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# Occupational Therapy: Autonomy, Governmentality and Subjectification\*

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**ABSTRACT** | This paper explores Occupational Therapy (OT) interventions using a dialogical perspective with therapists and people with functional diversity.<sup>1</sup> Framing the dialogue between the discourses that participate in the therapeutic process, the paper reflexively explores the interferences in the forms of subjectivity that the discipline promotes under the governmental umbrella. The research uses ethnographic and narrative material as the basis of its methodology. The material suggests that OT, like other health disciplines, constitutes a governmental mechanism of bodily regulation that produces subjectification through certain procedures: distributing persons in space, regulating their use of time, and perfecting their performance of activities. The reflection allows us to reconsider the construction of the “patient” in OT interventions considering the rights of persons with functional diversity.

**KEYWORDS** | Occupational therapy (Thesaurus); subjectification, governmentality (Author’s Keywords).

## Terapia ocupacional: autonomía, gubernamentalidad y subjetivación

**RESUMEN** | Este trabajo explora las intervenciones de Terapia Ocupacional (TO) utilizando una perspectiva dialógica con los terapeutas y con las personas con diversidad funcional.<sup>2</sup> Enmarcando el diálogo entre quienes participan en el proceso terapéutico el texto explora reflexivamente las interferencias de este diálogo sobre las formas de subjetividad que la disciplina promueve bajo una perspectiva gubernamental. La investigación

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1 “The term that we, as members of the Independent Life Forum, propose for referring to this group is women and men with functional diversity, which we believe is the first term used to denominate them that does not assign any negative or medical character to the vision of human reality and places emphasis on their difference and diversity as values that enrich the world in which we live” (Romanach and Lobato 2015. My own translation.)

2 “La manera en la que desde el Foro de Vida Independiente proponemos denominar a ese colectivo, al que pertenecemos, es mujeres y hombres con diversidad funcional, ya que entendemos que es la primera denominación de la historia en la que no se da un carácter negativo ni médico a la visión de una realidad humana, y se pone énfasis en su diferencia o diversidad, valores que enriquecen al mundo en que vivimos” (Romanach and Lobato 2015).

utiliza como metodología material etnográfico y narrativo. El material sugiere que la TO, como otras disciplinas de la salud, constituyen un mecanismo gubernamental de la regulación corporal que genera la producción de subjetivación través de ciertos procedimientos como la distribución de las personas en el espacio, la regulación del uso del tiempo y el perfeccionamiento de su desempeño de las actividades. La reflexión permite reconstruir la construcción del “paciente” en las intervenciones de TO, considerando los derechos de las personas con diversidad funcional.

**PALABRAS CLAVE** | Terapia ocupacional (Thesaurus); subjetivación, gubernamentalidad (palabras clave de autor).

## Terapia ocupacional: autonomia, governamentalidade e subjetivação

**RESUMO** | Este trabalho explora as intervenções de Terapia Ocupacional (TO) utilizando uma perspectiva dialógica com os terapeutas e com as pessoas com diversidade funcional.<sup>3</sup> Delimitando o diálogo entre os que participam do processo terapêutico, o texto explora de forma reflexiva as interferências desse diálogo sobre as formas de subjetividade que a disciplina promove sob um ponto de vista governamental. A pesquisa utiliza como metodologia material etnográfico e narrativo. O material sugere que TO, como outras disciplinas da saúde, constituem um mecanismo governamental da regulação corporal que a produção de subjetivação gera por meio de certos procedimentos como: a distribuição das pessoas no espaço, a regulação do uso do tempo e o aperfeiçoamento de seu desempenho das atividades. A reflexão permite reconstruir a construção do “paciente” nas intervenções de TO, considerando os direitos das pessoas com diversidade funcional.

