

Toward a Caring Curriculum: Can Occupational Therapy Be Taught in a Caring Context?

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Caring is often cited as the central component of many health care professions. It is also identified as an equally important factor in patient physical and emotional recovery. In examining health care education, however, curriculum is becoming increasingly focused on the development of technical competence and skill with little focus on the affective aspects of providing care in a caring context. In the field of occupational therapy, little is written regarding facilitation of caring behaviors in occupational therapy students. Through examination of the educational philosophies of Paulo Freire and Nel Noddings, a framework for a caring curriculum can be developed. Through use of signature pedagogies in occupational therapy, the author utilizes fundamental aspects of a caring curriculum put forth by Freire and Noddings to develop a curriculum that not only develops the individual's technical skill, but makes them emotionally competent as well. Though the work of Freire and Noddings was not explicitly intended for higher learning or health care professional education, the principles put forth are not only relevant but provide a viable framework for the development of caring professionals. The benefit of this proposal will ultimately be to patients whom these emotionally competent occupational therapists serve.

Ask any health care professional about the most important aspect of his or her professional practice, and you are likely to hear, "I really care about my patients." Most health professions are founded on the ideal of caring for others. When examining the curriculum of health professional programs (particularly occupational therapy), however, little is provided in terms of methods to facilitate caring behaviors. Though most therapists espouse the notion of being caring professionals, educational programs have become increasingly focused on developing technical competence. The question, therefore, remains, "How do we teach caring?" and, "Can we create caring professionals who are both technically and emotionally competent?" One might suggest that caring is an intrinsic personality trait that one either possesses or doesn't possess. Educational theorists, such as Paulo Freire (2005) and Nel Noddings (2007), however, suggest otherwise. It is the intent of this paper to explore the idea of teaching or facilitating caring behaviors through a caring curriculum in occupational therapy professional education.

Caring can be defined in many ways and in many contexts. In some contexts, caring is defined merely as the practice of looking after those unable to care for themselves (Caring, 2014). In the context of providing care, however, caring takes on a much grander meaning. Caring implies displaying kindness and concern for others, having thought or regard, and showing compassion (Dictionary.com, 2014; Oxford dictionary, 2014). Caring also incorporates the concepts of ethics, social justice, and social competence and involves receptivity, an ability or willingness to receive new ideas or opinions; engrossment, obtaining all of the attention or interest of another; and reciprocity, engaging in an exchange with others toward mutual benefit (Larin, Benson, Wessel, Martin, & Ploeg, 2014).

The importance of caring in the health professions cannot be understated. When patients are asked about the qualities of their therapists that facilitated recovery, they frequently state that their therapists were not only technically competent but demonstrated caring behaviors (Battaglia, Mirabile, Shenker-Goldmacher, & Poole, 2001). Patients often cited affective qualities of their therapists that facilitated an environment that allowed for both physical and emotional healing. Good technical skill, though important, was not sufficient unless these skills were provided in a warm, supportive manner (Battaglia et al., 2001).

Murphy, Jones, Edwards, James, and Mayer (2009) explored the perception of caring behaviors of first-year and third-year nursing students. As these students moved through their educational programs into clinical practice, their perception of caring behaviors as part of nursing practice actually decreased. Though caring is a core nursing value, the educational process appears to have a negative effect on caring behaviors. It is possible that students start educational programs with strong beliefs regarding the role of caring in practice and often find that political and economic factors driving practice decrease their ability to engage in expressive care. Further, as practice becomes more technical, education focuses more on developing instrumental and physical competence while neglecting social and emotional experiences (Murphy et al., 2009).

Beagan (2003) investigated how exposing third year medical students to a course in social and cultural issues affected awareness of how social and cultural diversity influences their practice, the lives of their patients, and the patient-physician interaction. To the researcher's dismay, a majority of the medical students interviewed believed gender, race, sexual orientation, culture, and class made little or no difference in how they practiced. Students were found to be unaware of

issues related to socioeconomic diversity and were ignorant of racism, sexism, homophobia (even among fellow students), and relations of dominance and subordination. They further had little ability to relate to their own socioeconomic and cultural advantages (Beagan, 2003).

