process of gaining consent for participation in research (especially in health and social care) is a complex one, requiring thought and an understanding about the true nature of trust.

Summary

I said that I would remind you once again about what exactly I had been talking about for the last 40 minutes:

- Complexity
- Thinking
- Ethics.

The three main points for you to remember and take away with you are these:

1. *Complexity theory* should help us to think about how we approach research in occupational therapy
2. *Thinking* should be valued and time given to its creative process

Professor Jenny Butler urges thinking deeply about research ethics in her stimulating Casson Memorial Lecture. (Photographs above: Steve Broad.)

3. *Ethical thinking* in research requires a deep understanding of the nature of trust.

So, as I end this Casson Memorial Lecture, I would urge you all to (as Dr Elizabeth Casson suggested):

- Be motivated by your curiosity
- Be fascinated by what is difficult.

Thank you.

Acknowledgements

- Jennifer Creek, who planted the seed.
- Council and officers of the College of Occupational Therapists, for their stimulating thoughts and discussions.
- Oxford Brookes University and the College of Occupational Therapists, for enabling me to fulfil my work roles as and when I was able to over the past few months.
- Colleagues past and present from Dorset House and all over the United Kingdom, whose conversations and discussions feed my thoughts and stimulate my mind.
- The Elizabeth Casson Trust, for awarding me the Readership for 5 years.
- Sally Feaver, for her help and support.
- Hugh, Lianne and Dominic, for their love.

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