**PALAVRAS-CHAVE** | Terapia ocupacional (Thesaurus), subjetivação, governamentalidade (palavras do autor).

## The Occupational Complex

It could be argued that the development of the social sciences goes along with governmental transformation in the adjustment of individual life to societal productive needs. Present forms of production demand the constitution of free and responsible citizens, capable of managing and governing themselves (Bustos 2012; Castro-Gómez 2000). Under present cognitive capitalism (McQuade 2015) and neoliberalism<sup>4</sup> (Biagini and Fernández 2014), the social sciences must manage populations by identifying those individuals who are able to behave as responsible self-regulated citizens and promote and implement interventions directed to those unable to behave according to current societal demands. Professionals become agents in the reconstruction of *active citizenship*, and health disciplines exercise power over the body by regulating *time, space, and activity* (Tirado and Domènech 2001). These forms of regulation are framed within a context of open control

where governmental rationalities incorporate a set of practices that constitute, define, and instrumentalize relational strategies (Medrado-Dantas 2002). In her article, “Do not ask me to remain the same: Foucault and the professional identities of occupational therapists,” Hazel Mackey (2007) examines how contemporary reorganization of the workforce impacts OT practice and the identity of Occupational Therapists (OTs) in relation to the persons with whom they work (Mackey 2007). OT is part of a governmental mechanism<sup>5</sup> that assembles different semiotic-material practices in order to regulate the population’s dispositions and behaviors (Gutiérrez 2011) inside and outside the institutional regulatory device that contributes to the formation of subjects and subjectivities (Barry, Osborne and Rose 1996). The process of becoming a subject is socially and historically located within power-knowledge relationships that are in accordance with the prevailing governmental rationality. These modes of subjectification (Deleuze 1987, 125-128; Strozier 2002) provide a visible representation of power both along the dimension of control and the dimension of productivity, guiding the ways that “we think and feel about ourselves” (Gil 2004, 17).

Within current forms of governmentality, Ingleby (1985) identifies the “psy-complex” as a governmental technology that contributes to the subjectification process (Ingleby 1985). This is a technology that

3 “A maneira na qual, desde o Fórum de Vida Independente, propomos denominar a esse coletivo, ao qual pertencemos, é mulheres e homens com diversidade funcional, já que entendemos que é a primeira denominação da história em que não se dá um caráter negativo nem médico à visão de uma realidade humana, e se enfatiza em sua diferença ou diversidade, valores que enriquecem o mundo no qual vivemos” (Romanach e Lobato 2015, tradução livre).

4 “Alternative nomenclature ‘neoliberalism’ to explain how hegemonic market discourse created an ‘ideological fantasy’ which, based on what we call gladiatorial ethics, redefines the classic concepts of liberalism” (Biagini and Fernández 2014, 1, my own translation).

5 The term governmentality is used to describe the governmental rationalities that mold the intentions and decisions of the population and define the ways in which the population exercises its freedoms (Foucault 1991).

interconnects networks of theories and applied institutional practices that involve professionals in regulating the subjectivities of OTs and patients (Parker 1996 y 2008). Within this network, occupational science considers OT to be a healthcare profession focused on the user that deals with the promotion of health and wellbeing through occupation. The main objective is to allow people to participate in activities of daily life (WFOT 2012). Furthermore, occupational science focuses on the study of activities that people do in their daily lives and how these activities influence and are influenced by their occupation (WFOT 2012). These constitute knowledge and practices that contribute to the regulation of people from their occupational dimension.

OT and occupational science thus maintain a symbiotic relationship (Clark and Lawlor 2009), constructing and regulating the “occupational” dimension of bio-psycho-social understandings of the human condition and broadening the range of theory and practices governing behavior (Da Silva *et al.* 2011). This constitutes a particular device (Beckett and Campbell 2015) that can be understood as an “occupational complex” (Gutiérrez 2011), a specific aspect of the psy-complex that operates along two streams of rationality: care provision and scientific interventions (Rivero 2005). Care provision connects with the logic of charity and common good that inspires religious Christian society of our time, portraying professional care as “helping others” and these practices become legitimated by scientific knowledge.

