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Autonomy and dependence: opposed and mutually excluding? Contribution to an ethics of care

Autonomia e dependência: opostos e excludentes? Contribuições para uma ética do cuidado

Autonomía y dependencia: ¿opuestos y excluyentes? Contribución para una ética del cuidado

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Abstract

With the increasing demand for care work, its study has been at the forefront in the healthcare sphere, in public policies, in gender studies, work, and personal relationships. There is a social discourse on the subject that raises questions related to both the political and social context in

which it occurs and what can be termed as the micropolitics of interactions between caregiver and care-receiver. On this issue, the care-receiver, when in a condition of high dependency on care, is considered devoid of autonomy by the dominant patriarchal discourse. This perspective is understood as limiting the agency and interactions of the care-receiver in a condition of dependence. Approaching the issue critically, in light of Social Constructionism and Phenomenology, this reflection contributes to the epistemological discussion on dependence and autonomy, especially in the care of elderly individuals experiencing a dementia process. Effective possibilities are observed for the cared-for individual to exercise their autonomy. It is noted how this autonomy can emerge through the relationship with caregivers and their responsiveness, primarily through corporeality, as opposed to verbal and rational language.

Keywords: care ethics; autonomy; dependence; old age

Resumo

Com o aumento da demanda pelo trabalho do cuidado (care), seu estudo tem estado em pauta na esfera da saúde, nas políticas públicas, em estudos de gênero, trabalho e relações pessoais. Há um discurso social sobre o tema que levanta questionamentos relacionados tanto ao contexto político e social em que este se dá quanto ao que se pode nomear de micropolítica das interações entre cuidador e pessoa cuidada. Sobre esta questão, a pessoa cuidada, quando em condição de alta dependência de cuidados, é considerada desprovida de autonomia pelo discurso patriarcal dominante. Este olhar é entendido como limitante à agência e às interações da pessoa cuidada. Abordando a questão de forma crítica, à luz do Construcionismo Social e da Fenomenologia, a presente reflexão contribui para a discussão epistemológica sobre dependência e autonomia especialmente no cuidado de idosos que apresentam processo de demência. Constatam-se possibilidades efetivas para aquele que é cuidado exercer sua autonomia. Nota-se como esta pode emergir através da relação com os cuidadores e da responsividade destes, principalmente por meio da corporeidade, em detrimento da linguagem verbal e racional.

Palavras-chave: ética do cuidado; autonomia; dependência; envelhecimento

Resumen

Con el aumento de la demanda del trabajo de cuidado, su estudio ha estado en primer plano en el ámbito de la salud, en las políticas públicas, en estudios de género, trabajo y relaciones personales. Existe un discurso social sobre el tema que plantea interrogantes relacionados tanto al contexto político y social en el que se desarrolla, como a lo que se puede denominar micropolítica de las interacciones entre el cuidador y la persona cuidada. En este sentido, la persona cuidada, cuando se encuentra en una condición de alta dependencia de cuidados, es considerada carente de autonomía por el discurso patriarcal dominante. Esta perspectiva se entiende como limitante para la agencia y las interacciones de la persona cuidada. Abordando el tema de manera crítica, a la luz del Construcionismo Social y la Fenomenología, esta reflexión contribuye al debate epistemológico sobre la dependencia y la autonomía, especialmente en el cuidado de personas mayores que presentan un proceso de demencia. Se observan posibilidades efectivas para que aquel que recibe cuidados ejerza su autonomía. Se nota cómo esta puede surgir a través de la relación con los cuidadores y su capacidad de respuesta, principalmente a través de la corporalidad, en detrimento del lenguaje verbal y racional.

Palabras clave: ética del cuidado; autonomía; dependencia; envejecimiento

Introduction

Over the last few decades, with global aging and changes in family structure, traditional strategies of caretaking had to be reviewed (Debert & Pulhez, 2017; Molinier & Paperman, 2020). The caregiver's role, designated mainly to women and limited to the domestic sphere, has been amplified since they joined the formal job market, as well as caregiving modalities have been diversified due to the growing demand for care work in general outside of the family circle (Tronto, 1989). Concerning this theme, it urges a reflection about the meanings emerged by conceptions and power relations in the micro-context of caregiving interactions, as well as about what is culturally understood and valued in these practices.

