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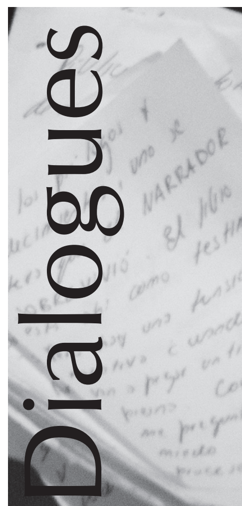

Care work in the health sector based on the psychodynamics of work and the care perspective: An interview with Pascale Molinier

El trabajo del cuidado en el sector salud desde la psicodinámica del trabajo y la perspectiva del care: Entrevista a Pascale Molinier

***Wlosko**, Miriam*[1]; ***Ros**, Cecilia*[2]

ABSTRACT This interview with Pascale Molinier was carried out in Buenos Aires in October 2014, in the context of activities organized by the Health and Work Program at the Department of Community Health of the Universidad Nacional de Lanús, Argentina. The interview explores the relationship between work and subjectivation, examining the role of work in the structuring of the psyche, in the dynamics of pleasure and suffering, and in the construction of gender identities. "Feminized" work – that of nurses, caregivers and maids, among others – is examined from a "care" perspective, analyzing its intrinsic invisibility and impossibility of being quantified and measured, which makes it a challenge to management-based logic.
KEY WORDS Work; Mental Health; Gender Identity; Health Personal; Caregivers; Management.

ABSTRACT Esta entrevista a Pascale Molinier se realizó en Buenos Aires, en octubre del 2014, en el contexto de las actividades organizadas por el Programa de Salud y Trabajo del Departamento de Salud Comunitaria de la Universidad Nacional de Lanús, Argentina. La entrevista aborda la relación entre trabajo y subjetivación, examinando el rol del trabajo tanto en la estructuración psíquica, como en la dinámica placer-sufrimiento y en la construcción de las identidades de género. Se examina el trabajo del cuidado "feminizado" –enfermeras, cuidadoras, mucamas, etc.– desde la perspectiva del "care", analizando su invisibilidad intrínseca y la imposibilidad de ser cuantificado y medido, lo que constituye un importante desafío para las lógicas de gestión y de management.
PALABRAS CLAVES Trabajo; Salud Mental; Identidad de género; Personal de Salud; Cuidadores; Gerencia.

[1]Psychologist. Professor, researcher. Coordinator of the Health and Work Program, Departamento de Salud Comunitaria, Universidad Nacional de Lanús, Argentina. PhD in progress, Facultad de Psicología, Universidad de Buenos Aires. miriwlos@gmail.com. [2]Psychologist. Professor, researcher. Coordinator of the Health and Work Program, Departamento de Salud Comunitaria, Universidad Nacional de Lanús, Argentina. PhD in progress, Facultad de Psicología, Universidad de Buenos Aires. roscecil@gmail.com

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INTRODUCTION

Pascale Molinier is a Social Psychology professor at Université Paris 13 Villetaneuse, director of the Unité Transversale de Recherche Psychogenèse et Psychopathologie, associate director of the Groupement d'intérêt Scientifique-Institut du Genre (GIS-IDG), and director of publication of the multidisciplinary journal *Les Cahiers du Genre*.

She is the author of the books *L´enigme de la femme active*,[1] *Les enjeux psychiques de travail*,[2] and *Le travail du care*[3]; co-author of the book Qu´est-ce le care?[4] with Sandra Laugier and Patricia Paperman; co-author of *El trabajo y la ética del cuidado*[5] with Luz Gabriela Arango Gaviria, and the author of several articles. She has conducted different research studies about the problems related to work, subjectivity, and gender based on the perspective of the psychodynamics of work,[a] to which she has made significant theoretical-conceptual and methodological contributions.

Her wide experience in investigation and intervention in the field of the psychodynamics of work and gender studies, as well as her contributions to care work,[b] motivated us to talk with her about the role of work in health and in the subjectivity of workers.