### **Responsibly Approaching Occupational Therapy Interventions**

The governmental character of the social sciences goes along with the development of methodologies that translate the knowledge and agency of participants into a set of procedures to produce “wellbeing.” Critical perspectives need to develop methodologies that can transform the predominating character of social research and contribute to the construction of a collective ethical and political knowledge that can transform present society into a better place in which to live. At the same time, any research has to consider that, although we cannot “escape from the exercise of power, we should at least strive to avoid forms of domination”<sup>6</sup> (León 2006, 53). Although some authors have considered social research a form of domination (McDowell 1992), it is clear that social research reproduces power relations (Gitlin 1994; Oliver 2007), and these power relations have to be counter-balanced by considering dialogical and reflexive perspectives in the development of critical methodologies, among other things (Harding and Norberg 2005). Dialogical

perspectives localize the research position socially and indicate the political character of social research by considering the multivocality and heteroglossia within social phenomena (Hynes, Coghlan and McCarron 2012) and emphasizing the political character of the signifier (Danow 1991). This research has complemented dialogicality (Marková 2003) with the notion of “field” (Spink 2004) by integrating the different connections, interrelations, and experiences of the researcher. Reflexivity, on the other hand, monitors the position of the researcher and its effects on the production of knowledge (Berger 2015). Instead of an individualistic reflexivity, where the researcher unfolds his/herself to the reader, this research endorses a perspective where the reflection is acted upon by both the researcher and the subject, taking into consideration the community in which they are involved (Adkins 2002). The perspective of the researcher and the knowledge produced by the research is cross-examined by the participants and other researchers while the research is being carried on (Cohn and Lyons 2003), a process that has been implemented using ethnographic and narrative material. Along with the dialogical and reflexive process, the political implications of the research practice and the knowledge it produces have been considered and reflected upon. The work of Donna Haraway has been influential here in her insistence that research should strive for habitable worlds and connect different positions of knowledge (Haraway 1997), while carefully considering the ethical and political implications of representing other people’s experiences and considering our responsibility with respect to the knowledge produced and the implications of such knowledge. This consideration, of great importance when developing a relationship between researcher and subject, is now part of mainstream qualitative research (Cohn and Lyons 2003).

Furthermore, the ethical dimension, as noted by Lincoln (2000), must be intrinsic to the relationship between the position of the one who has the knowledge and the position of the one who reconstructs said knowledge, as both participate in its construction. In this sense, instead of blindly applying institutionalized ethical canons, we need to ethically localize the research within the specific relationships between participants and researchers in terms of personal agreement and negotiation within an institutional context. Ethical absolutes and minimums are insufficient, as ethical relationships are predicated on each new encounter (Lincoln 2000). In this particular study, participants were aware that the ethnographic research was being carried out within the different contexts —therapy, teaching and social movement—, and participants were able to review the research notes. The development of the research, both in terms of the definition of the topic and the different positions taken during the research —lecturer, therapist, activist—, positions the researcher in different ethical and political positions, positions

<sup>6</sup> My own translation.

with different responsibilities. The development of the research has taken into consideration that:

We must be prepared to accept our moral and political responsibilities. This means that as feminist researchers, we cannot indulge in the illusion that our position is less influenced by history than that of others, and we must develop methods to evaluate the work carried out thanks to the use of feminist methodologies.<sup>7</sup> (Biglia and Bonet 2009, 3)

Political involvement with the functional diversity movement has had an important impact in redefining my role as researcher, therapist and lecturer, and developed my sense of responsibility regarding the conditions of people with functional diversity. As noted by Townsend, an ethical perspective involves producing knowledge that is useful not only for the researchers, but also for the community of persons whose experiences have been recorded (Townsend *et al.* 2003), in order to improve their living conditions.

The ethnographic material was recorded in a field diary (FD) —February 2006 to August 2007— based on my experience as an Occupational Therapist both in academic teaching and therapeutic practice in Catalonia, Spain. While doing the research, I was also involved in a social movement relating to functional diversity, and ethnographic data was also collected on these activities. These research decisions were inspired by this remark by Schneider: Autobiography constitutes “a space of risk” (Schneider 2002, 471) —moral, political, technical, and epistemological—, and the fieldwork has been understood as the development of “modest interventions” (Haraway 1997) and critical reflections on my professional role and the implications of our interventions. These decisions opened up a space of incertitude as the development of the research led me to question my role as lecturer and professional while diffracting (Van der Tuin 2014) the concepts and practices that ground OT. The uncertainty was also present when having a twofold role —therapist/activist— when working in the activist association on functional diversity, since the association considered that the medical-rehabilitation perspective was perpetuating the oppression of people with functional diversity. These uncomfortable positions were quite productive in bringing about a reflexive and critical understanding of my role as a member of the discipline.

