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Expanding client-centred thinking to include social determinants: a practical scenario based on the occupation of breastfeeding.

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Abstract

Background: Client-centred thinking in occupational therapy underemphasizes the influence of social determinants and societal-level factors on occupation across the life course. When client-centred thinking focuses solely on the local or immediate contexts of individuals, therapists may not fully recognize or understand how social determinants can create barriers to occupational participation and performance.

Aim/Objectives: We critically examine gaps in traditional thinking about client-centredness and demonstrate how the complex interplay between social determinants and societal-level factors may lead to occupational injustices.

Material and Methods: A practical example from a recent study on breastfeeding and accompanying scenario is used to examine limitations in current client-centred reasoning. The Life Course Health Development framework, a theoretical framework examining contexts of health disparities, is applied to illustrate the opportunity to expand thinking about client-centredness.

Results: The Life Course Health Development framework may be a useful addition to client-centred thinking about social determinants of occupation.

Conclusion and Significance: Expanding client-centred thinking to include awareness, understanding, and respect for social determinants of occupation may enhance therapist-client interactions and outcomes of the occupational therapy process, and address gaps in current thinking that may contribute to occupational injustices.

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Keywords

critical thinking; occupational justice; social determinants; theoretical development

Introduction

Client-centred theory in occupational therapy has traditionally focused on the client's participation in the occupational therapy process, emphasizing self-efficacy, enablement, and empowerment as guiding principles of practice (1–4). For therapists incorporating client-centred thinking into their clinical reasoning, application of these principles often occurs solely within the immediate context of the individual client, such as the hospital, clinic, or client's home. While thinking about client-centredness at this immediate and individual level is an essential component of the occupational therapy process, a societal-level perspective that fully considers the influence of social determinants on occupational participation and performance is frequently neglected. Client-centred reasoning that fails to encompass social determinants of occupation may perpetuate disparities in health and occupational injustices. Hammell (2013) proposed that occupational therapists critically reflect on the construct of client-centred practice (5); therefore, we examine how the influence of societal-level factors on occupational participation requires client-centred thinking about social determinants of occupation.

As occupational therapy expands beyond treating individual clients to include addressing needs of populations (6–8), rectifying this neglect of social determinants and societal factors by capturing the influence of institutions and systems on occupation in client-centred reasoning becomes necessary. Recent scholarship in occupational therapy has suggested the concept of social determinants of occupation and the need to incorporate a broader understanding of social contexts into client-centred thinking (5, 9–11). Specifically, Townsend and Wilcock (11) propose the “use of the language of justice to talk about determinants and forms of occupational well-being and social inclusion that take differences in people and contexts into account (p.77).” Participation in occupation can be restricted by social determinants and societal-level factors such as policy. While contemporary frameworks of the domain and process of occupational therapy (1,12,) and models for practice (13–14) acknowledge the social environment in the evaluation and intervention process, occupational therapy practice rarely moves beyond aspects of the local environment to consider injustices that emerge from systematic denial of access to occupation. Therefore, we propose that social determinants of occupation are an important context for thinking about client-centredness.

It is well established that health follows a social gradient, with higher social position associated with decreased morbidity and mortality (15–18); factors that make-up social position, such as level of education, income, and type of employment, have particularly strong influences on health over the life course as well as the individual's capacity for occupational participation. Social sciences and public health theoretical models are placing increased emphasis on associations among environmental factors, the development of health, and health equity. In particular, the life course perspective on health and social determinants

offers a potentially useful lens for considering the influence of social determinants on occupational participation and performance, and the need to expand client-centred thinking to include social determinants (19).

Life course theory arose from the epidemiologic study of health disparities and social determinants of health, and recognizes the value of health equity (19). Life course epidemiology is based on the premise that complex biological and social factors impact health development over the lifespan. Life course perspectives are particularly interested in the long-term effects of risk factors, especially the relationship between early life exposures and adult chronic disease (19–21). One such perspective is Halfon and Hochstein's Life Course Health Development (LCHD) framework (20). The LCHD framework identifies relationships among risk factors, protective factors, early-life experiences, and individual long-term health outcomes, including chronic disease. It depicts health as a consequence of multiple determinants expressed through diverse contexts: genetic, physical, social, family, psychological, health care systems, and culture/policy (20–21). It is unusual that a single factor alone has a substantial impact on health outcomes; more commonly, multiple factors interact to create what Halfon and Hochstein describe as *multiple nested environments*. Different health trajectories emerge in response to these nested environments. Trajectories are built over the life course and patterns can be hypothesized for individuals and communities based on social determinants of health.