Historical Trends and Current Challenges in Occupational Therapy Pedagogy

Current challenges facing occupational therapy education are enumerated in the American Occupational Therapy Association's *Maturing of the Profession Task Group Report to Ad Hoc Committee for Future of Occupational Therapy Education* (Jensen, Peters, Pierce, Reed, & Reitz, n.d.). This report states that the culture of professional education is becoming one that places much value on technical knowledge and practical skill rather than humanistic aspects of the curriculum, leaving little room for student self-assessment or creative and narrative work. The report also identifies how historical approaches to occupational therapy education are being challenged by changes in health care delivery and increased demand, leading to a deficit in the affective and relational components of education and practice (Jensen et al., n.d.).

Shaber, Marsh and Wilcox (2012) identified three signature pedagogies employed over the history of formal occupational therapy education: (1) relational learning, (2) affective learning, and (3) active engagement ("learning-through-doing"). The first model, relational learning, is learning that occurs through human connection. This pedagogical model highlights the importance of teacher-student relationships through mentorship, apprenticeship, and modeling. The human connection made between mentor and student, and ultimately therapist and patient, is considered to be essential (Shaber et al., 2012).

The second model, affective learning, is based on transforming personal identity. Affective learning involves changes in attitudes, beliefs, and values through the teaching of transformative topics. Through shaping of character, students become part of the culture of the educational program, its customs, and ways of relating to others while exploring events that impact the lives of patients (Shaber et al. 2012).

The last model, active engagement, has been used in many forms over the history of occupational therapy education and has increasingly become the center of most professional education programs. The importance of learning-by-doing and teacher-student relationships is emphasized because the modeling and feedback provided during the application of principles shapes behaviors and develops specific skills. Occupational

therapy education relies on fieldwork experiences to help develop the skills of occupational therapy students before they enter professional practice (Shaber et al., 2012).

The practice of educating occupational therapy students, however, is undergoing great change. The profession is becoming increasingly technical, with education focusing more on developing technical skills rather than facilitating affective aspects of care. This limited focus often leads to a decrease in caring behaviors, limited socio-cultural awareness, and limited development of emotional-social intelligence (Beagan, 2003; Larin et al., 2014; Murphy et al., 2009). The implementation of increased class sizes and geographic separation of teachers and students has also limited the human connection, further impacting the moral and ethical foundations of professional education (Jensen et al., n.d.).

Pedagogical Theories of Freire and Noddings: Models of Caring

Paulo Freire

Though the work of Freire and Noddings was not explicitly developed for higher or professional education, the theories, concepts, and beliefs espoused in their writings can provide a framework for the development of a caring curriculum. Freire's "Pedagogy of the Oppressed" established the need for use of a humanizing pedagogy (Freire, 2005). Freire's concept of humanism is centered on the capacity of humans to shape their experiences and achieve self-actualization in their development of full humanity (Salazar, 2013). Humanization is the process of becoming social, thinking, communicative, transformative individuals who participate in the world around them. Individuals must become conscious of their presence in the world and how that affects interactions with others (Freire, 2005).

In relation to pedagogy, Freire's ideology requires educators to have a clear ethical and political commitment to change in relation to oppressive societal conditions. Students must be engaged with the world in order to facilitate social change (Freire, 2005). Though no specific teaching methods are explicitly expressed, Freire encourages teachers to listen to their students and build on their life experiences in order to engage in contextualized, dynamic, and personalized education that facilitates social change and humanization of the learner (Salazar, 2013). This pedagogical approach involves a mutual dialogue between teacher and student that leads to greater critical consciousness of the process of identifying—and taking action against—social, political, and economic contradictions and realities, and it improves the individual's ability to

perceive social, political, and economic contradictions and take such action (Freire, 2005; Salazar, 2013).