The following dialogue took place in the framework of the activities[c] that Pascale Molinier carried out in Buenos Aires in October 2014, which were organized by the Health and Work Program at the Department of Community Health [*Departamento de Salud Comunitaria*] of the Universidad Nacional de Lanús, Argentina.

Pascale Molinier, Buenos Aires, 2014.

DIALOGUE

Miriam Wlosko: The issue about the relations between work and the processes of health and mental disorders is undoubtedly complex. Two important questions arise at this point: the first question is related to the role of work in an individual's psychic structure; may it be asserted that work shapes the subject's psychic structure, or is it a "complement" of a psychic structure that is already shaped? The second question is connected with the role of work in the etiology of psychological and psychiatric disorders. What is your opinion about these issues?

Pascale Molinier: I believe both questions are related to the concept of "work centrality." I do not think that work has the socio-historical value of an invariant. However, in western societies, since the 19th century, work has been an activity that enables – or prevents – creativity. The human subject needs to be creative and give meaning to their life through creative processes. The psychoanalysis, for example, in Freud's work, proposes three activities connected with creation: art, religion, and scientific and intellectual work. We think ordinary work is also a place where subjectivity can be expressed, and we have clinical evidence that proves that. In the area of the psychodynamics of work, we study what I would call forms of subjectivation that arise from the encounter between the psychic subject and the work situations. From this point of view, work is not a "complement," as many people in the field of psychology believe. It is not a complement considering that people, at work, act in response to an experience of reality, thinking of reality as a contingency, as something unexpected, as something that stands up against what is expected. It is a situation in which the subject has to make up something and put their intelligence into action. This experience is a suffering experience

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because it is hard, it is anxiogenic, and it is distressing. Moreover, it is an experience which is felt in the body, in the sense of corporeality, the pulsion-driven body, the body as an entity capable of being affected. Affected by what? By distress, by fear, by compassion, by boredom, by many feelings of affection that arise within a context which is totally different from that of the family or affective life, in the traditional sense of the term. It is a new experience for the subject and, from this perspective, it is not a complement because it did not exist before, it is created by their subjectivity. This is why we speak of *subjectivation*.

Christophe Dejours speaks of "self-fulfillment." I think it is rather a change, a mutation, that was not envisaged since the previous life, the particular experience that is produced as a result of the encounter with the real component of work is something completely new. In turn, this new experience is recorded in the subject's history. An interesting concept that helps the articulation between the childhood psychological background and work is that of *symbolic resonance*, given that work enables the subject to solve the unconscious difficulties that arise from their history. Symbolic resonance refers to the connection between the subject's unconscious mind and the possibility of changing the sources of personal suffering through this process of creation at work. For instance, if your mother suffers from a mental disease, you cannot do much to help her even with the existing affective bond; nevertheless, if you are a psychologist or psychiatrist, through your work, you will be able to solve some of the problems related to your personal history. Explained in a very schematic way, this is the meaning of symbolic resonance. However, there are situations in which this process cannot be applied. If we consider the same example, you were not able to take care of your mother when she was ill, but, being a health professional, neither can you take care of the ill patients that you have now due to, for example, problems connected to the organization of work. In this case, there is a repetition of suffering which represents a possible source of psychopathological decompensation. Accordingly, through symbolic resonance, it is possible to understand how this new experience may be recorded through the point of view of sublimation, the sense of life, the pleasure felt at work, and being successful; or otherwise, through the "anti-sublimation" perspective. This notion refers not only to the lack of sublimation, but also to the fact that there is something in the work that hinders the processes of creation, creativity, and sublimation. It is in that moment when a process of decompensation may occur unexpectedly, which is one of the consequences of suffering at work. Suffering can turn into pleasure through the process of sublimation, but, at the same time, it can become too heavy of a burden for the subject, making them fragile and, in that way, facilitating the onset of illnesses, such as mental illnesses and others. In the field of the *psychodynamics of work*, we deal with subjectivity, but focus on singular subjectivity, which is personified in diverse bodies that may experience, or not, decompensation episodes in different ways. For that reason, it is not easy to develop the epidemiology of suffering at work, since the forms of decompensation have very singular characteristics.