When tracing some considerations about care, multiple notions can arise. There is a traditional concept, which approaches the meaning of “gift” or a personal quality of being concerned with others, linked to the female gender and the mother’s role (Gilligan, 1982). This understanding, extremely attached to family relations and to idealized maternal characteristics such as kindness and altruism, has been questioned and widened. Among central critics are feminist researchers who point out that care is an activity rather than an act of love and can be done inside or out of the family circle, despite gender or social class (Molinier & Paperman, 2020; Tronto, 1989). Critics made to this concept have widened the notion of care to include the care work executed professionally or not, paid for or not, related to domestic work and care for other people.

Therefore, care presupposes a relation which has at least two actors: the person who cares and the one who is cared for. Particularly in this field, there is a relation that has become even more important to observe as the population grows into old age: care for older adults in a condition of dependence, mainly after the increase in dementia rate, specifically in Alzheimer (Melo et al., 2020). In recent years, Alzheimer's Disease has increased in Brazilian context, and the burden it represents for society, families and policymaking has become more evident. In the following decades, the impact of dementia tends to be even more substantial in the developing world, making it crucial to think about care strategies in the present time (Durgante et al., 2020). Families and institutions show

difficulties in dealing with this type of care due to the complexities the disease brings and what is understood as care.

When we talk about people in deep need of care who present functional impairments and how they are socially seen, it is common to think about them as less autonomous (Agich, 2003). This understanding is conceived in opposition to the patriarchal model of an ideal individual (Tronto, 1989; Agich, 2003), described as someone cognitive and socially able to manage daily activities who operate decision-making freely and by their own (autonomous). This notion of autonomy has been socially and historically built and operates mainly on the legal sphere, as writes George Agich (2003). According to this author, when this discourse is transposed to health and care spheres, it interferes in the way we see and take care of people demanding special and long-term care, including people with Dementia.

Goals

Given the relevance of this issue and the increasing importance of studies on Dementia, the main goal of this paper is to discuss the implicit ethics in care relationships involving dependent people and their caregivers, particularly concerning the autonomy of people with Dementia. The aim is to propose an alternate model to the traditional one, according to which people with these severe impairments are not seen as autonomous.

Method

In order to achieve that goal, critical theories were explored: Social Constructionism (Sabat & Harré's) and Phenomenology (researcher George Agich's propositions). It is necessary to point out that, even though these theoretical choices belong to different epistemological frames, they were chosen carefully in order to create no opposition. The aim was to come up with an intersection of theories that could help to create either an epistemological path on autonomy taking specifically the body and embodiment aspects of ethics in the relations, as well as giving practical examples applied to older adults demanding for deep care. In that way, the chosen theories do not confront but complement each other: with the Social Constructionists it is expected to build the epistemological field of care and relations that will guide the explanation. Georg Agich's

work, in addition, with his broad investigation on autonomy and dependence in long-term care, helped to shed light both on the historical context as well as towards the practical implications of this critical model of ethics in care relations with people with Dementia.

The path was designed to be a theoretical reconstruction of an ethics of care towards a praxis of care.

Results and Discussion

The dominant discourse of the autonomous individual and its implication for care – a historical contextualization

Studies on care bring, even in an implicit way, a social discourse about this practice, with concrete implications. The ethical dimension of care has emerged as an issue for academic discussion since Carol Gilligan (1982), who proposed the existence of a specific ethical model in caregiving, named “ethics of care”: this one would be different from the traditional ethics model, which is based on abstract moral principles and universal rules. According to her, the nominated “ethics of care” is a typical female attitude towards moral questions, based primarily on the concern about others and the maintenance of relationships, rather than on logical thought and universal rules. In a few and simple words, it changes from “this or that has to be done because it is the right thing to do” (traditional) to “let’s consider how this and that person feels and the personal consequences of each possible act” (ethics of care). The discussion that followed hers in gender studies carried mainly a critical tone, denouncing the gaps in Gilligan’s thoughts for naturalizing women as responsible for this kind of care.