Through analysis of literature, Salazar (2013) identified five key tenets of a humanizing pedagogy. The first is the importance of the full development of the person. This requires reciprocal opportunities for teachers and students to share their lives, a demonstration of compassion for lived experiences, and the situating of learning in social issues relevant to the experiences of marginalized communities. Education in the context of a humanizing pedagogy must include the psychological and emotional dimensions of human experience. This requires the education process to facilitate respect, trust, reciprocity, active listening, mentoring, compassion, and interest in the student's well-being (Bartolome, 1994; Cammarota & Romero, 2006; Gay, 2010; as referenced in Salazar, 2013).

Freire also challenged the "banking" model of education, in which students are merely banks where information is deposited and stored. Banking requires little student input or reciprocity and promotes passivity, acceptance, and submissiveness. This leaves education highly scripted and skill-focused, limiting the student's process of learning (Salazar, 2013). The product of banking education is a student who is unable to act as an agent of change (Freire, 2005). Freire (2005) contends that in order to eliminate this "banking model" of education, education between teacher and student must become a two way dialogue in which the teacher no longer is a teacher of students but also receives knowledge as information gets passed between the two. The teacher and student become jointly responsible for teaching and learning as this open dialogue and critical evaluation of what is being presented leads to greater understanding (Freire, 2005).

Freire (2005) also identified the need for student-teacher interactions to lead to critical consciousness regarding the student's own contribution (and contribution of society) to their perception of social injustice. Teachers become agents of change in this regard through the use of respect, mutual trust, verbal teachings, and being exemplary role models. A problem-posing dialogue develops in pursuit of humanization for all individuals and is grounded in one's lived experiences to foster action and change. This cultivates a connection with global issues, critical thinking, and a connection between life experiences and society (Salazar, 2013).

The next tenet was identified as praxis, or the reflection and action taken upon the world in order to create change (Freire, 2005). Praxis results in power being shared between teacher and student which, in turn, transforms power and privilege toward decreasing social injustice and increasing freedom. Praxis relies on educators engaging students in critical reflection, posing challenges to inequitable systems, and

challenging students to critically engage in the world in order to create change (Salazar, 2013).

The final concept is the educator's responsibility for promoting humanism through his/her pedagogical principles and practices. The most relevant for this discussion is the educator's ability to build trusting and caring relationships with students. Educators must listen to students' interests, needs, and concerns; know students on a personal level and attempt to understand their life experiences; model kindness, patience, and respect; tend to students' emotional, social, and academic needs; create a support network for students; allow for risk taking and active involvement; and facilitate student's connection with their communities (Salazar, 2013).

DasGupta and colleagues (2006) related Freire's principles to medical education and identified fundamental values of medical professionals, including principles of patient welfare, autonomy, and social justice. Students are asked to think critically about subject matter, doctrines, processes of learning, and society. A more humanistic education (rather than the "banking model") incorporates aspects of problem-posing and co-intentionality in order for students to have some autonomy, incorporate their own past experiences, and reinforce practical application of what is taught in the classroom. Teachers must engage students in a dialogue in which students can engage in reflective thought (DasGupta, et al., 2006).

In the greater social context, educators challenge students to think critically, view students as complicated and substantial human beings, and challenge knowledge of the world. Therefore, clinicians not only will be trained clinically and technically, but also will uphold high moral and ethical standards. These behaviors are often facilitated through placing trainees in the position of their potential patients, allowing them to experience social injustice, challenge prejudices, and develop an understanding of communities they serve (DasGupta, et al., 2006).

Nel Noddings

Noddings (2007) has also written extensively on the philosophical basis for a caring curriculum. According to Noddings (2007), caring can be distributed throughout any curriculum design by organizing the curriculum around themes of care (i.e., caring for one's self, others, the natural world) that are then emphasized throughout educational planning. Educational achievement is not only reflected in academic achievement, but through a fundamental change in the way students see themselves and the world around them. Caring themes connect students to greater questions about the meaning of life, the students' role in society, and their connection to others (Noddings, 2007).