Narratives with participants identified by key informants from the ethnographic study were also carried out. After sending out twelve letters asking for participation, seven narratives were carried out. The letters outlined the research, its ethical assurances —

confidentiality, constant access to the data produced and psychological wellbeing— and the themes of the narratives. Four narratives were undertaken with experienced Occupational Therapists and three with people who had received Occupational Therapy in relation to physical and mental issues. The following is a list of the participants and the initials that will be used to identify them throughout the remainder of the article: (Méndez, B.) Professor of O.T. with experience in physical rehabilitation; (Moratinos, C.) Professor of O.T. with experience in mental health; (Guzmán, S.) Occupational Therapist with experience in geriatrics and mental health; (Vidaña, L.) Occupational Therapist with experience in physical rehabilitation; (Centeno, A.) Activist in the “Movement for Independent Living” with experience in OT; (Poca, A.) Writer with experience in OT; (Esther) Bank executive with experience in OT. Different steps were followed in order to construct the narratives (Schöngut and Pujol 2015). There was an initial interview with the participants that has been transcribed and textualized in order to produce a first-person, coherent narrative. Subsequent meetings worked on the improvement of the textualized interview following the directions of the participants and discussing the issues arising from the subsequent versions. This process terminated when the participant approved the text as a final version. This is a methodological practice that deepens participants’ understandings in comparison with conventional interviews (Balasch and Montenegro 2003).

The revision of the material identified three distinct themes following a thematic analysis (Braun and Clarke 2006) complemented with an interpretative phenomenological analysis (Smith 2011; Smith, Flowers and Larkin 2009): (a) occupational therapy as a normalizing discipline, (b) the performative dimension of occupation; and (c) tensions within Occupational Therapy interventions.

### Occupational Therapy as a Normalizing Discipline

The regulatory constraints of occupational therapy is a theme that stands out in the material. Routines contribute as a disciplinary element for social adjustment and adaptability: “We would arrive at 10 o’clock in the morning; we would meet for an hour and a quarter to talk and say ‘good mornings,’ and this was very therapeutic” (Gutiérrez 2011, 186). These disciplinary procedures define a clear and linear timeline in order to guide therapeutic subjects towards specific goals that define a desired future that shapes present subjectivity (Tirado and Domènech 2001). This infliction of an idealized future can lead to deception once the disciplinary procedure is no longer needed or has proven unsuccessful: “Fifteen years after my accident, I realized that in all of that time in Occupational Therapy, nothing was true; it was all a continuum of fiction-truth,

7 My own translation.

and the fiction could become reality when you made it so" (Gutiérrez 2011, 158). Disciplinary procedures define an *occupational fiction* projecting possible scenarios which the patient has to accommodate in terms of occupational performance: "Only in therapy was there a plan to carry out, a construction... my situation was very particular, and there was a future in which to realize 'that' that had been..." (Gutiérrez 2011, 155).

The institutionalization of OT creates a normalized language leading towards the establishment of a standardized understanding of the "patient," and the routines are applied differently depending on the taxonomical ascription of the subject. The understanding of the therapeutic subject diminishes agency as it highlights the acceptance of the present living and therapeutic situation if he/she wants to have the possibility of an improved future: "It seemed natural to me how I had changed, that I was a 'bag of problems' and I had to strive to improve" (Gutiérrez 2011, 122). This is an individualized understanding of the problem requiring important physical and psychological effort that the participant has to accept passively. This understanding on the part of the therapeutic subject has a direct implication in the process of subjectification. For example, using an electric wheel chair constitutes a failure in the rehabilitation process: "having totally internalized this discourse that blamed me, it all added up to it being my fault that I couldn't move the chair, because in theory if I had done more hours of therapy or if I were 'less disabled' I could have managed to get out and about" (Gutiérrez 2011, 126). These classificatory practices contribute in the differentiation of the 'normal' from the 'deviant' (Foucault 1975).

