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Occupational Therapy on the margins

Nick Pollard, Dikaios Sakellariou

Abstract

This article discusses occupational therapy's pursuit of social concerns through practice with marginalised groups or engaging with diversity. In this article we understand the term marginalisation as referring to people who are socially excluded from the rest of the society in which they live because of some economic, cultural, or social difference. We take the perspective that the experiences of marginalised people offer one means of assessing public health and social cohesion. We also explore the profession's recent literature on social transformation. Occupational therapy's narrow demographic profile and dominance of a Northern discourse are critically discussed in terms of engagement with how the problems of marginalisation, such as health inequality and poverty, impact on occupation. We address some of the problems which arise through professional and organisational power when working with marginalised people. The article concludes with an overview of the complexity of challenges in developing actions to meet diverse needs from a profession that is still growing.

Introduction

Although occupational therapy is recognised as an allied *health* profession, its origins as a profession in the USA were in concerns about the relationship between society and health. There has been a consistent tension between occupational therapy objectives of enabling participation in daily life and the biomedical concerns prevalent in healthcare (Hocking 2008a, 2008b, 2008c; Molineux & Baptiste, 2012; Guajardo & Mondaca, 2016). The profession has not always prioritised social concerns but the last few decades have seen an

increasing exploration of the wider implications of participation in everyday life as a social justice issue (Aldrich, Boston, & Daaleman, 2017). Increasingly, occupational therapy literature is addressing practice with different marginalised groups.

There are more people without than within the key influential groups in the social hegemony. These influential groups, a "core cabal of the capitalist executive and the power elite"(Goodman, 2016, p328) exert pressures on the structure of society through the uneven distribution of resources toward those who are already wealthy. This ultimately affects health outcomes amongst those who are poor and in various ways, marginalised. Examples include some very significant areas such as the occupational needs of women (McGrath, 2016); of older gay people (Twinley & Price, 2016), or disabled people (Block, Kasnitz, Nishida & Pollard, 2016).

Marginalisation may be understood as an aspect of the cultural superdiversity (Vertovec, 2007) many societies experience. Social differences may be seen as more significant than similarities. Although, as ,for example, David Sibley (1995) has discussed, there is a historically established idea that the quality of civilization can be judged by the experiences of those who live in its peripheries or who are socially excluded, the commentators tend to come from a dominant and powerful (white, middle class, male, western) cultural group to whom the full variety of excluded spaces tends to be invisible (Owens, 2016). Factors such as cultural colonisation, a focus on economic growth and marketised consumption (Goodman, 2016) have produced many social victims amongst those whose experience of exclusions occur in the prison systems, or as refugees, (Jakoby, 1981), the poor (Levy, Center, & Peart, 2002), older people (Tejawinata, 2013; Wiesel, 2000), children (Armstrong-Dailey, & Zarbock, 2001), and women (McCann, 2009). In combination, all these groups together may

be numerically far from marginal, but the social distribution of power, wealth, and opportunity is unequal and concentrated in a small part of the population.

To address the needs of marginalised populations, occupational therapy may need to re-evaluate its relationship with biomedical discourses to prioritise social concerns. In nursing, such an approach has been named as "action nursing"(Goodman, 2016, p 331).

Watson (2006) suggested that the remit of occupational therapy is working with people with diverse and marginalised experiences whose disabling conditions affect their ability to participate in community and social life in a meaningful way, i.e. through an approach that respects diverse cultural reflections of the identity – or being - which is expressed through doing. Even as large an issue as mental health practice can be aligned with the discussion of 'diverse roles' for occupational therapists (Clewes & Kirkwood, 2016). Kirkwood, (2016: xxiii) points out that the complex and diverse nature of society is having an effect of widening occupational therapy practice, thus occupational therapists are getting "everywhere". However, this may simply be a process of getting people to conform to the social expectations of the health system rather than to address local or culturally determined occupational needs (Naidoo, Van Wyke and Joubert, 2017). Ramugondo (2012) has called for an 'occupational consciousness', while Guajardo, Kronenberg and Ramugondo (2015) demand the practices of occupational therapies, rather than a single conceptualisation of occupational therapy is necessary to address account of the diversity of identities this complexity suggests.