Taking Gilligan’s concept in a critical but constructive way, Joan Tronto (1989), Molinier and Paperman (2020) think about ethics in care relationships, underlining that taking care is not a ‘gift’ or an exclusively female ethics. They define care as a social activity that anyone can take despite gender, class, or ethnicity. Thus, these feminist authors put away the essentialist point of view that naturalized ethics of care as female and timeless, and, at the same time, put in evidence how this ethical positioning demands a singular moral questioning that is far from universal moral rules and the abstract individual model that predominates in Western thinking.

As Tronto emphasizes, traditional moral philosophy tends to conceive individuals as autonomous and rational; she argues that, on the other hand, people in need of care are not seen the same way. Bill Hughes, McKie, Hopkins and Watson (2005) summarize this issue with the sentence “to be cared for is to be in deficit” towards the socially expected, as it is seen socially as a deficit of agency. One effect of this traditional description of the individual (rational, and the only responsible for their acts) is to overestimate autonomy rather than dependence as a constitutive aspect of the human being. The autonomous individual is considered free to act for oneself regardless of any constraints other than their own free will. Having said that, when someone is considered devoid of autonomy, the condition of dependence seems to create an inequality in the relationships in which the dependent individual is “guarded” by the autonomous one. When someone loses their (legal) autonomy, a hierarchy is installed in that relationship, demanding that the dependent one becomes connected to an autonomous other. However, this may lead to an authoritarian and oppressive situation (Agich, 2003; Tronto, 1989).

When someone’s autonomy (in that view) is limited, we tend to think about who will exercise it for them (Agich, 2003). Then, still inside legal discourse, dependence is linked with the condition of delegating one’s autonomy to another. As far as it is spread and received with legitimacy in the health and care fields, this description is questionable concerning the discursive effects that it builds. Sabat (2021) argues that, historically, biomedical perspective has emphasized this view regarding people who experienced dementia, who were seen as devoid of autonomy since it was linked exclusively to the specific cognitive abilities they had lost.

How can we consider, then, autonomy in concrete situations of people in dependence demanding for care, like people in old age with progressive dementia?

Autonomy in a condition of dependence: a relational goal

Caring for people in a condition of dependence, id. est., those who have not developed it yet, like toddlers and children in primary infancy, and those who have lost or cannot exercise their (legal) autonomy fully, such as older people with dementia or those with special needs, is something that demands important ethical questioning. When considering the concrete situation of babies, the dependent older adults, people with

special needs and the ones who are not the abstract individuals of the legal discourse, we talk about embodied individuals, considered within their corporeity (Agich, 2003; Sabat, 2021). The embodied person, according to Agich (2003), comes in opposition to the abstract individual conceptualized by the liberal theories, and is described by the phenomenologist as the concrete individual that lives the “everyday life” (p. 125), the daily routine, surrounded by the social living world and subject to the biological conditions of their own body and to the relational environment they are part of. The embodied person is considered not only within their body conditions but integrated with their habits, feelings, history and relational environment.

Overton (1997) explores the origins of this term in modern phenomenology: when talking about relational theories and relational beings, it is necessary to start from a perspective of a particular body experiencing the world: these interactions will model a certain type of “perception, thinking, meanings, intentions and desires” (p.331). These words mean that experiencing the material and relational world comes first to even the simplest perception. That set, it can be said that the way we perceive and function is not universal but unique depending on the context created by the conditions of our body (and gender, ethnicity) and the environment. Therefore, a young-popular-class-black-married female nurse who works on a long-term care facility experiences the world differently than a white-middle-class-widowed-old lady with dementia living there, for example.

As embodied subjects, then, people diagnosed with dementia will face a change in how they experience the world and the others. They show as most common symptoms impairments in memory and language and difficulties in motor and perceptual abilities, needing help in most daily activities they once could manage on their own (Sabat, 2019). It is considered a chronic and progressive disease, which may stabilize depending on the person, but tends to progress, increasing the amount of help needed day after day. The fact of dealing with a progressive Dementia, we may presuppose, creates a whole new set of elements the person and their social environment have to deal with in the everyday life, the way the routine is set changes in various ways and some burden may occur. Many simple activities can become a lot more challenging than before. Habits that once were taken for granted such as remember to take medicines at a given time of the day begin to require a lot more of attention and help.