Occupational therapy is heavily influenced by the medical model that individualizes disability as the result of a negative event —illness or trauma— that reinforces the limitations of "disabled" people in comparison to "normal" people. It has to be noted, for example, that orthopedic interventions are usually accepted in order to resemble the "normal body" but not to improve the potentialities of the "disabled body." Therefore, intervention focuses on decreasing the "negative" consequences of "disability" as compared to the "normal situation," thus leading towards a conceptualization of the "disabled" as a permanently maladjusted and sick body (Ferreira 2010). This is an aspect that has important effects in the subjectification of the "disabled body" in terms of uneasiness and discontent. The occupational therapist (Gúzman 2008) states in his narrative that "It is important to analyze the society that pushes us to develop certain standards, which, in my view, are sometimes selected by the person, but at other times are very much influenced by the context. This effect can provoke dissatisfaction with one's lifestyle, perhaps not immediately, but in the long term" (Gúzman 2008, 209). Disability studies, in contrast, locate disability in the social and

environmental context, questioning the pathologizing and individualist constructs of the medical model and endorsing the view that disability is defined by the context in which it is occurring (Torres 2002).

## The Performative Dimension of Occupation

Far from occupying a fixed position in the social structure, the subject is constituted from his or her acts: "to do, to dramatize, to reproduce, these seem to be some of the elementary structures of embodiment" (Butler 1990, 300). The iteration of power-charged practices generates performative effects that penetrate the processes of subjectification from which the subject is configured. Therefore, "performativity covers the footprints of repetitive constructions, and therefore brings with it regulation and constriction" (Vidiella 2014), as opposed to a concept of performance that might serve to subvert the norms imposed by performativity. As OT defines certain repetitive practices, those practices have performative effects that impact subjectivity: "People in Occupational Therapy are confronted with their limitations when they are unable to do what they did before. Intervention challenged them, encouraged them, and there were those who did not want to see their limitation or could not meet expectations and they had much distress." (Gutiérrez 2011, 210). Performing previous activities [in OT] exposes the difference between present and past performances. The performance is different, slower, broken, painful, in a body that has changed (Field Diary, 521). This experience, when in dialogue with "available" discourses, diminishes personal valuation by adopting common negative concepts suggesting loss or lack of value such as handicap, disability or deficit. There are few options that provide a positive assessment of the difference that provides human dignity and gives value at performing activities differently. "In the hospital system you began to steer towards a new role, that of being a burden to family and society; you need to be cherished" (Gutiérrez 2011, 118). And about his role in rehabilitation, he states that "he was an object in the development of the activities: I was washed, dressed up, put to sleep, fed,... without being able to decide when, how or with whom. Even worse, there was no need for me to learn to teach and advise people on how the assistance should be given to me" (Gutiérrez 2011, 256).

Understanding the subjectification of disability from the performative perspective allows us to situate the process of becoming subordinated or disabled as a form of subjection. As noted by the A. C. narrative "it is very difficult to change this way of thinking, because it is very easy to internalize. And you don't ask yourself whether getting up at five in the morning to catch two or three buses, having to wait for an hour for each one, because some don't have ramps, and then getting home late in the evening for the same reason, is a reasonable price to pay to be able to go to school" (Gutiérrez 2011,

130), considering that the living conditions of exclusion were “normal” as they were the result of an individual situation. However, while Butler noted that this is a power exercised over the subject, submission is also a power assumed by the subject, and this assumption constitutes the instrument of becoming (Butler 1990, 22). In this sense, collective actions such as activism within the Spanish Independent Life Movement possibilitate new roles that transform the traditional role of the “patient” or the “disabled” (Gutiérrez 2011). Therefore, OT must be aware that the processes of subjectification present within the occupational intervention, as well as the *normative occupational fiction* (Gutiérrez 2011, 249) projected towards “perfect/normal” bodies and actions, may limit the possibility of understanding the situation from a perspective of rights and dignity. In this regard, Ferreira considers that the offer of recovery with the medical model is based on a “medical model” that will never be “legitimized” (Ferreira 2010).

