

Care and occupational therapy: what kind of care definition do we have?¹

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Abstract: Care can mean different things to different people. Often, it is understood as referring to professional actions associated with an individualistic approach. In the context of healthcare, it is usually understood as a professional action, referring to service provision. In occupational therapy, the definition of care is not well explored. Drawing on sociological and anthropological literature, we performed a non-systematic literature review to problematize the definition of care and its application in occupational therapy. Defining care as an expression of social support, a fundamental attribute for maintaining life and the basis for the development of essential components of social life, we discuss four of its dimensions: the biomedical, the person-centred, the tacit, and the collective. We argue that occupational therapy, historically, has been aligned with biomedical care and has made moves towards the person-centred dimension. We argue that occupational therapists should explore ways to articulate all four care dimensions of care to inform their practice.

Keywords: *Comprehension, Sociology Medical, Anthropology Medical, Occupational Therapy/Trends.*

Cuidado e Terapia Ocupacional: que tipo de definição de cuidado nós temos?

Resumo: O cuidado pode ter diferentes significados para pessoas diferentes. Muitas vezes o cuidado é compreendido como referindo-se às ações profissionais associadas a uma abordagem individual. No contexto da atenção à saúde, geralmente o cuidado é entendido como uma ação profissional, referindo-se à prestação de serviços. Na terapia ocupacional, a definição de cuidado não é bem explorada. Com base na literatura sociológica e antropológica, foi realizada uma revisão bibliográfica não-sistemática para problematizar a definição do cuidado e sua aplicação na terapia ocupacional. Definindo o cuidado como a expressão de intenso apoio social, atributo fundamental para a manutenção da vida e base para o desenvolvimento de componentes essenciais da vida social, discutimos quatro dimensões: biomédica, centrada na pessoa, tácita e coletiva. Argumentamos que a terapia ocupacional, historicamente, foi alinhada com o cuidado biomédico e tem feito movimentos na direção de uma abordagem centrada na pessoa, sendo que os terapeutas ocupacionais deveriam explorar formas de articular todas as quatro dimensões do cuidado para alcançar o objetivo da profissão.

Palavras-chave: *Compreensibilidade, Sociologia da Saúde, Antropologia da Saúde, Terapia Ocupacional/Tendências.*

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1 Introduction

The term ‘care’ can assume different meanings, depending on the context. In the context of healthcare, it is usually understood as a professional action, closely linked to service provision. Although it is very frequently spoken about, care in occupational therapy is not well explored, and generally is applied when linked to a specific disease, such as “stroke care”.

In this article, we aim to explore definitions of care, focusing on how the term is mobilised in occupational therapy. We argue that it is important to appreciate the complexity of care and acknowledge its various dimensions.

2 Care: What Does it Look Like and What Do People Try to Achieve?

Care is considered to be an expression of intense social support, a fundamental attribute for maintaining life and the basis for the development of essential components of social life (FINE, 2005), which is a tacit life attribute. An etymological reading of the noun *care* understands it as: “The provision of what is necessary for the health, welfare, maintenance, and protection of someone or something”, a dedication to someone or something, special attention, restlessness, concern, zeal, burden, mission, or responsibility (OXFORD..., 2018).

As an analytical category, care was developed by feminist scholars and first examined within the family, focusing on the distribution of unpaid labour and responsibility (REICH, 1995; FINE, 2005). Despite critical contributions by feminist scholars, care is still viewed as a female, apolitical activity, belonging predominantly to the domestic sphere of women (FINE, 2005; SORJ, 2014).

Care is inextricably linked both with practice and with emotions. It is a part of everyday life and can be seen as a response to regular or unexpected situations, which can create a rift in the occupations of a person, family, community or population. Rummery and Fine (2012) define care as “a feeling or emotion involving a disposition toward others” (p. 323). Empathy is seen as fundamental to the expression of care (HOLLAND, 2008).