When taking care of older adults with dementia, however, it is usual to admit they have lost more capacities than they usually have and there is a tendency to underestimate the older person's abilities. Sabat (2019) affirms that "significant, fundamental aspects of being human survive the brain damage caused by diseases leading to the diagnosis of dementia" (p. 171) and warns against the underestimation and the tendency to see the old person as someone radically different from whom they used to be before the diagnosis. So, how can care actions take place in such a complex scenario? Agich (2003) makes a singular contribution about this. In his work on long-term care for older adults, he questions the term "paternalism" to characterize care practices with people in a condition of dependence. The author goes back to the word origins from Latin, which contains the prefix "pater-," meaning "father". He points out that that word signalizes a care type that is more protective and suppressive of the other's autonomy. This way, by classifying care as something paternalist, we collaborate with the logic of devoiding people in need of care of autonomy and, as a consequence, caretaking is turned into a power relation, which brings serious ethical implications.

By naming care to people in a condition of dependence as "parentalism", Agich invites us to see autonomy and dependence through a different lens, rather than the liberal discourse and dichotomy. By choosing the prefix "parental", he points towards a specific care relation that follows human development closely, underlining the possibility for the care partner to help the other in exercising their autonomy, instead of suppressing it. Then, care is seen by a different perspective: as an emancipation factor, which is provided by an alternative and wider description. The caregiver is understood as an escort and an assistant for development, both in a progressive way in early childhood, such as in the possibility of maintenance of agency in old age and dementia process.

Brazilian researchers in Developmental Psychology are empathetic to a relational and parentalist description of care and recognize that fact in their investigations with infants (Amorim et al., 2012). For them, having a relationship with others is a condition for babies to learn culturally shared meanings, as well as build interpersonal meanings, even in absence of verbal language or a highly complex cognitive processing. In that way, care means the relation established from a dependence condition aiming to promote learning, world recognizing, knowledge, and, therefore, the development of the child's autonomy. By analyzing childcare practices, we can notice that autonomy can emerge

from dependence. This setting of permeability, therefore not a dichotomy, between dependence and autonomy is highly valued by George Agich, who also gives examples comparing early childhood to later age in terms of the necessity of the other. The aim is not to infantilize older adults, but to value the caregiver as an escort rather than someone who takes the protagonism from the cared person on their own actions.

Reviewing crystallized conceptions, Social Constructionist currents in general, claim as well the relational nature of building meanings, supporting some thoughts on these complex notions of autonomy and dependence. Unlike other epistemic currents, the understanding is that there are no intrinsic characteristics that define us, but we rather build and are built fundamentally in relation (Martins et al., 2017). A relevant concept for this discussion is the notion of *self*, which involves epistemic aspects about what we understand as such, as well as elements that constitute a person and refer to their identity. Despite the difference among Constructionisms, the relational and dialogical nature of self is emphasized, through narratives about self in the context of relations (Shotter, 2017), or focused on its dialogical nature (Hermans & Kempen, 1995).

As suggested by Harré (2016), it is possible to think about relationships with others as an ontological condition. Being in relation is a human condition, constituted dynamically through different positioning in the interactions, as it happens in relationships of care. The notion of “relational autonomy” derived from this discussion and has been explored by feminist theories and other researchers focusing on care ethics and patients’ autonomy (Verkerk, 2001; Jacobs, 2019). By seeing autonomy as relational, the interaction is emphasized as well as the mutual implication of the care partner and the person cared for in the process of guaranteeing the agency potential of the care receiver. This process invites to a permanent co-construction, based on the established dynamics of the relation of care.