Cecilia Ros: Which contribution can the psychodynamics of work make, on the one hand, to the issue related to the centrality of work in the construction of health and gender identity, and, on the other hand, to the construction of relations of domination and its possible subversion, which are generally underestimated in the majority of the psychological, epidemiological, social, and political analyses?

PM: Work plays a central role in gender identity. The world of work is entirely constructed on the basis of a sexual division of labor. That is to say, there are feminized tasks and masculinized tasks. This sexual division of labor exists in every society and has the characteristic (the domination issue is intrinsically connected with the concept of sexual division of labor) that, not only proposes feminized and masculinized tasks, but also values the tasks of men at a greater social value than those tasks performed by women. The concept of work has been built on the basis of salaried and male activities. Until the 1980s, that is to say, until not so long ago, household work – rearing children, taking care of elderly people – was not included in the concept of work. Considering the sexual division of work as the core of analysis is a challenge from the point of view of both the struggle against any form of domination among men and women

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and the struggle within the group of men or the group of women, since they are not homogeneous groups. Reflecting on the topic of gender identities from the perspective of work implies taking into account the sexual and social division of work. It is clear that the gender identity of an executive woman is not the same as that of a maid. The female group does not exist by itself. There are gender identities that are constructed in relation to different experiences of reality, but we already know that these experiences are socially sexualized, in the sense that men and women do not perform the same tasks. This is a blind spot of psychoanalysis because it considers male and female identities to be only connected to the sexuality. We think that, in this work experience, diverse forms of sexual subjectivation are developed in the sense that the affection and the suffering experienced at work are not the same. For example, attending to the vulnerability or suffering of others – which is a central attitude in all the activities known as female such as care, health, education, or home care work –; all these activities expose female workers to a form of suffering known as *compassion*, because they have to *feel*, attend to the difficulties of other people, as it is necessary in order to do a good job. For instance, you cannot keep working as a nurse if you are not able to give certain attention to other people. Being a physician is different, because you can focus on the technical work of medicine and delegate what is called "human" work to the nurses. It should be noted that, for example, in the case of female physicians, they are expected to give certain attention that is not necessarily expected from male physicians. It is really important to recognize that female physicians have to deal with the fact that people expect better care from them than from male physicians. This applies to nurses but also to female physicians. Consequently, the way in which female physicians construct their own work experience is neither necessarily nor exactly the same way as for male physicians.

MW: In your studies, the notion of "care work" is a central concept. How would you define it? How would you relate this notion to the female-dominated professions such as nursing? And, what does it mean that the relational dimension of hospital care is mainly invisible or invisibilized? How can you make this invisibility of care work compatible with the criteria and methods of evaluation that are expected in the organization and evaluation of hospital work?

PM: According to Joan Tronto,[9] care is a "species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web."[10]

Care work is everything that is necessary to maintain an *ordinary world*. The hospital is an extremely frightening world for people, and it has nothing to do with an ordinary world. How do we construct this ordinary world where people talk to each other and are attentive to others and where coffee is served in a ceramic cup and not in a plastic glass? Constructing this ordinary world seems to be very simple, because we always have the idea that this world is out there, but it is not. It is constructed day after day, night after night; it is a job that has no limits in time and becomes evident only when it has worn away, when it disappears. However, the ordinary world lies within normality and we are certain that it will remain there, but it will not: this ordinary world is the subject matter of a whole field of work, which we call "care work." In my opinion, this dimension of the ordinary world is really important.

This work is invisible, it cannot be "quantified." It is not possible to employ evaluation methods seeking to "measure this work." The reason why this work cannot be measured – something that all management tools seek to do, that is to say, to quantify the number of ironed shirts, to measure the figures of concerning care and developed products, and so on – is because care mobilizes particular relations. Consequently, in order to understand the choices, the ways in which people organize their work, and the answers given to the needs of others, it is necessary to go through other forms of description, such as stories, tales, and contextual narrations, which help to understand the reason, which is different each time and explains why people made one choice or another in relation to their job.