At institutional levels, schools must be organized to provide continuity and support while building an atmosphere of care and trust. Teachers integrate caring behaviors into student interactions, including allowing students to be expressive, developing an open dialogue with the students, and showing regard for the students' educational and personal growth (Noddings, 2007). For a caring curriculum to be successful, it requires enthusiastic support from the entire team of instructors who participate and find value in a caring curriculum (Noddings, 2007).

Like Freire's, the dialectical aspects of a caring curriculum outlined by Noddings (2007), require teachers and students to share beliefs and experiences that shape behaviors. Caring requires having needs heard and having those needs treated with respect. The teacher is therefore tasked with the challenge of providing compassionate, consistent guidance. By teachers becoming models of care, students are not only personal recipients of this caring behavior, but become a reflection of these caring actions. It is the teachers' duty to develop students with a capacity to care while these students are in pursuit of technical and academic competence (Noddings, 2007).

Caring must also direct policy. Larger class size, a more technically centered curriculum, and distance and hybrid learning formats are increasingly being implemented in higher education, often limiting teacher-student interactions. Noddings (2007) contends that policies reflecting a caring curriculum should encourage smaller schools or cohorts, with greater teacher-student interaction in order for students to develop the affective skills that are too frequently lost when education becomes impersonal. Furthermore, Noddings (2007) identifies the need for teacher continuity throughout the educational experience. It can be stated that continuity is equally important for a professional education cohort as these continued relationships help foster caring behaviors (Noddings, 2007).

Developing a Caring Occupational Therapy Curriculum

When using the concepts of Freire and Noddings as the structural framework for a caring curriculum in occupational therapy, there are some fundamental criteria that must be met. The first criterion is overwhelming support of a caring curriculum by the entire faculty or department. Without a concerted effort by all involved in this teaching endeavor, the establishment of the ideals presented by this caring curriculum will be limited. Furthermore, policies must support and provide the infrastructure for this type of program. This would require Occupational Therapy programs to follow an on-campus cohort student model.

Coursework would be presented by a core team of full time faculty that would provide instruction over multiple courses throughout the educational process. Each student would be assigned a clinical mentor from the start of the program and would have contact with that mentor into their first year of employment. This would establish a relationship of trust and open dialogue with a mentor that has a personal investment in the student's development into a caring professional.

In terms of a pedagogical model of caring, caring themes would be present in all courses. These themes would include—but not be limited to—medical ethics, social justice, social and cultural awareness, humanitarianism, the social and psychological impact of illness, challenges of community integration, and the development of a holistic view of patients as human beings rather than defining them by their illness or disability. Aspects of the three signature pedagogies in occupational therapy—relational learning, affective learning, and active engagement—will also be represented and utilized in this model (Shaber et al., 2012).

Utilizing aspects of relational learning, mentorship, and modeling will play a major role in developing caring behaviors in students. Mentees will have the ability to discuss experiences, fears, and personal limitations related to their own human experiences. Mentors will ultimately have to create an open dialogue with their mentees in order to create a relationship of mutuality and trust. This is reflective of Freire's humanizing pedagogy as it reflects a curriculum that is inclusive of respect, trust, reciprocity, active listening, mentoring, compassion, high expectations, and interest in the student's overall well-being (Bartolome, 1994; Cammarota & Romero, 2006; Gay, 2010; as referenced in Salazar, 2013). Through modeling of empathic and caring behaviors, professional interactions with patients and other professionals, and exemplification of the behaviors and beliefs that occupational therapy is founded upon, students grow into technically and emotionally proficient therapists (Shaber et al., 2012).

Aspects of affective learning would be represented through use of service learning. Though often associated with active engagement models, service learning in this instance would be utilized as a transformative tool to shape attitudes, beliefs, and values (Shaber et al., 2014). Service learning would be a representation of what Freire termed "praxis." The theory of service learning, which in many ways represents the teachings of Dewey and Freire, allows for students to experience the world concretely rather than through abstract classroom assignments.