## Tensions within Occupational Therapy Intervention

### Autonomy and Independence

The notions of “autonomy” and “independence” have specific meanings and dramatic implications for people with disabilities (Reindal 1999). While independence is the ability to do things for yourself without external support, autonomy is the ability to decide for yourself regardless of the level of assistance needed to accomplish such decisions (Querejeta 2004). However, professional practice focuses primarily on independence: “when we began as a profession, we were focused on working with people with disabilities, and we focused on independence. Many therapists and other professionals today confuse autonomy with independence, and focus only on independence” (Gutiérrez 2011, 172). Even if these concepts are not explicitly acknowledged, they are implicitly used by focussing on “functionality,” “at work there was no distinction between the concepts of independence and autonomy, and emphasis was on functionality or being equipped” (Gutiérrez 2011, 200).

Everyday practices signal the importance given to “independence” as compared to “autonomy.” For example, the widespread use of scales that rate independence based on the level of assistance required for self-care activities defines independence and infers autonomy as a result. By focusing on independence, the individual is forced to approximate to the ideal normal body regardless of his/her personal aspirations and projects. It should be noted that high levels of autonomy can be achieved regardless of the levels of independence, and focusing on independence can, in some situations, undermine the levels of autonomy:

The effort to rehabilitate this lack of independence results in a surrender of individual will to the decisions of others regarding what to do. This concession has the consequence of institutionalizing women and men with full autonomy, because of their lack of independence.<sup>8</sup> (Palacios and Románach 2008, 126-127)

Low levels of independence can diminish autonomy in such a way that agency can be negated in terms of inability to do things for oneself: “I was simply a ‘high-level tetraplegic’ and ‘high-level tetraplegics’ could not do anything for ourselves; therefore, it was automatically inferred that we couldn’t decide for ourselves either” (Gutiérrez 2011, 119). This should be read within the background of the autonomous ideal of the “able body” prevalent in post-Fordist societies. Present forms of subjectification assign a lower value to persons with disability, as they are dependent on others, and associate disability with the inability to self-govern. “Having a disability” makes you a “second-class citizen” (Oliver 1998). It could be argued, therefore, that professional practice that prioritizes independence over autonomy has disabling performative effects. This is particularly relevant in some forms of OT where the occupational perspective is reduced to training the subject for self-care of everyday activities under a biomedical life-contextualized-predesigned rationale (Mocellin 1995).

This tension comes into play in the management of personal assistance, a service that supports independent living and allows persons of any functional ability to assume responsibility for and control over the support required for independent living and full social participation (Blanco *et al.* 2009, 3). “In my personal experience working as an Occupational Therapist and personal assistant to Naya, I often found myself thinking that we were co-authors, that is, a collaborative team, but I also felt a pull to return the authorship to her, as the decisions were hers, and I was only the assistant in realizing these decisions” (Field Diary, 73-74). The personal assistant helps to carry out the occupations that are selected by another person, challenging the notion of doing for oneself, without help—here understood as independence—, and replacing it with the notion of deciding for oneself—understood here as autonomy—.

The figure of the personal assistant is very useful when imagining possibilities that shift the focus away from doing for oneself, allowing for a projection of the professional practice centered on interdependence.