Autonomy and dependence as positionings: dynamics on care relationships

As pointed out previously, there are a few points that can be emphasized concerning autonomy and dependence. First, both are conditions we are all under, even when autonomous in the legal sense. Agich (2003) mentions that “even when adults we can sometimes be more dependent than independent in our interdependence” (p. 100).

Dependence in any measure and some vulnerabilities are universal conditions, given by the simple fact that we live in society, as we are all interdependent (Debert & Pulhez, 2017; Verkerk, 2001).

The second and third relevant points refer to that autonomy and dependence occur when we are in a relationship, and those are not static but dynamic conditions. Given these conceptual appointments, we propose that autonomy and dependence can be considered, in health and care spheres, as elements for negotiation of meanings in discursive practices (Jacobs, 2019) at situated interaction between the caregiver and the one who is cared for, as embodied agents. Thus, autonomy and dependence can be understood as “positioning” (Harré & van Langenhove, 1999). Through this lens, interaction gains dynamicity, and additionally, different characteristics and positions can be assigned to the distinct actors during an interaction, keeping the characteristics and relational history.

Taking Harré’s (2016) contributions in depth, we can understand the individual’s constitution and their selfhood as dynamic, as well as the fact that identarian aspects are built during discursive practices, in the multiple and continuously established interactions. Thus, it can be observed that there are no universal qualities that define the self. Therefore, the caregiver is not essentially autonomous in the same way as the person cared for is not described exclusively as dependent or devoid of autonomy, once these positions are negotiated in interaction. Sabat (2021) endorses the relevance of Harré’s positioning theory in the study of selfhood in dementia, giving many examples of the different behavior that people with dementia assume depending on the care partner or professional’s response to them.

As a hypothetical situation to illustrate the question, we can think of an older person with a cognitive impairment being cared for by a relative. The older person, no longer able to realize basic daily activities without help, including intimate care and eating, is considered functionally dependent, if employed the liberal concept. In a given situation, when rejecting some meal offered by the caregiver, the older relative can be positioned as autonomous, demonstrating one’s will, even with a simple head shake or by closing their lips. Agich (2003), in his phenomenological view, classifies as “volitional” autonomy expressed this way. The author, thus, presents other dimensions of autonomy, rather than rational or cognitive.

In this example, rejecting a meal communicates something to the caregiver, even not in verbal language, putting the older individual in an active position and the relative in a responsive position towards this attitude not always expected. In this interactive field, the older person's autonomy emerges, which invites the caregiver to position themselves. The caregiver can, in this case, act in an authoritarian way by forcing the old person to feed or search for other ways to position in this conversational line or on the established mute dialogue (Scorsolini-Comin & Amorim, 2010). The caregiver's response will depend on the conversational line, which means both previous interactions between these people and their history of communication as well as the meanings created between them and feelings towards one-another. Caregivers do not act authoritarian in bad faith, but they position themselves in that way due to past interactions and existing meanings.

In works on personal *self* in Alzheimer's Disease, Sabat and Harré (1992), and later on Sabat (2021), it is discussed that one of the main causes for "the loss of self" in this condition is a product of the way this person is seen and treated by the caregivers, professionals and family members rather than exclusively by the conditions imposed by the disease itself. An illustrative case is mentioned by Sabat and Harré (1992) of an old lady that attends a daycare facility. Although she has the verbal language reduced, she was able to help in the activities, she took her meals without help and communicated through gestures. Her capacities were not shown at home, where her husband, noticing the loss of verbal language, did not recognize her *self*, id. est., her agency capacity. Several variants may have influenced the inability of the husband to recognize his wife's potential autonomy, such as: his mourning for the abilities she had lost and for how their interactions used to be; previous conflicts between the couple; his lack of ability in taking the responsibilities she once had at home and feeling frustrated for that. Not considering this point would be to restrain the husband in a caregiving role and not seeing him as capable of (re)positioning himself in this interaction. Out of rage or other feelings towards the wife or himself, the husband can feel constrained to take care of her, not feeling free or autonomous in this decision.