Dewey's philosophy regarding experiential learning is centered on principles of continuity and interaction. For Dewey, education is described as a process of living and experiencing. These experiences

occur on a continuum in which all experiences build from one to the next. With proper direction, student experiences lead to positive student growth and development. Further, for learning to be fully integrated and applicable, Dewey believed learning must occur through transactions between the learner and the environment. These transactions must ultimately be accompanied by reflective thinking about the experience in order to process what was observed and experienced, leading to true learning. Education should facilitate this process of continuous reconstruction of experiences (Dewey, 1929, 1938; Giles & Eyster, 1994).

Allowing students to experience the communities they will serve, to actively view and experience limitations faced by these communities, and to think reflectively of their experiences will not only encourage caring behaviors, but allow for integration of these behaviors into their daily practice (Cone & Harris, 1996). This service-learning approach further challenges the banking model of education so often discussed by Freire in that students get to experience the world, reflect, and become agents of change. Critical consciousness also develops as students reflect on and process the inequalities present in society. In this model of Occupational Therapy education, situational learning through service learning will be transformative of behaviors and beliefs, be integrated through transactions with the community, and be integrated through reflection of experiences.

To incorporate social learning into the curriculum, the first-year cohort would have to agree as a group (or smaller groups) on a service-learning project to be completed in the summer of their first year of the program. Students would prepare their project under the mentorship of the appropriate faculty member. An example of a service project could be the completion of accessibility evaluations of their own college campus and surrounding community. Students can experience life in a wheelchair while trying to access various parts of the campus or spend a week with a student with a disability to determine how accessible the campus and surrounding neighborhoods truly are. Upon completion of the project, students would compile a report to present to the University. In doing so, students essentially become agents of change. Students will also critically reflect on their experiences, discuss how these experiences altered their preconceived notions, and identify what needs to be done to correct these inconsistencies in practice.

Lastly, the occupational therapy caring curriculum would incorporate aspects of active engagement. Students would engage in therapist-patient interactions under the guidance of a clinical supervisor or mentor. Active engagement would incorporate the actual process of patient treatment and the identification of non-technical aspects of holistic treatment that students

may miss while attempting to be technically competent. This is a difficult task because the institution often has little control over the student-teacher interactions that occur during fieldwork experiences. For active engagement to be useful in developing affective qualities of students, these experiences would require supervisors in the field to be acutely aware of the goal of the curriculum and to facilitate and model caring behaviors for the fieldwork student. Active engagement would also be incorporated into the curriculum by providing students with opportunities to experience simulated clinical interactions during their academic coursework. Facilitating these experiences in the classroom would allow for student reflection as a group, the discussion and exploration of social and cultural considerations to be made, and ultimately the facilitation of caring behaviors.

In all, a caring curriculum reflective of the ideals put forth by Freire and Noddings would have to incorporate aspects of policy change, change in delivery models, a commitment of faculty, and an open and honest dialogue on the part of teacher and student. Caring behaviors are facilitated through mentorship, service to the community, and active engagement in social change. Developing clinicians who are reflective of past experiences, are aware of the role of power, are ethical and compassionate, and are becoming agents of change would be the educational goal.

These concepts are not only applicable to occupational therapy pedagogy. As the literature states, many health professions have found that the educational process does little for developing these skills and behaviors in students (Beagan, 2003; Larin et al., 2014; Murphy et al., 2009). The ideas put forth in this caring curriculum could potentially be utilized as a fundamental basis for many helping profession educational programs (e.g., Nursing, Physical Therapy, Speech-Language Pathology). One should fear the effects on the health professions when education is no longer personal and when students are no longer required to explore the affective nature of the care they provide in exchange for purely technical knowledge. As the focus of health care education moves steadily toward increasing technical skill and the methods of content delivery rely more heavily on distance and hybrid models, the need to incorporate these concepts will become increasingly evident and important.

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