Caring:
A Philosophy for Practice

(philosophical base, OT practice)

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In October 1964, the American Occupational Therapy Association (AOTA) held its Annual Conference at the Hilton Hotel, Denver, Colorado: the theme of the conference: Research. In April 1980, the AOTA is holding its Annual Conference at the Hilton Hotel, Denver, Colorado: the theme of the conference: Caring. Research and caring, topics selected as themes for two conferences held in different decades, may seem to fall at opposite ends of a professional continuum. However, the topics have a direct relationship to each other as well as significance to the profession and its development.

Research and caring are inherent techniques of two distinct but interrelated domains that are of crucial importance to occupational therapy. The first domain is the philosophy-methodology of the science of occupational therapy; the second, the philosophy-methodology of the art of therapy. The science of therapy emphasizes the cognitive side of learning, while the art of therapy stresses affective development. Science philosophy-methodology provides a model for therapeutic reasoning and methods. Research is the primary technique in the science of therapy. The second domain, the philosophy-methodology of the art of therapy, provides a model for therapeutic relationships. Caring is the primary technique inherent in the art of occupational therapy.

This paper will be directed toward the art of therapy, emphasizing caring as the basic ingredient in the philosophy of occupational therapy practice. The concept of caring as a process to facilitate growth and development of another person will be explored. To develop this concept, three components of the caring process will be discussed. Although the focus will be on the art of therapy, comments regarding the development of the science of occupational therapy and the relationship of the philosophies of both domains will be included.

The Growth of Research

At the 1964 conference, Tommye Duncan, program chair, stated that "A profession grows or dies—it does not stand still." (1, p.1) Research is a necessary ingredient for that growth. Dr. Elizabeth Yerxa, at this same conference, proposed, "The development of the research attitude in every student and every clinician is the beginning of the development of professionalism in occupational therapy. Once critical thinking becomes a habit, research activity inevitably follows. To substantiate...
The concept of caring was introduced as an inherent ingredient within our philosophies of practice.

clinical practice upon knowledge rather than assumptions is the future's greatest challenge to the clinician... Our profession will live because we will accept this challenge." (2, p 22) Indeed, our profession has accepted the challenge: we have not stood still, but have grown and developed.

Since 1964, the AOTA has made major strides toward developing the necessary research attitude suggested by Yerxa: for example—in 1967 the AOTA and APTA joined to sponsor a research conference held in Puerto Rico; in 1971-1972, AOTA received funding to provide research training to practicing clinicians, resulting in 19 published research studies related to sensory integration; in 1976 the American Occupational Therapy Foundation sponsored a research seminar in St. Louis with a subsequent report on the state of research, research needs, and recommendations for strategies. In addition, the Foundation has provided financial support to more than 20 practicing clinicians to assist them with their individual studies; a research advisory council has been activated, and a person has been hired to spearhead plans for research-related activities. At this conference we are hosting a Research Forum with more than 200 persons attending.

In 1964, The American Journal of Occupational Therapy might have had one research-related article in any given issue; in 1980, more than 90 percent of the published articles report research findings. Currently, plans are underway to develop a research quarterly for occupational therapy. During the past decade, research funding and promotion within the Association have been the topic of more than 30 resolutions proposed. These resolutions have fostered open communication and debate among the members. Our schools are graduating more master's degree therapists, and two doctorate programs have begun.

These activities of our Association indicate that as a profession we have assumed a research attitude. We accept as a truth the necessity to "be concerned not only with facts but also with broad concepts which need constant examination and investigation." (3, p 20) A science of occupational therapy is evolving.

Although the Association has made notable strides since 1964, occupational therapy has not attained the scientific status that elicits guaranteed funding for research, numerous graduate students and doctoral programs, and considerable data to substantiate our practice. In 1980, occupational therapy is not considered a model of science nor is such a model promoted by the majority of our educational processes.

As members of the AOTA, each of us must continue to recognize research as part of our performance as therapists. We cannot passively accept research, but most become actively involved with the promotion of our model of science. The development of a research attitude is the beginning but it is not enough. The decades ahead must result in an increase in research activity or our profession will not continue to grow.

According to Jantzen, the keynote speaker at the 1964 conference, in research, there are four choices for the occupational therapist—director of research, translator of research, collaborator in research, and consumer of research. As active research participants within a service profession, the majority of us will, and should, accept the role of consumer of research. As consumers, our functions will have the greatest single impact upon the growth of the philosophy-methodology of the science of occupational therapy. The simple economic law of supply and demand will have an effect upon our scientific growth and development. When practitioners adopt a research attitude and assume the role of consumers of research, the demand for facts will increase and hence the supply will expand. As consumers, our demands will be heard and those who choose roles of director, collaborator, or translator of research will have an opportunity to provide research activity.

Association activities such as research conferences and workshops may stimulate the development of a profession's research attitude, but the organization cannot be expected to define the scientific model of its profession. Development of the model of science is dependent upon the research activities of the members of the profession. Each practitioner must become an active research participant and accept a research role whether it be as director, collaborator, translator, or consumer.