### Sickness versus Occupation

The clinical-hospital setting favors a practice centered on illness, which standardizes and homogenizes interventions. “Homogenization of interventions

8 My own translation.

promotes the pursuit of a 'purity' of diagnosis required to define the intervention" (Field Diary, 76), for example, in regards to the inclusion/exclusion criteria for care programs. "This is especially complicated when [...] they are translated (these criteria) to community psychosocial interventions, generating 'fictitious classifications' that are unsustainable within settings in which what unites people are their ties and social relationships" (Field Diary, 75-76) and not their diagnoses. Regarding this point, during my fieldwork, in a technical meeting to evaluate a support group for persons with epilepsy, there was a debate regarding the inclusion criteria, since there are people who have diagnoses other in addition to epilepsy —epilepsy and Down's syndrome, for example—. Opinions in favor of a "diagnostic purity" necessary for the intervention and for inclusion in the group were difficult to support in the context of an organization focused on supporting the social integration of the persons involved. Working within a framework of illness thus leads to the risk that these professionals will require an ideal subject for intervention to meet their expectations and fit the diagnostic criteria.

When the professional bases the intervention on the illness rather than on the person, the diagnosis takes precedence over other intervention criteria such as age, life project, and/or education. Intervention based on illness articulates the perspective of a fragmented occupational subject (Gutiérrez 2011, 57) that bases recovery on a body part, thus resulting in a passive subject, the recipient of assistance, moralizing a sense of "for one's own good" that leads to certain practices that go beyond the medical sphere and enter the territory of lifestyle prescriptions that necessarily impact the person's occupational dimension and compel him or her to become an amoral occupational subject (Gutiérrez 2011, 55). In this way, expectations are adjusted, wishes are accommodated, the body becomes docile, and the intervention space is governmentalized and subjectified: "supposing that each of us there had a job to do, many of us had to swallow the bitter, broken memory of our past and learn to be only a patient" (Gutiérrez 2011, 161). Basing intervention on the illness allows for a level of medical intervention in which severity and age can shape an intervention. However, each person performs occupations until the last day of his or her life and, therefore, criteria based on illness alone cannot be adequate to guide professional practice.

Protocolization and simplification of treatments (Field Diary, 42) work against OT, by limiting the possibility of an active role and an occupational and community perspective in the intervention. However, strategic use of institutional quality assurance policies to optimize the services for users can validate the role of the Occupational Therapist in favor of the interests of the person: "because it is the process that justifies the intervention in response to a given need" (Gúzman 2008, 222).

### Passive versus Active

The patient's perspective (passive) is related to the degree of participation in decision-making: "prioritization of treatment was done at two levels. At the first level, the definition of the treatment objectives based on the diagnosis, the person's history, his or her needs, were pre-defined by the team and focused strongly on the development of abilities. The second level, the selection of activities, included the person's participation" (Gutiérrez 2011, 138-139). This practice, common among health care teams, leads to a subject-object configuration, as the person is excluded from decision-making, while the professional performs actions framed by the political rationalities of the occupational complex, from the scientific perspective -in which "expert knowledge" is established to provide help and care-, to the desire to support the "wellbeing of the other."

Undoubtedly, the care setting also places tension on the participation of the person: "They gave me what I needed, they were master builders and if there had been more time, they would have done it in a more collaborative manner. And much more efficiently" (Gutiérrez 2011, 159). Because "when you do everything so quickly... in the end it doesn't get done, you get all worked up and then nothing. Everything ends up being a waste of time, of energy, of money, of emotion... the patients feel offended and mistreated. Each person has a different illness and the therapists have to take the time to really get to know each person or 'whatever' to explore with them the possibilities and support them in forgetting the sadness of their lost body..." (Gutiérrez 2011, 159).

However, it is possible for the person to have greater influence on the treatment, due to his or her level of education, motivation, abilities, context, and/or the relationship between the therapist and the person with functional diversity, which makes the intervention gratifying both for the person and for the Occupational Therapist (Gutiérrez 2008). "We didn't know the objectives of the activities. This is a grave error, because the person gets bored, feels sick and condemned... They don't understand what they are doing it for... They see it as nonsense... I guess that all the therapists used the activities for specific reasons... even if the patient didn't know what they were... I admit that I grasped the meaning behind what I was doing only when the Occupational Therapist gave it to me... These were the rare moments of harmony in a department where disorder reigned, as it did throughout the hospital" (Gutiérrez 2011, 157). In Poca's experience, the possibility of reaching the first level of participation and decision-making reconfigures the experience of OT and gives it meaning.