Elsewhere it is argued that occupational therapists need to work "underground" (Stouffer, 2016: 220) to develop their work with social minorities. These seemingly contradictory perceptions of margins, of diversity, and of working underground whilst belonging to the profession may reflect a tension in the profession. Owens (2016) and Beagan (2007) have

discussed how occupational therapists may observe society from within a restricted social profile since most occupational therapists are white, middle class women. There is a risk in assuming that the hierarchical order of the world, especially one which is dominated by the perspectives of powerful English speaking countries, must be the normative view, and anything different is marginal or other (Guajardo, Kronenberg and Ramugondo,2015). If the majority of the evidence and knowledge base of the profession is based in the northern part of the globe and its perspective, then the professional vision of normality will reflect this view. Turn the world upside down, so that the South is on top, and the perspective by which society is assessed immediately is ordered differently (Garcia-Ruiz, 2016; Guajardo & Mondaca, 2016).

Divides

As divides in many societies persist or become wider (e.g. regarding access to healthare, health indicators, and income) there is less support for redistributive policies (Andersen & Curtis, 2015; Brown- Iannuzzi, Lundberg, & McKee, 2017; Steele 2015). The effects of these divides are widely felt by people through rising occupational imbalance, poorer health, and reduced life chances across a spectrum of needs (Clouston 2014; Pickett, & Wilkinson, 2015).

The consequences of these divides for health and social care have been challenging. Policy tends to be determined by an elite perception of the global market which emphasises costs. Governments around the world increasingly follow a neoliberal ideology, whereby an economics-based rationality permeates all aspects of daily life, including the domestic sphere and healthcare. Recent examples include the negative effects the neoliberal restructuring of the healthcare system in Chile has had on several groups, including women and people with

disabilities (Rotarou & Sakellariou, 2017a, 2017b) and the detrimental effect of austerity policies in Greece on the population's health (Kentikelenis et al., 2011).

Health and social care spending is a key area of government responsibility and expense, and governments have shifted the financial burden from being a public concern to individuals to choose how their care is financed. As health and social care is expensive, many cannot afford to make up the shortfall when public services retreat (Koch, 2012). A concern with social transformation and practical action has been expressed in some of the occupational therapy literature, arguing across the scale for everything from simple intervention to higher level negotiation (dos Santos & Gallasi, 2014; Kronenberg, Simo Algado & Pollard, 2005; Kronenberg, Pollard & Sakellariou, 2011; Lopes & Malfitano, 2016; Pollard, Sakellariou & Kronenberg, 2008; Pollard & Sakellariou, 2012; Sakellariou & Pollard, 2016; Watson & Swartz, 2004; Whiteford & Wright St Clair, 2005Some of these ideas have been developed in the global south and in non-anglophone literatures (dos Santos & Gallasi, 2014; Lopes & Malfitano, 2016; Simo, Guajardo, Correa, Galheigo, & Garcia, 2016).

Authors such as Beagan (2007; 2012) and Owens (2016) suggest that occupational therapy has often silenced those people who do not conform to a narrow stereotype of white, middle class, heterosexual and female and articulate a critical perspective of health policies, the priorities for intervention, the need for new critical dialogues, and of directions within the profession itself. With so many margins indicated in the literature the marginal may be much less out of the ordinary than the term implies. For example, people with disabilities (Block, Kasnitz, Nishida & Pollard, 2016), people who are the main business of occupational therapy, rarely have a voice in the construction of its apparatus, tools and interventions.