Not only the care provided by the family, but professional care can also be challenging for the exercise of autonomy. Jacobs (2019) mentions that promoting patient's autonomy is claimed to be the main goal for formal care organizations which employ nurses at home care jobs in the Netherlands. This notion, however, tends to be

taken by these employers in its common sense (the liberal concept), and autonomy is seen strictly as independence: nurses are trained to let the old persons do the daily tasks by themselves and help only in specific points. This misconception creates standard actions for the nurses that can lead to seeing the old people the same way, fixed in a stereotype, acting always the same and not as singular persons who can vary their way of feeling, their preferences and needs depending on the context. Sometimes they can be more dependent and not willing to do the tasks, for being tired or just demanding attention. This is another example of not promoting but denying autonomy by not seeing the old persons' selves. Recognizing someone as capable of autonomy is to be in relation and attentive, not presuming a standard characteristic (for example, independence) that is not the rule.

As the examples show, autonomy can be denied either if we do not see capacities that are there yet (example of the lady and the husband) or if we presume capacities that are not always there (standardize actions in the nurse's training). Autonomy in this scenario is, therefore, not only the capacity to execute tasks, but being able to express wills, weaknesses and to be seen as a subject with a self which, as said, is not static but dynamic. Agich speaks about the "psychosocial correlates of autonomy" (2003, p. 119): any arrangement that enhance the possibility of the person to express their own personhood or the characteristics that identifies them as themselves.

We can notice, furthermore, that autonomy can be exercised even without verbal language, as well as put in evidence the need of legitimating the agency capacity of the person cared for by the care partner. As pointed out by Hermans and Kempen (1995), dialogical processes are not limited to verbal language, as the authors talk about "dialogical actions". They affirm it is necessary to consider the body in relation in a dialogical action aiming to apprehend the human being and their development avoiding the dichotomy trap of autonomy-dependence by looking carefully to the context of the interaction. The authors take corporeity into account and consider non-verbal expressions and their potential in building meanings, as language considers mutual responsivity (Leiman, 2002). That takes into the scene the other, concerning whom one's position is (re)placed, the language considered in a relational and situated way.

Therefore, we can suggest the possibility of discursive practices through corporeity (Overton, 1997; Sabat, 2021), allowing the dynamics in care interactions.

Agich (2003) concludes that embodied practices are not cognitive, deliberate choices, but conducted spontaneously in concrete situations, showing the importance of affection in these embodied practices of care. According to the author, only a real affective bond will eliminate the sense of obligation for taking care of a relative, for example, and a certain affection built with professionals will lead to a true recognition of an older person's volitions. Those thoughts reiterate the importance of establishing a relationship between the caregiver and the care receiver: the shared meanings, emotions, and conversational lines will lead to the necessary dynamics to occur so both can act autonomously.

This implies a replacement of where we allocate these psychological constructs, since the individuals' inner qualities, autonomy and dependence begin to be considered as embodied and situated processes that take place in social interactions. This proposal implies that subjectivity is considered as depending on the other in history, culture, embodied practices and affectivity. Based on these perspectives, we open new possibilities for analyzing dynamic positioning in care interactions. Thus, the "effective autonomy must be found not in the mental process of choice and deliberation, but primarily in the embodied action" (Agich, 2003, p. 243). Actual autonomy, as Agich calls it, can be found in the meaningful choices, not in any choice. This autonomy emerges whenever a person is recognized by someone attached to them as someone capable and their self is not denied but valorized. In this way, at a given situation, washing the dish for an old person knowing them and being aware that, on that moment, they would feel cared for with this act enhances more their autonomy than letting them do this task indiscriminately, proving a so-called "independence".

Since autonomy is not intrinsic but depending on the other and on the context, ethical principles on care, then, cannot be taken as universal rules, but demand critical thinking at each embodied situation. It is a quite complex task that leads us back to the feminists' views of ethics. According to Irigaray (1993, as cited on Hughes et. al., 2005), exercising ethics of care in an embodied manner in the direct interaction between cared person and caregiver would annulate the understanding of this relation as domination. However, Tronto (1989) refers clearly that the care relation will always be unequal at some point, and, therefore, that always demands moral questions. Irigaray's view can seem romantic, sounding as if we could eliminate this inequality only by referring to an ethics distinct from the traditional and patriarchal one. Whilst it is not possible to

eliminate it, as Tronto points out, we should consider carefully the moment of the interaction, which leads us to notice the different positionings happening even in the interior of this unequal relation.