Moreover, there is a very important dimension that is not measured either, which is totally absent in the management tools: temporality. Care is

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something that is situated within temporality. This is well reflected in the care of individuals with disabilities and children or adults suffering from mental disorders. For instance, female family caregivers, nurses who work in psychiatric hospitals, when talking about their patients, say: "We have spent our entire life with these people." The bonds are very strong, so how can you measure that? It is impossible. For that reason, it is necessary to consider care work as a job that can be defined as *invaluable*.[11] We must take this very seriously: *it is something that cannot be negotiated and, consequently, it is necessary to create other methods to evaluate that work*. Furthermore, that is what people want: when people go to a hospital or health center, they need somebody to take care of them, to relieve their distress, to respond to their need of sitting on a chair, for example. As you can see, these needs are indeed very specific, very simple, but, if nobody has the time or availability to think about those needs, the situation may become very difficult for those people. Calculating the economic value of care is not easy. It must be thought in a different way and it implies a paradigm shift in the values scale. In our societies, people who perform specialized activities within the health field are highly valued: anesthetists and surgeons, among others. As they become more specialized, they are granted higher efficiency value. The truth is that this system works and it works economically, but, in order to be measured, care cannot be segmented, it cannot be specialized, because the truth is that everybody can give a glass of water to another person; it is not a specialization, it is an ethical value and work. As a consequence, this is a challenge for management.

MW: In many of your works, you mention that in the care activities – those carried out by nurses, domestic workers, children caregivers, and others – there is a "necessary invisibility." If the work is well done, it has to be invisible, it has to disappear, and it only becomes apparent when it is not well done. However, the problem is that not only does the work disappear, but also the recognition of its existence and even of the person who did the work. Thus, it would be interesting if you could tell us what happens when this necessary invisibilization occurs and how it affects the recognition of people in care work.

PM: Part of the answer is in the question, since the truth is that care mobilizes a *discreet know-how*. The intelligence that is mobilized in care work aims at anticipating needs: if you are thirsty and you have to wait three hours to get a glass of water, then that is not care; but, if the glass of water is given exactly at the same time that you start to feel thirsty, then it is care. It is necessary to anticipate the need. When we analyze care work, we realize that all care work is based on small gestures that are barely seen but require a psyche-driven work, a mental work, a cognitive work which is really important to anticipate the needs. Responding to a certain need is responding in a suitable way and on time, and it is not easy at all, thus, it is invisible. However, it can be narrated, we can tell a story of these activities in such a way that, although care work is not visible, a person can access it through words. The issue about the invisibility is important because, when you work with a person's naked body, it is necessary to conceal that work and, in that sense, there is a necessary invisibility that you cannot transgress, as it is necessary to protect people's privacy. For that reason, care work is not visible and, thus, it is barely recognized as knowledge. However, legitimacy can be achieved through trust, and that is the main problem. Those who have hierarchical positions (administrators, physicians, and even nurses) do not have absolute trust in the ability of caregivers: assistants, relatives, many people who carry out basic care work. These people have no legitimacy from the point of view of the hierarchy. Very important efforts must be taken here in order to change from the paradigm of visibility and recognition to a paradigm of *saying*, that is to say, a paradigm of words, stories, and trust. I think that psychologists may play an important role in this transition, for instance, analyzing the practices. In this type of analysis, we will not simply see what people are doing, but we will listen to what people *say* about what they are doing, which is totally different and means having trust in the word of those who are considered inferior. It is something that stems from a very simple principle, but which is socially difficult to be fulfilled, since many care activities are performed by the least qualified people: for example, in France, by immigrant and poor women. Consequently, the legitimacy of their speech, of their word, is weak, and that must be changed.

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CR: From a certain perspective, someone could interpret that this invisibility of care turns this activity into something hard to define, something immanent, something that can only be understood in the work itself. Does this attack the issue that questions whether it is possible to be trained for care work, or it is possible to do something aimed at transmitting the knowledge of care? Otherwise, it may appear as "natural" skills of the caregivers.