Care can be seen as an integral part of social relationships, which can be intimate, familial, and/or professional (RUMMERY; FINE, 2012). People need to take care of other people, or allow themselves to be taken care of, for a variety of reasons,

related to health, social, cultural and/or political reasons. Care is part of daily life and is often done because it is there to be done, as Kleinman (2009) has demonstrated.

For the philosopher Heidegger, care is a fundamental quality of humans, because being human only occurs by being together with others, which includes necessarily caring for and being cared for (REICH, 1995; KLEINMAN; VAN DER GEEST, 2009). For Tronto (1993), care represents a moral practice, and is related to doing something that is recognized as good on a social, political, and personal level.

Care is related to how people support and take care of each other in different life situations. It is “a species activity that includes everything that we do to maintain, continue and repair our ‘world’ so we can live in it as well as possible” (TRONTO, 1993, p. 103). Sometimes, and just sometimes, we need specialized care, which can be delivered by a health and/or social professional, who by providing care enters the everyday life dynamics of another person.

2.1 Professional care

For Tronto (1993), the process of care can be broken down into four distinct phases, starting from a concern (caring about) and progressing to making plans (taking care of), engaging in care giving practices (care-giving) and finally anticipating a response (care-receiving) that has the potential to modify the process. Paid caregiving, often characterized as un- or low-skilled labour, is often associated with domestic care, which has frequently been understood as feminized and undervalued labor (SORJ, 2014; GEORGES; SANTOS, 2014). In several high-income countries in Europe and elsewhere, it is usual for immigrants to be employed as caregivers in nursing homes, often with poor salaries and poor work conditions (GEORGES; SANTOS, 2014).

Another form of paid care is the skilled, professional care provided by healthcare professionals. Such care is associated with technical work, biotechnologies, proceedings, drugs, and protocols (KLEINMAN; VAN DER GEEST, 2009; CONTATORE; MALFITANO; BARROS, 2017). In this context, it is rare to discuss emotions, ethics, empathy and everyday life. However, these factors are present in all professional actions, involving “concern, dedication, and attachment” (KLEINMAN; VAN DER GEEST, 2009, p. 159). In other words, to be a professional who delivers care “is about acknowledgment, concern, affirmation, assistance, responsibility, solidarity, and all the emotional and practical acts that enable life”

(p. 161). There is evidence demonstrating the social support as an element more relevant than the access to some technologies, in the care of some diseases, such as Alzheimer (CARPENTIER; GRENIER, 2012). In order to discuss professional care, we identified four distinct, yet complementary, dimensions of care: the biomedical, the person-centred, the tacit, and the collective.

2.1.1 Biomedical care

The most institutionalized, socially recognized and diffused dimension is related to biomedical care, which is most often applied to the health sector. It can be described as a set of technical and technological procedures aimed at treating a disease as the sole and main object of care. It is characterized by a concentration of knowledge and power in the physician and in the hospital; the creation and validation of protocols that improve procedures for greater safety, efficiency, speed and low cost; the development of guidelines based on the empirical-classificatory clinical method and physiopathological and anatomical reasoning; the production of care actions lacking a personalized view of the assisted subject (CAMARGO JUNIOR, 2005; TESSER, 2007; CAMPOS; BEDRIKOW, 2014). In short, biomedical care focuses on generalizable, mechanistic, and analytical characteristics (CAMARGO JUNIOR, 2005), which can be transferable to different sectors besides health.

2.1.2 Person-centred care

The person-centred dimension diverges from the biomedical model in that it proposes another way to view care. It has grown as an area of research, informing the production of practices aimed at the humanization of care actions undertaken in the health field. This dimension aims at promoting a holistic view of care, whereby attention is paid to psychological, social, and cultural issues, and how these related to people, individually or collectively (CAMPOS; BEDRIKOW, 2014). Person-centred care seeks to value the context of the person in its collective aspects, and acknowledges this context as an influential and sometimes determining dimension of care.