Guajardo & Mondaca (2016) and Owens (2016) suggest that the clinical focus of the profession has blinded it to social and political issues conditions which perpetuate or

exacerbate illnesses and disabilities. By ignoring them the profession contributes to marginalisation. It may be challenging to reflect on and recognise the complex interplay of factors and cultural assumptions that nestle alongside the beneficial components of underpinning theory and evidence (Owens, 2016). Culture, structures, institutions and collective experiences are difficult to change (Bilewicz, 2016; Hornsey, 2016) but occupational therapists have begun to unravel some of these critical issues and prevailing social attitudes, for example to gender or social disadvantage(Galhiego, 2011; Gutiérrez Monclus, & Pujol Tarrès, 2016; Olin, 2017).

Therapy, and justice

Experiences of marginalisation cannot always be addressed through the occupation focused tools and theoretical underpinning concepts the profession has developed. For example, occupational justice is a key term in professional discourses around marginalisation and social participation. As commentators within the profession and occupational science have found, powerful and reductive positivist constructs around practice can obscure the need for social transformation (Farias, Rudman, & Magalhães, 2016; Gordon, Lapointe, MacLachlan, & Craik, 2016; Kinsella & Durocher, 2016; Mirza, Magasi, & Hammel, 2016).

The role of occupational therapists (amongst others) is connected with their professional power which involves working within the interests of their employers, such as state or corporate healthcare systems which, as dominant players in the organisation of services, are able to determine how needs are met. Examples of this may be working within the need for corporate safety and limited liability in clinical decision making (Durocher, Gibson, & Rappolt, 2016), or organisational communication and efficiency priorities (Goldman et al. 2016). These principles become margins within which people with disabilities and people with experiences of mental distress may be contained by groups of professional workers such

as occupational therapists. The needs and interests of people with disabilities and people with experiences of mental distress do not rank so significantly as powerful professional collaborations supported by knowledge of clinical expertise.

These problems arise as functions of the power, efficiency and organisation through which many different and marginal experiences are managed (see Foucault, 1977). Occupational therapists developing their work in emergent roles may even have the effect of bringing groups within the reach of these controls. In reaching hard to reach groups, such as asylum seekers or homeless people occupational therapists may have to negotiate with agencies such as the police in order to provide a safe service to these people without them being subject to arrest. Thus, while the aim of the professional might be to offer therapeutic or social intervention, this may also be understood as the benign aspect of their 'soft policing' (Whittington, 1970) role, maintaining social stability on behalf of the authorities and state organisations for which they work. Shakespeare, (2013) points out that people with disabilities sometimes experience professional interventions as unjustified controls, constraints and restrictions on personal capacity. As occupational therapists work with an increasing variety of marginal groups, it is important that intervention is collaboratively evaluated with the people for whom it is intended.

Conclusion

It has been argued that the discourse around 'occupational therapies without borders', or around working with marginal groups, has led to a ’movement’ about the role of occupational therapy, and the objectives to which its members might be set to work (Frank, Baum, & Law, 2010). Diversity and fluidity are major tropes in global society, and they are driven by economic instability and uncertainty, inequalities in the experience of wealth and health. Since this is the centennial year of the profession, it is worth remembering what some of the

antecedents for occupational therapy were in the work of people like Octavia Hill, whose concern about the impact of social and economic marginalisation on health and welfare was an expression of a romantic tendency towards the spiritual and search for enlightenment through doing. Occupational therapy, Hocking (2008a, 2008b, 2008c) points out, came out of identifying that people at the social margins, particularly those with long term disabling conditions needed interventions to address their chronic conditions, restore self-esteem and hope.

Social transformation is complex and must take different forms according to local contexts and needs. Occupational therapy is a small profession for which this represents a significant challenge. There will always be tensions between interest groups and issues of representation in which the most powerful and effective gain the most resources. Social transformation may even be understood differently by individuals within the same community, and as a consequence will never have a definitive, scientifically rational, decisive process, it will always have to be negotiated according to the present situation, the ebbs and flows of policy and different administrations, conflicts and disasters. People on the peripheries of society are often the focus of temporary attention when they are perceived as a problem, until a new problem arises. Many of the problems people with disabling conditions experience have social origins. Occupational therapy is an action based approach to working with people by facilitating them to negotiate for the means to have control over their own lives.

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