Having that said, we can recall the contributions from Harré (2016), as the individual self is considered dynamic, and their identarian aspects are built in the discursive practices in an embodied interaction. Therefore, there are no universal characteristics that define individuals, so the caregiver is not necessarily autonomous, as well as the cared person cannot be described exclusively as dependent and devoid of autonomy, once these positions are negotiated during interaction. With these thoughts, we do not aim to point out the unlimited possibility of repositioning in care interactions, even because, as in the example, functional dependence tends to endure especially in degenerative and chronic diseases. This configuration circumscribes the positions that can be taken by care actors, but it does not prevent the dynamics to occur.

It is important to state that promoting dynamics between autonomy and dependence in relationships of care is a goal for the care practices in general but do not depend on caregivers themselves. Caregivers, professional or informal ones, as well-known in care literature, already suffer from burden of many kinds (Durgante et al., 2020; Jacobs, 2019), and this does not aim to be one more. In this paper, the aim was to show that changing how we look to those interactions would improve the quality of care and to make notice that this change goes far beyond the interaction moment itself, beginning on how we construct knowledge (Agich, 2003; Sabat, 2021), how we train health professionals (Jacobs, 2019) and how we deal with informal family caregivers (Sabat & Harré, 1992). Research could be done in order to understand whether including a critical discussion based on the ideas brought here on professional training and support groups for caregivers could impact on their level of burden, helping them to feel more autonomous and less burdened in their caregiving as well.

Conclusion

From the starting point of critical theories of the traditional notion of care, it can be understood how the concept of autonomy based on the Western model of the autonomous individual is problematic when talking about health and care, especially in

the case of dependent people in need of it. In its different currents, Constructionism brings elements to the reflection by looking to the person fundamentally in relation, embracing the notion of development and different possible positioning in discursive practices in interaction.

The invitation is to consider positioning not only in verbal terms, but also through corporeity. An infant or an older person in a dependence condition does not often possess verbal resources, but communication and interaction through corporeity find their way to happen. The caregiver needs to tune their sensibility to be responsive to this communication, being attentive to the way they position the person cared for, as thinking about them as devoid of a sense of self will lead them to respond as such. Hence, autonomy can be exercised in interaction, maybe not in its traditional and cognitive way, but in its volitional manner, as Agich says (2003).

This reflection opens a path to understand dependence not as a problem but as a condition, *id. est.*, we are interdependent in building meanings, as well as building identity. In addition, it opens a path to the possibility of the dynamics between dependence and autonomy from discursive (re)positioning, when in embodied action in the dependent older adult-caregiver relationships. Then, we can propose the elimination of the dichotomy between these two notions aiming to gain a wider reflectiveness concerning ethics in care actions. As a guide to interventions and reflections in this field, one could adopt the following sentence: “what it means to guarantee the maximum of autonomy in the process of deepening functional dependence”.

When leaning on these propositions, we can think about how care given to the older people happens inside the family circle and in institutions. Being attentive to these ethical thoughts would be of a great importance to the qualification of caregivers and even in technical orientations to families, in order to avoid oppressive situations in caregiving. It can be pointed out as well that considering dependent older persons as capable of agency would alert to the importance of valuing them as subjects of rights to public policymaking. Valuing care and its actors in the public sphere would be a manner for the State to take their responsibility concerning this population, considering the growing demand for shared care with families.

In conclusion, the understanding of care both as a non-oppressive relation and a mutual responsibility between caregiver and care receiver would be the direct effect of

the change from the traditional view to a critical one concerning autonomy. When looking closely at care interactions, we may see that the traditional view of autonomy cannot be applied to embodied individuals, since they are not the abstract human being this notion implies. Embodied agents carry a history, a social context, a body and feelings. That said, by considering care both an act of work and affection, we invite the development of an embodied ethics, more respectful of the autonomy of both the caregiver and the person cared for.

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