The aim of this paper is to critically examine gaps in thinking about client-centredness that fail to identify and reflect on social determinants of occupation. We use an example from a recent study of breastfeeding behavior to illustrate how the application of the Life Course Health Development (LCHD) framework, a theoretical framework examining contexts of health disparities, may extend current client-centred theory in occupational therapy.

Client-centred thinking encompassing social determinants: use of the LCHD framework

Breastfeeding is an innate human behavior that has consequences for health development (22–24). It can be classified as an occupation of feeding and eating, and as an occupation of child rearing and health management and maintenance (25). A recent study considered how factors potentially associated with continued exclusive breastfeeding fit within the contexts of the LCHD framework (under review). Factors from the Infant Feeding and Practices Study II (IFPS II), a study described elsewhere (26), were mapped to the most appropriate LCHD context (20). Table 1 shows how the factors aligned with LCHD contexts and the proportion of factors in each context that were statistically significant in bivariate analysis with the outcome of exclusive breastfeeding for at least four months. The LCHD framework assists in client-centred reasoning about the influence of diverse contexts on breastfeeding by acknowledging barriers to participation that are beyond the individual client's control and embedded in social determinants of health and occupation. The interaction of multiple contexts to create a nested environment for occupation is illustrated in the following scenario where we question client-centred thinking and what constitutes it by

identifying gaps in thinking about social determinants of occupation. Factors identified as significantly associated with continued exclusive breastfeeding are italicized.

Scenario: Client-centred thinking about social determinants of breastfeeding

An occupational therapist working in a hospital setting in the *southern United States* evaluated a 3 week old infant with a history of *late prenatal care*, preterm birth at 32 weeks gestation, mild respiratory distress, and nasal-gastric tube feedings for readiness for oral feeding by breast and bottle. Intending to use a client-centred approach, the therapist interviewed the infant's mother, Lucy (a pseudonym), to determine goals most important to the family. Lucy shared her desire to breastfeed and described this feeding method as an important aspect of her identity as a mother. As part of the comprehensive occupational therapy evaluation, the therapist assessed the infant's body structures and functions for oral feeding and observed a coordinated suck-swallow-breathe pattern during non-nutritive sucking. The therapist developed and implemented an intervention plan that included preparatory activities to develop coordinated oral motor skills for breastfeeding, adaptations for positioning to enhance postural control, and modifications to the physical environment to decrease distractions during breastfeeding. As part of her client-centred approach, the therapist actively engaged Lucy with her infant throughout the occupational therapy process. By the time Lucy's infant was discharged from the hospital at 5 weeks old, a successful breastfeeding relationship had been established. The occupational therapist felt satisfied that she had practiced in a client-centred manner by enabling Lucy and her infant to meet their identified goal of breastfeeding.

The infant was re-evaluated by the occupational therapist 2 months later, as part of a developmental follow-up clinic at the hospital. Lucy disappointedly shared that she had stopped breastfeeding 4 weeks after her infant was discharged from the hospital due to multiple barriers to participation in this particular occupation. The occupational therapist had not previously considered these factors, all of which were social determinants, as part of her client-centred reasoning about occupational participation for Lucy and her infant. Specifically, Lucy was a *23 year old, unmarried woman*, with *high school education* who worked an *hourly-wage job* as a *retail clerk*. While her employer was sympathetic over the premature birth of Lucy's infant, the job did not offer any *paid time off* and Lucy's supervisor stated she could only hold Lucy's position for 8 weeks. Although Lucy had expressed breast milk in the hospital prior to her infant's ability to feed orally, when she asked her supervisor whether she could *take breaks* in one of the retail store dressing rooms to express breast milk, she was told that would not be possible. Lucy attempted over her lunch break to use a breast pump in the restroom of the mall where the retail store was located; however, there was no electrical outlet to plug in her pump and she was not able to afford a more expensive battery-powered pump. She pumped before and after work and two times over night after her infant woke to breastfeed, but after several weeks she was too exhausted to keep up this routine.