According to West, "The practice of occupational therapy is the greatest single force in determining our credibility." (5, p 11) Occupational therapy practice is the visible expression of our theories, principles, and concepts. Research activity provides the necessary evaluation of and justification for that practice.
In turn, research data can be used to distinguish our profession and its services from that of others. Through research a model of science shall emerge and our unique services will be justified (5).

Caring—The Art of Therapy
The science of therapy provides the means to and justifications for our therapeutic theories and methods. However, science is not the essence of practice. The essence lies in the art of therapy, or the application of our scientific principles of purposeful activity and human relationships. Through the science and art of therapy our profession provides a unique service, out of which a person can gain a new level of healthfulness.

Occupational therapy principles center around the use of purposeful activity to maximize the performance achieved by each client (6). Activity is not provided to a client nor practiced upon a client. Occupational therapy does not provide care-to nor does it take-care-of a person—rather, our concept of care is something engaged in with a person, a mutual cooperation. Occupational therapy health care is an active relationship geared to “helping another grow and actualize himself.” (7, p 1) Therefore, the concept of caring as an occupational therapy philosophy can be defined as a process of relationships that involves growth and development. To care for a person is to help the other grow, develop, and adapt (7). Caring is a process to help another gain self-actualization, achieve a state of independence, and “move toward healthfulness.” (8)

Clarification of the concept of caring reveals our potential within the health care arena. By specifying the components of caring, therapists acquire the knowledge that enables them to make logical choices regarding services with clients. Caring is not a skill that stands apart from those skills needed in the sciences, but rather, caring integrates the philosophies-methodologies of the science of therapy into a more humanistic focus (9).

According to Helen Hopkins, the early pioneers in our profession believed that health can be influenced by the use of muscles and mind together in games, exercises, and handicraft, as well as in work (10). The emphasis on health through activity has continued to be the dominant theme of occupational therapy. However, through the profession’s developmental course, the theme has been emended to emphasize health through purposeful activity. Hall states that purposeful activity is meaningful and meaningful making is central to human development (9). “Human life cannot be meaningful if it is not at the same time purposeful and directed to goals.” (9, p 85) He proposed that it is the purposefulness of behavior and activity that gives a human life order; activity without purpose would be a series of episodes that are not integrated into a meaningful pattern. Therefore, one of the basic tasks in promoting human growth is to identify one’s “central purpose” and find ways of fostering the ability to successfully explore and interact with the environment (9). Fostering Man’s abilities requires a caring process.

The occupational therapy concept of health through purposeful activity has evolved into the development of a humanistic profession, one whose body of knowledge lies in human behavior and activity, as well as in the effect of pathology upon behavior and the effect of activity upon pathology (6). Although occupational therapy has its foundation within the medical model, the correction or relief of pathology is not the focus of our services. The “caring and curing” orientation of occupational therapy has a different emphasis than the “caring and curing” orientation of the classical medical model. The “caring” is not the taking-care-of the person, but helping the person learn to take care of himself/herself. Caring involves an internal receiving by the client, not an external giving by the therapist. It is through the internal receiving that activity becomes purposeful.

The “curing” of problems is not just to restore to a state of normalcy or eliminate pathology, but to enhance people’s abilities to adapt to their state of health and function within the environment. Curing involves helping people find meaning as they develop abilities that allow them to “feel at home in the world.” Our focus and commitment to “caring and curing” as a process to facilitate health through purposeful activity distinguishes our services.

In his book, On Caring, Mayeroff proposes that the concept of caring is best developed by disclosing its relationship to other significant concepts such as trust, humility, hope, and courage (7). In our development of caring as a health care process, Mayeroff’s proposals can be applied. When his concepts are adopted, three major components
of health caring can be identified: knowledge in caring, skill in caring, and attitudes in caring.

**Knowledge in Caring**

Knowledge is an aspect of caring that appears to apply more directly to the philosophy-methodology of the science of therapy; however, to “know in caring” is an art and requires the integration of affective and cognitive domains. Knowing is general and specific, direct and indirect, and explicit and implicit.

Mayeroff proposes that to care for someone we must know many things. Caring involves knowing who the person is; what his or her abilities, limitations, and needs are; and what is conducive for his or her growth and development. In addition, knowing must include the ability to respond to another person’s needs, and recognition of your own abilities and limitations (7).

A therapist knows not only about generalities of the profession but also about specifics—techniques, individuals, methods, behaviors, pathology, and activities. Therapists use general knowledge about occupational therapy principles and concepts to provide health care for a particular person. By caring for that person, they learn more about occupational therapy in general (7).

With the caring process, to know something directly is to experience it as existing in its own right. The caring therapist directly knows a client as a unique individual, as someone in his or her own right, not as an average, a generality, or a number on the Gaussian curve. When we experience direct knowing, we know an individual as a unique being, not as a stereotype.

Indirect knowledge refers to having information about something without experiencing it in its own right. For example, indirect knowledge provides information about expected characteristics of a person whose scores may fall two standard deviations below the mean. Or if you were to learn that Johnny had autistic-like tendencies, you would have some indirect knowledge about Johnny. Indirect knowing is an important part of knowledge in caring, but to truly care for someone we must experience direct knowledge (7).