PM: That is true, but care is transmitted through the word and the stories. It is a method that works very well among teams of male and female caregivers. They talk to each other and, through these stories, the experiences and knowledge are transmitted. However, in order to do this, time is needed, and we know that time is very limited in the workplaces as well as in the space we are interested in, in this case, the hospital. From my point of view, it is a terrible mistake that, precisely in these places, there are neither spaces to share the word nor groups in which the word can be passed on. Female caregivers should be allowed to talk about their work and become aware that the word is a fundamental tool in care work. It is important to convey trust to the word, to the word within the teams, without being necessarily evaluated or without taking place in the presence of the boss. Because the worst thing that can happen to care – which is frequently seen in the services sector – is having a script to establish relations. For example, in call centers, fast food chains, or banks, workers have scripts or speeches that tell them how to communicate with people, but which are totally pointless. The relationship that is established is absolutely artificial but, of course... it can be measured: "*You have three minutes to*," "*You have to answer in this way*." That is exactly the opposite of what the care perspective is.

MW: How would you associate the care perspective with the evaluation methods of the prevailing managerial models, which are seen not only in hospitals and other health sectors but also everywhere? Because this is undoubtedly a hallmark of capitalism at present: measuring, counting, evaluating.

PM: Yes, the problem is that managers know nothing about care. Fortunately, they know about management, which is important. It would not be a problem if management was not the ruling discourse, a discourse which thinks that everything can be solved based on its own criteria. That is false. The supremacy of the management discourse is a serious mistake. Managers, under this perspective, cannot do much; the others are the ones who have to change something. I think that *male and female caregivers have an inalienable knowledge in the management categories*. Caregivers must defend, promote, and make visible this knowledge, in such a way that we could imagine a world where the voice of management exists along with the voice of care at the same level. It is a utopia but it might work, and it sometimes works at a micro or local level, because there are managers that do listen to caregivers who know how to talk about their work without reducing it to the management categories, in other words, without participating in the disappearance of their own work within those categories. In my opinion, the idea which considers that there are several languages, several communication systems, and many descriptions of the labor world is very important; it is necessary to provide descriptions based on care, in order to change the force relation and to make the managers listen to a different voice. I believe that this is possible if, and only if, caregivers become aware that care work is associated with a strong criticism of neoliberalism; it represents a really strong social and political challenge for caregivers.

MW: Why is care work a challenge to neoliberalism?

PM: Because it cannot be measured. Managers will keep saying "If it cannot be measured, it does not exist"; therefore, it is necessary to fight against this discourse, and this fight cannot be carried out in isolation. For that reason, the care perspective is not only a description of the labor world, but also a political perspective.

CR: From your perspective, is there something like a "discourse of care" or would you only limit care to some types of work or task?

PM: On the one hand, there are professions and trades that are specifically focused on care; but, on the other hand, care work is common to many

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activities and is not restricted only to the services sector. Who does not have in their family an elderly parent, someone suffering from Alzheimer's disease, a disabled child, or someone suffering from cancer? This is part of people's ordinary life, and it is also a way of showing our vulnerability. Vulnerability is the Achilles' heel of neoliberalism because it is a blind spot. In the neoliberal perspective, all individuals are independent, young, healthy and happy, and have initiative. However, this model of human being is pure fiction; thus, we are experiencing total cultural alienation, we live in an ideological lie, because the daily life of a human being is not like that. Care makes vulnerability visible, and for that reason I believe it is very important.

The combination of the psychodynamics of work and the care perspective is very powerful to destabilize this fiction, this social imaginary of neoliberalism. By explicitly stating the relation between subjectivity and work, it is possible to respond to the hegemonic management discourse.

MW: In your research studies related to female nurses and caregivers that work in retirement homes, you show how the know-how in nursing implies a hard discipline of the bodies in the professional socialization, through which the psychic position required to carry out the nursing work is built. Based on common sense, at present, the prevailing perspective regarding care workers (of the health and education areas and of all the professions related to working with others) considers the "love" for sick people, children, and so on, as a "natural gift," as "knowing how to be," in which this naturalized love covers the caregivers' work. In your papers, you make a "critique of devotion," in which you assert that it is necessary to denaturalize this love that masks the notion of socially constructed femininity. And you talk about "compassion," a term that has a very religious impact in Spanish.