### Intervention and Socioeconomic Variables

The practice of intervention is influenced by many categories: "The treatment that the patients received varied widely... due to economic reasons and privileged



social functions. For example, if a woman was a mother, it didn't matter if she stayed slow and could hardly talk; the question was whether she was able to recognize her children and to salvage her role as mother... The rest of the person didn't matter. The people were —and of course in the public hospital the classism was even more obvious ... —institutionally conditioned to fulfill a social function in life, and not, obviously, for diversity... —[It was] emotional, functional, economic determinants, etc. that prioritized salvaging a function for each person, usually their job, if they were lucky enough to have one... and goodbye to all of the other possibilities... In my case, I was lucky because my social role was... better emphasized... because I was a writer and a university professor... This made my projection easier... my social function was noble and created expectations about what I might still achieve" (Gutiérrez 2011, 160). In her experience, being a university professor was "an island of good luck amid the general misfortune (since) they had to do something with me" (Gutiérrez 2011, 161).

It is vital to examine the production and representation of socioeconomic categories in the occupational intervention critically. Axes such as "poverty, race, sex, and age are factors that intervene in the production of disability, but the fundamental character of these themes is never recognized in the theoretical or experiential understanding of disability" (Oliver 1998, 40). For reflection on this, it is useful to apply the notion of intersectionality (Esguerra and Bello 2014) in considering the social determinants not as isolated factors (Cairney *et al.* 2014) but rather as the interaction of various social categories that result in a given social position (Davis 2008). This consideration has both theoretical and methodological relevance for OT intervention, since it reveals the dimension of power articulated in the reproduction of these categories as forms of governmentality and subjectification present in the intervention practice. Reflection on these themes makes it possible to develop other ways of acting, opening up space for the everyday political dimensions of our practice. As noted by Martínez, "questioning the concept of femininity is not sufficient; we must also question the concept of masculinity, of heterosexuality, and also categories such as race, class, identities associated with consumption and work, the so-called stages of development, etc." (Martínez 2006, 62).

## Conclusions: Localization of Occupational Therapy

The exploration of governmental practices in the position of "therapists" points to subjectivation processes derived from some forms of OT. Uncovering the disciplinary and performative processes involved in the professional intervention makes it possible to rethink the relationship between the provider and the subject of the intervention and the processes by which knowledge

is produced. In particular, clarifying the tension within the practice regarding independence and/or autonomy shows the limitations of intervention practices that focus on independence and the need to explore the issue of Occupational Therapy intervention from the perspective of both autonomy and interdependence (Reindal 1999). Rethinking the intervention situation as the interconnection between different positions and acknowledging the knowledge of both the provider and the receiver of therapy makes it possible to localize the therapeutic relationship within the specific circumstances of the person instead of aiming for a normalized pattern.

This is relevant, for example, when evaluating the importance of the independence or autonomy of the receiver of therapy. Recognizing the knowledge of the person receiving therapy opens up different axes of understanding that locate intervention within a complex and manifold perspective. Uncertainty and complexity are both characteristic of our societies, and OT should address these facts instead of hiding them. OT takes place in a concrete local situation and therapeutic practice should consider the local knowledge that shapes these practices. Theory and practice constitute a dialectical relationship of constant reflection.

Understanding OT and the science of occupation as an occupational complex allows us to problematize the imposition of the liberal subject on therapeutic contexts, recognize the context of vulnerability and social discrimination, localize the therapeutic relationship and acknowledge people with functional diversity as active and autonomous citizens in their own way. Moreover, considering the performative dimension of occupations helps us to keep in mind the processes of subjectification and governmentality in which we participate. This point of view, which makes visible the political dimension of the occupational complex, allows us to undertake everyday actions in pursuit of the challenge of achieving dignity, rather than capacity, questioning our professional role, challenging and problematizing the neutrality and depoliticization of the professional practice. Practitioners are accountable for their practice: they have a responsibility to review their professional knowledge critically and to make it available to the public (Higgs and Titchen 2001, 528).

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