With caring, we know some things explicitly and some implicitly. Explicit knowledge can be put into words, while implicit knowledge cannot be articulated. In a caring relationship we frequently know more about a person’s behavior than we can put into words. Implicit knowledge is the art of “being with the person”; it is something you feel.

Ironically, implicit knowing, so vital to our therapeutic relationships, may directly influence our profession’s degree of acceptance. Too frequently, knowledge is restricted to what can be verbalized, to the “pure scientific model.” Restricting knowledge to what can be put into words is like restricting the meaning of communication to only the spoken word (7).

Knowing in caring, then, includes general and specific, direct and indirect, and explicit and implicit knowledge. Knowing in caring includes affective and cognitive learning and requires an interweaving of the philosophies-methodologies of both the science and art of therapy. To know in caring is truly an art and basic to the essence of our practice.

**Skill in Caring**

The second component, “skill in caring,” is similar to an aspect Mayeroff calls “alternating rhythms.” (7, p 15) Skills promote movement and flexibility within our therapeutic relationships. Caring skill is dependent upon a three-fold process of continually assessing our actions, learning from our past actions, and adapting our present movements. The outcome of the process results in the “alternating rhythms” of being able to maintain or modify our own behaviors and actions so that we can better help another. Skill also includes abilities to alter our actions back and forth between a “narrower and wider framework.” (7, p 15) For example, a certain behavior of a client may be assessed as an isolated episode, having no relationship to what went on in the past nor what will follow. We then adapt within a narrow framework. In another situation, a behavior may need to be examined within a larger framework, one suggestive of trends, tendencies, and/or long-term effects. Our skills in caring promote our flexibility within a relationship. Skills provide us with the abilities to adapt our behaviors according to the demands of the environment at any specific time and at any specific place. Our scientific philosophies-methodologies may provide us with knowledge about a specific technique; however, skills in caring provide us with the ability to modify the technique according to another person’s needs.

Skill in caring facilitates the internal receiving of the client and provides meaning in the activity process.

**Attitudes in Caring**

Caring attitudes include ingredients of patience, honesty, trust, humility, hope, and courage. Patience is the process of enabling the “other to grow in its own time and in its own way.” (7, p 17) As Mayeroff notes, “A (therapist) who cares is patient because he (or she) believes...
in the growth of the other...” (7, p 18)

Honesty is a positive attitude of seeing others as they are and not as one would like them to be or feel they must be. To help clients grow and realize themselves, a therapist must be honest and go to the other person as a unique individual (7).

“Trust in caring is the process of "letting go," of aiding a client’s independence and sense of responsibility for self. Therapeutic relationships must foster a dependency upon the therapist, but a trust in the client to grow and be independent.

A humble attitude allows therapists to continually learn about the other and about themselves. Therapists who “know” their clients completely and feel they have nothing more to learn, do not care.

We therapists hope our clients will grow through our caring. Hope is an attitude of realizing the present with its possibilities and energies for growth and modifications. Hope in caring provides us with the art of setting expectations for the growth of clients. An important aspect of hope is courage (7). Courage in caring is the reaching out for and attempting new frontiers. Ayres once said, “A therapist can venture into territories where a scientist dare not proceed.” The courage to venture into unknown expectations is vital to caring.

Through caring, our therapeutic relationships facilitate growth of another. The art of therapy is in caring for each human as a unique and highly flexible creation who is trying to adapt to life by progressing and, at times, retrogressing along certain pathways (11). Caring is the basic ingredient in purposefulness, as caring provides meaning for human life to grow and develop.

Summary
In this presentation I have cited a few examples of the development of our profession’s research attitude and then made an appeal for increased research participation for our members in order to justify our unique services. The concept of caring was introduced as an inherent ingredient within our philosophies of practice. Caring was discussed as a process to “help the client help himself,” which gives meaning to another’s life. This concept of caring is the essence of our practice. Therefore, our research activity should be directed toward exploring and justifying the caring process as a vital health care service.

Yerxa stated in 1978, “As occupational therapists, we are at home with the mundane stuff of everyday living, but society does not yet value the commonplace, everyday activities of play, leisure and self maintenance.” (8, p 29) She went on to say that “society does need us but it has not yet found that out.” (8, p 29) Yerxa appealed to each of us to “reaffirm to ourselves and society the significance of the mundane stuff of daily living. If we can hold on, articulate and perpetuate the valuing of everyday activity, we can give society the opportunity to catch up with us. For what we value is what existence is about, finding meaning in all that we do.” (8, p 30)

In this message, I perceive the need for our profession to come to grips with what it is we value—to acknowledge our professional-client health care interaction as one of “mutual cooperation.” Our profession values caring as a process to help another grow and develop. We value active participation with “the everyday stuff of daily living” as a purposeful means to provide meaning to human life. The interweaving of our philosophies-methodologies of science and art distinguishes our services.

During the past decade the science of therapy has begun to grow. During the decades ahead, we must profess our values and stimulate growth of the philosophies-methodologies of the art of therapy. Each of us must become an active research participant and promote our concepts of health care as a process that adds meaning to activity, thus moving the person to a new state of healthfulness (8).

REFERENCES