PM: It also does in French. Etymologically, *compassion* means to share; it therefore means to *suffer with*. I find it much more interesting than empathy, which is currently a predominant trend; because empathy is constructed on the basis of the idea of *suffering like*, and I do not think that the female nurses suffer like sick people; they *suffer with*, it is a relationship. In a certain instance, this idea became very interesting because the nurses told me: *"Not compassion! Because we are not nuns."* This was a controversial beginning that turned out to be very positive during the debate with the nurses. Today, I speak more in terms of "sensitivity towards the suffering of others" and care, because care has this affective dimension that doesn't require references to compassion.

In this sense, all my efforts are aimed at showing that care is work. It is necessary to meet the needs, and this is not only an intellectual concern, but "something that has to be done." And this is very important because care must not be associated with femininity, love, or the support for the family or a political party. I can argue that care is work, but it must be said: many female caregivers speak of *love*. Once, I asked a group how they would define a good worker, a good caregiver. They answered: "*A person that works with the heart*." This is their *saying*; people cannot escape from it when the intention is to speak about work. Would it be proof of a lack of distance or professionalism? Are the female caregivers wrong when they speak of love? There is a semantic deficiency in the world of affection. We use the word love to speak about or to refer to very different feelings: love in marriage, erotic love, love for children... It is a generic word used to describe very different things in the world of affection. Therefore, the question would be: which connotation does the word love have for these female workers? We can approach this word through a radically contextual perspective. It is as if someone speaks in a foreign language and has to understand this strange word: love for the elderly, love for the patients. The word "love" appears in stories that tell about how to "put up with" care work because it is extremely hard work and involves a great physical burden. In care work, the fatigue is very severe and is highly underestimated. The working conditions are extremely difficult – there is a lack of time, too many patients with insufficient staff, and even contempt. In France, most caregivers are migrants: women from Saudi Arabia, the Antilles, the Caribbean, Haiti, Southern Africa, Cambodia, Vietnam. These women, who do not have fair complexion, are socially despised and are not given social recognition. The issue related to disgust, to working with excretions and

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all the body fluids, often come up in the stories. Therefore, caregivers can bear these issues if they work with the heart. In this sense, love is not a denial of work but instead stands for *work ethic*: in order to do a good job, female caregivers have to mobilize a set of feelings of affection that they call "*love*," but this set of feelings masks things bearing a terrible ambivalence. It is clear that there are some people that caregivers love and others that they hate. At this point, the collective dimension emerges. If there is a well-organized collective of female caregivers, they choose their patients. As those relationships are very special, you cannot take care of all the people in the same way: there are people you like and people you dislike; then, a collective work is needed, which depends on the word, on the discussion, so that "ungrateful" people are not left without care. For that reason, care is not considered a value or a personal skill; it is always a collective construction. In order to *work with the heart* caregivers need to rely on a collective construction of people who think that working with love makes sense. However, this does not mean that all the feelings of affection are positive or natural, or that they come from the bottom of the heart... This has nothing to do with that representation of care work. The truth is that for female caregivers the word "love" represents those things that they value, something that is necessary to be put at stake in order to bear the difficulties arising from these feelings of affection in the relationship between the caregivers and the patients, the elderly, and others. Therefore, love does not imply a lack of professionalism, in fact, it is the other way around. The misunderstanding between the caregivers and the trainers, managers, or bosses results from the construction of that "distance," the called "optimal therapeutic distance" that has to be kept with the patients, and which is almost always regarded as "being further away." For female caregivers, it is exactly the opposite. It is about how to come close to people who stink, who are blind, insane, mean, or who may be racist, and so on. For those women, the difficulty does not lie in taking distance but rather in coming closer in order to build a human relationship with individuals, and all of this is embodied in the word "*love*." Therefore, "*love*" is not just a word, it represents an entrance door to all these stories and narratives, which construct the care perspective.