Lucy also shared with the occupational therapist that during her last postpartum visit, the nurse expressed concern that Lucy may be exhibiting possible signs of *postpartum depression*. Her infant's premature birth, the anticipation of her *planned return to work*, and her *limited financial resources* were all a source of increasing stress. Lucy's parents provided her with occasional assistance with child care, but due to their own need to work, they were unable to provide full-time child care. Lucy qualified for a subsidized daycare program, but in order to maintain the subsidy she was required to *work at least 40 hours per week*. Although Lucy requested that the daycare provider hold off on bottle feeding her infant if it was close to the time Lucy arrived to pick her up so that Lucy could breastfeed, the daycare often ignored this request and Lucy's infant was satiated when Lucy arrived to breastfeed. Further, the daycare provider expressed discomfort over handling expressed breast milk and the *daycare environment* did not have a quiet area where Lucy could breastfeed her infant. When Lucy expressed her dismay over the cost of artificial formula, the daycare provider reminded her that she qualified for subsidized artificial formula through the *Women Infants and Children (WIC) program*. The occupational therapist's client-centred thinking failed to consider how societal and institutional norms and policy may influence and determine occupational participation.

At the end of the follow-up visit with the occupational therapist, Lucy repeated her disappointment over her inability to continue breastfeeding her infant. She was aware of the many developmental and health benefits of breastfeeding and was pleased when she and her infant were able to establish breastfeeding despite her infant's premature birth. She wondered whether she would have had access to different resources or support for breastfeeding if she lived in another community—or if she had the type of job that offered paid family leave. The occupational therapist regretted that her client-centred reasoning had not considered how these social determinants may create barriers to continued occupational participation for Lucy.

Discussion

In this scenario, the occupational therapist intended to use a client-centred approach by actively engaging the family in establishing goals and encouraging Lucy's active participation in the occupational therapy process with her infant; however, this use of traditional theory and models guiding critical thinking about client-centredness and occupational participation failed to address social determinants of occupation. The therapist recognized the importance of enabling participation in breastfeeding and the importance of empowering Lucy in her role as a mother; however, her client-centred reasoning did not consider how social determinants influence occupation. Intervention activities developed the skills and abilities of the client, adapted the activity of breastfeeding through positioning, and modified the physical environment to support occupational participation. This approach was successful within the social environment of the hospital; however, the therapist did not recognize the societal factors that were potential barriers to Lucy's occupational participation, such as workplace environment and policies. The LCHD framework is a helpful lens for identifying social determinants of occupation and addressing gaps in critical thinking about client-centredness.

Currently, models guiding occupational therapy practice do not fully elicit therapists' client-centred thinking about social determinants of occupation and societal factors that disrupt occupational participation. The LCHD contexts include factors that require broader critical thinking about social influences on occupation compared with frameworks of the domain of occupational therapy (1, 12) and models describing person-environment-occupation transactions (13–14). In occupational therapy research and practice, emphasis has been placed on recognizing and understanding the complex interplay of factors within the environment that influence occupation (13, 27). The Person-Environment-Occupation (PEO) model provides a lens for examining occupational performance within complex, dynamic environments, and can inform client-centred thinking (13). This theoretical perspective helps examine transactions between personal and social aspects of the environment; however, the influence of socio-demographic characteristics and social policy on occupational participation or the capacity to develop occupational potential (28–29) is often underemphasized. For example, PEO (13) describes relationships with political, legal, economic, and institutional systems as an aspect of the social environment, yet the occupational therapy process tends to view the client within their local environment, such as the clinic or the client's home, as the unit of analysis instead of incorporating these broader social contexts. Further, the *Occupational Therapy Framework: Domain and Process, 3rd Edition* (9) defines the personal context as characteristics of the person that are not a part of the health condition, whereas LCHD acknowledges that socio-demographics contribute to health (12, 20).

In a recent series of articles, Hammell (5, 30–31) called for occupational therapy to critically reflect on the philosophical underpinnings of our profession, including client-centred practice. Dominant theories of occupation and occupation-based practice are grounded in predominantly Western, white, middle-class values and are not easily transferrable to client-centred practice with a diversity of people (5, 32). Barriers to client-centred practice are often identified as within the client and there has been little examination of barriers that emerge from therapist attitudes and/or beliefs or broader social and political contexts (33). A recent study of therapist and client participation in the therapy process described three types of barriers to client participation in the therapy process: the client's lack of knowledge about the problem, workplace organizational and financial problems, and the client's lack of ability to participate and expressed concern that the therapist and his/her abilities or attitudes are not acknowledged as barriers (2). Therapists' failure to acknowledge social determinants of occupation and the influence of broader societal policies and practices on client occupational participation is a barrier to client-centred practice that requires further study.