2.1.3 Tacit care

The tacit dimension of care can be described as a fundamental attribute related to the sustainability of life; in other words, it is an implicit knowledge

that makes social life possible (CONTATORE; MALFITANO; BARROS, 2017). The tacit dimension of care can be characterized as a dynamic interaction between personal practices and the social context, influenced by traditions, personal experiences, and experiences transmitted by the communities, placed as informal actions.

2.1.4 Collective care

Collective care refers to the interconnection between individuals and society and the influence of culture as a fundamental element influencing how people take care of themselves, at personal and professional levels. An exploration of the dialectic relationship between gender, social class, race, and other markers of social difference is fundamental to understanding how care is mobilized in society (GEORGES; SANTOS, 2014). Tronto (2007) argues that care is associated with the state and democracy, configuring the possibilities of care in a political sense. The collective dimension of care highlights the macro-level social process and their influence on how we understand and how we receive care. Therefore, in order to collectively understand the actions of care, there is a need for valuing the public spaces in which such actions can be undertaken, developed and carried out by social actors.

3 Occupational Therapy and Care

Occupational therapist's professional identity is linked to promoting participation, social inclusion, and engagement in meaningful occupation, "to enable people to participate in the activities of everyday life" (WORLD..., 2018). While all dimensions of care are relevant to occupation, occupational therapists have allied themselves predominantly with the biomedical dimension. Taking a historical approach, Friedland (2011) explains how early occupational therapists were involved with enabling people to find something meaningful to do. Friedland highlights that the trajectory through the health system was just one among many possibilities, like social service, nursing, and education. However, she states that the health system has created an amalgam of what a good occupational therapist can and should be doing, creating a barrier to working across systems. Even though occupational therapists are active beyond the health system, like in social services (MALFITANO et al., 2014) and education (CLARK; CHANDLER, 2014), the health system and its power structures, notably biomedicine, still influence the profession (RUDMAN, 2018).

Therefore, biomedical care is the dimension that is the most prevalent in the profession, associated to illness, rehabilitation technical processes, and others approaches. Kleinman and Van der Geest (2009) argue that the biomedical model is actually far from care, influenced by an individualistic consumerism of “biotechnology-medical-industrial complex” (p. 162).

Occupational science and therapy scholars have critiqued the biomedical dimension of care (FARIAS; RUDMAN, 2016) and there is a notable and growing discussion about environment and context (LAW, 1991), community development (LECLAIR, 2010), occupational justice (WILCOCK; TOWNSEND, 2000), and occupational rights (HAMMELL, 2008), as important elements of care, further highlighting the person-centred dimension of care. Many discussions about client-centred professional actions (TOWNSEND; PALMADOTTIR, 2015) aim to the development of a professional care engaged with the real-life conditions of people.

Despite the importance of person-centred care, there is a recognition of the necessity to go beyond the individual in occupational therapy actions (LAUCKNER; LECLAIR; YAMAMOTO, 2019; GERLACH et al., 2018). There is a lack of knowledge regarding collective care and how occupational therapists can address communities, populations and also individuals, through a collective focus.

Based on these four dimensions, we can affirm that occupational therapists have developed your actions informed by the biomedical and person-centred care dimensions. About collective care, there is a small discussion in the field, but there is not enough knowledge about it to define and to use to inform practices. Nonetheless, the tacit care is one dimension that is not even discussed in the field.

If occupational therapy practices are based on occupation, participation and everyday life, it is important to acknowledge the emotion and the empathy necessary to work with others, acknowledge the moral dimensions inherent in the everyday. It is important to recognise that care requires a political view (TRONTO, 2007), to inform a critical understanding of the collective dimension of care. Such an understanding is related to the conceptualisation of occupational therapists as political beings (POLLARD; SAKELLARIOU, 2014) involved with justice, rights and citizenship in their practice (LOPES; MALFITANO, 2017). In other words, it is essential to connect the collective dimensions of care with occupational therapy practices.

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Author's Contributions

Both authors are responsible for the idea, conception and writing of the text and they approve the final version.

Notes

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