MW: It is interesting since it puts into perspective the issue of the feeling of affection as the key to think about the suffering and pleasure dimensions as well as the complex interaction between both dimensions associated with work, any work, or work as a whole. In this sense, how to move forward over that area without flattening dimensions of, at least, two fields that are connected: on the one hand, the field of social sciences of work, which bears the complexity of the idea of work, and all that it implies, and the social relations of domination that are always present at work; and, on the other hand, the dimensions of pleasure, displeasure at work, which emerge in the psychoanalytic approach and that the psychodynamics of work revisits to think about the feelings of affection. That is to say, how do you see this intersection between a pulsion-driven reading of subjectivity and a reading of the social subject?

PM: It is a methodological problem. When we start a new research study, we listen to people in accordance with a certain model. For example, if I am going to listen to a group of female caregivers, I have the idea that they have a pulsion-driven unconscious, that they may get excited by the contact with the body of others, or that they may feel uncomfortable with that contact, that they become involved with the sexuality of their patients because they know about their privacy, and so on. I start the research study with this model in mind, which has a very strong reference to psychoanalysis, and people speak about those issues, since they cannot tell you something different from what they know and feel, with their own body and their unconscious mind, which you can understand. For example, in our conversations, the female caregivers speak a lot about sexuality, and my fellow sociologists ask me: "Why?" But I did not ask anything about this topic! The topic just comes up! Consequently, I believe that this methodological aspect is very important. If you do not establish that connection with the unconscious mind and subjectivity, these topics will not come up in the research context. Listening to these stories about the world of work is an experience that causes a lot of suffering and distress because people tell you about all the things that do not work well. Under these circumstances, a defensive attitude is humanly expected. For this reason, the methodological dimension of the

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collective and of the multidisciplinary collective as a research method is fundamental: if the research study is conducted only by psychoanalysts or by occupational psychologists, or is based on a specific idea, all these people are too homogeneous to have a contradictory discourse within the group of researchers. The idea is, in a certain way, to create a conflict of interpretations (to fight against our own defenses), which is why we need multidisciplinary research groups.

In this context, the role of language is crucial. In this sense, there are two very important issues regarding the influence of psychoanalysis in the psychodynamics of work. The first issue is the ability to understand that the discourse does not mean exactly what it says, but, at the same time, people never say more than what they actually mean. The second issue considers that knowledge is on the workers' side, not on our side. If I am not prepared to lose all my concepts, there is no possibility of an encounter. It is a risk that we have to take. It is a high risk, but also a pleasure since, as Dominique Dessors said, "*it is like doing trapeze, you will have to let yourself go off the bar sometime*." I believe that this is really important in our research methods.

MW and CR: Thank you very much, Pascale.

FINAL NOTES

a. The psychodynamics of work was developed by Christophe Dejours in the 1980s; they "analyze the dynamics of mental processes mobilized by the subject's confrontation with the work reality.[6]

b. The concept of "care work" was initially developed by Patricia Paperman and Sandra Laugier[7] and refers to the group of activities that respond to the requirements which characterize the relations of caring for the other. In English, there are two terms to describe care: cure and care. While cure refers to the healing aspect of care, the term care is applicable to all the care activities from the beginning to the end of life. Care refers to taking care of the other in the sense of doing, producing certain activities for the maintenance or preservation of the other's life without dissociating the material activities from the psychological work that they imply. Care denotes the strictly affective dimension mobilized by specific activities that need to be done with "tenderness," "affection," or "sympathy." The concept is common to the entire social field as it is applied to child-rearing and household work, as well as, to the specialized care of sick people, whether children, elderly people, and others.

c. Another activity that Pascale Molinier carried out in Buenos Aires, in October 2014, was the lecture "Health and work issues in hospital workers: management culture/care culture. Are they impossible to reconcile?" at the Children's Hospital Dr. Ricardo Gutiérrez, organized by the Health and Work Program at the Departmento de Salud Comunitaria of the Universidad Nacional de Lanús. This lecture was published by the journal Topía[8].

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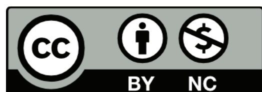

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