The patient-centred movement in health care has acknowledged the need for practitioners to understand how multiple contexts impact health and care delivery and may offer insights for further development of client-centred reasoning in occupational therapy. Social contexts are addressed through several domains of patient-centred care, including respect, "whole person" orientation, and access to care, which require practitioners to be aware of social and economic factors that may drive patient preferences and influence care (34–37). Furthermore, the domains of empowerment and engagement recognize the role of the patient and family as partners who actively participate in maintaining health and making decisions about their health care at the level they choose (34–37). Translation from patient-centred

theory to practice is ongoing and barriers to implementation exist. Yet client-centredness in occupational therapy may benefit from more explicit inclusion of these domains to help foster therapists' awareness of the influence of social contexts on occupation and health care more generally.

Medicine and medical anthropology also reflect on the practitioner-patient encounter and how the practice of questioning the patient about his/her illness experience has become deemphasized with changes in health care delivery. *Clinical gaze* describes the physician's process of observing the patient and thinking critically about the manifestation of disease, physical as well as social aspects (38–39). However, Foucault (38) discussed the shift in 19th century medicine to focus the gaze on diseased organs rather than the broader social illness experience. Contemporary medical anthropologists argue that ethnocentric assumptions of practitioners and structural barriers, such as rushed schedules and power differentials, and even cultural competency education contribute to *decontextualized difference* (39–40), which for client-centred reasoning in occupational therapy presents barriers to critical thinking about social determinants. Jenks (40) defined decontextualized difference as the tendency for practitioners to accept individual differences without critical reflection on the social and historical conditions that create disparities. Similar to the need to broaden clinical gaze, current thinking about client-centredness in occupational therapy may benefit from deeper acknowledgement of how social and political contexts create occupational injustices and may help avoid the situation of decontextualized difference.

Our practical example and application of the LCHD framework illustrate the complex interplay of factors across multiple contexts that create the potential for occupational injustices and need to be incorporated into client-centred thinking. Occupational therapy theory and models explaining the transactions of person-environment-occupation factors acknowledge the influence of social context on occupational participation; however, therapists may not recognize these barriers or may perceive barriers that emerge from social determinants of occupation as unchangeable. Discourse and study of client-centred practice traditionally examine person-focused interactions and intervention, rather than the group or population-level where the need for intervention addressing contextual barriers is more apparent. Further reflection and examination of the concept of client-centred practice at the societal-level may help deepen client-centred reasoning in general. Expanding thinking about client-centredness to include awareness, understanding, and respect for social determinants may enhance therapist-client interactions and outcomes of the occupational therapy process for individuals, as well as inform practice at a societal-level.

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Table 1.

Social determinants of health and occupation fit to LCHD contexts

Life Course Health Development (LCHD) context	Infant Feeding Practices Study II (IFPS II) factors *	significant factors/context total factors (%)
Physical	<i>Geographic region</i> Mother's work setting <i>Child care setting (daycare)</i>	2/3 (66.7)
Social/policy/cultural	<i>Race/ethnicity</i> <i>Mother's age</i> <i>Level of education</i> <i>Paid maternity leave</i> Planned timing of return to work <i>Baby care during work (mother keeps baby with her)</i>	5/6 (83.3)
Family	<i>Marital status</i> <i>Parity</i> <i>Breastfed other babies</i> Percent of family income to poverty level <i>Worked for pay prenatally</i> <i>Plan to work for pay postnatal</i> <i>Worked for pay in last 4 weeks at month 3 after birth</i> <i>Contribution of mother's pay to family income</i> <i>Hours worked by mother at month 3</i> Days of childcare per week Hours of childcare per day <i>Type of childcare provider (other family member)</i>	9/12 (75.0)
Health	<i>First prenatal care</i> Health insurance <i>WIC participation</i>	2/3 (66.7)
Psychological	<i>Risk of postpartum depression</i> <i>Childcare provider support of breastfeeding</i>	2/2 (100)

* factors in bolded italicizes were significantly associated with the exclusive breastfeeding outcome in bivariate analysis