

Standing firm on shifting sands

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First, thank you very much for the opportunity to speak to you today. It is a great pleasure and honour to be asked to speak to you all, and on a topic that is a real passion of mine. The nature of keynotes is that they are generally one sided with you just listening to me for the next hour or so, but I am going to ask you do a bit more than just listen. As the conference comes to an end today, I hope my paper might bring a few ideas together, give you some different ways of considering the issues of concern, and stimulate lots more thought as we go back to work next week.

Several decades ago, Mary Reilly (1962) proposed, perhaps quite boldly, that occupational therapy could be one of the great ideas of the 20th Century. While many of us might agree that the sentiment of her claim was completely reasonable and achievable, it is my view that her prophecy has not been completely realised even now as we sit in the 21st Century (Molineux & Baptiste, in press). I think, however, that there is a real chance that we can finally realise her dream. In fact I would go so far as to suggest that it is our *responsibility* to make sure that occupational therapy is one of the great ideas of the 21st Century. There are probably many reasons for why her vision has not been realised, and I will raise some of those with you later, but it is my view that the key reason is that as occupational therapists we have not been able to respond effectively to the changing world around us; that we have not been able to stand firm on the shifting sands.

Now before I go on I want to clarify something so you can see that I am not just being a grumpy, old, awkward academic. First, since being back in Australia I have had the chance to review some of the memorabilia that my parents are still patiently keeping for me in Brisbane. Recently I was looking back over some of my school yearbooks and found the book for Year 12 – no comments on the picture! Now hard as it may be for you to believe looking at that face, many years ago in the United Kingdom I was labelled, publicly, as the antichrist of the profession. You see, some people

think that in being critical of what we do as occupational therapists I am trying to destroy the profession. However, for the record, I am an occupational therapist and there is no other profession I would want to be part of. In fact, I was rather surprised to see that way back in Year 12 the career that I thought was most likely for me, was occupational therapist. So my comments today are shared to give you food for thought in the hope that together we can make the profession as great as it should be.

Why am I so committed to occupational therapy? Well the answer is pretty easy and is best captured in stories about three women in my life – my sister, my grandmother, and a former client. While I could tell you lots about all of them I will share just one story with you. My sister is about two years younger than me and while she never excelled at school she was doing fine, until she started having some difficulties at the end of primary school. They were nothing major, but she was just not achieving as highly as her teachers thought she was capable of, she was distractible, and labelled ‘hyperactive’. Despite all this everyone recognised her as a bright, friendly and intelligent girl and so there seemed to be a mismatch.

Thankfully a keen teacher suggested that Nerida might benefit from an occupational therapy assessment. My parents had

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never heard of one of those before, but nonetheless took Nerida along. When they got home from the assessment, they were very impressed and told me all about it, as they thought I might like to consider it as a career. So I investigated it and spent one week with occupational therapists in Brisbane for work experience. So convinced that it was the right career for me I applied to two occupational therapy programmes, was accepted by both and so my occupational therapy life began.

Of course the story did not end with my sister having regular occupational therapy while she was at school. She did go regularly and it did indeed make a difference to both her achievement at, and enjoyment of, school. Looking back, it is clear that occupational therapy made a difference to her. While we still do not always see eye to eye, as only brothers and sisters can, I can see that Nerida has had, and continues to have, a happy and successful life. She completed school. She left home and lived independently long before I did. She left Brisbane long before I did. She has had a very rich and diverse working life. She always seems to be able to find her feet, no matter what challenges emerge. And she has a caring partner, two fantastic daughters, and many friends.

This is just one of the reasons that I am firmly committed to occupational therapy, and why I think we need to make sure that the profession and our unique view of the world gain greater recognition, so that more individuals, groups and communities can benefit. So it is from that foundation that I critique our profession and challenge all of us to make the most of it.

The changing world around us

As outlined elsewhere being an occupational therapist in the 21st Century is a challenge for a range of reasons, and one of those is the pace of change (Molineux & Baptiste, in press). As I said in the short outline of this paper, it seems almost trite to state that the world is changing rapidly but, *the world is changing rapidly!* To borrow an idea from a great book with some strong links to New Zealand, being an occupational therapist requires a recognition of the complexity of the world within which practice takes place (Whiteford, Klomp, & Wright-St Clair, 2005). More than merely recognising this complexity, however, it is necessary for occupational therapists individually and collectively to regularly scan the practice horizon to identify emerging issues that may impact on practice so that we can be responsive.

As a good occupational therapist following the advice of my learned colleagues I do try to remain aware of what is going on around me, but I recognise that documenting and predicting social trends is a field of study in its own right. As such I am not going to attempt to comprehensively summarise what is going around us. There are numerous sources of this information with each having a particular focus or perspective, and so depending on your particular interest some may be more relevant than others, but one overview is presented by Molineux and Baptiste (in press). While any predictions of what the future might hold are just that, predictions, they can provide much food for thought, and are rich with occupational implications. The crucial question is how can we best respond as occupational therapists? I would

like to propose two possible responses. Please be warned that I am going to be deliberately facetious in some of what follows, and use some beach metaphors in keeping with the sandy theme of the conference.

Occupational therapists: Are we just dunes?

The first possibility is to wait a bit, see what happens and be guided by others. To let prevailing winds blow the sand any which way and form sand dunes... until the wind changes direction again. One could argue that this strategy is quite powerful. It would mean that we could be seen as responsive and flexible. Our colleagues, managers, funders of services, and governments will value our responsiveness and flexibility, they will tell us that, and when they do we will feel warm and fuzzy. Furthermore, and it might be slightly unfair, but this is how the profession has developed to date and it hasn't served us too badly, has it?

It is my suggestion that occupational therapy has, by and large, adopted this *modus operandi* and that while it has led to some benefits it has also caused some significant problems. To examine this idea I want to briefly review the history of the profession to understand where we are at the moment.

Wilcock (2001, 2002) has shown that the roots of occupational therapy reach well before the start of the 20th century. Furthermore, it is generally accepted that the modern profession was formally founded in the United States of America in 1917 when the National Society for the Promotion of Occupational Therapy was established (Kielhofner, 2004). That organisation was founded by a diverse group of people with backgrounds in health and the design and governance of society. They understood that occupation was important for human health. The founders' views were informed either by their own personal experiences of the restorative nature of occupation, or by their experiences of seeing occupation impact positively on the patients with whom they were working. The work of those who became known as occupational therapists was underpinned by several core assumptions: (i) the essential role of occupation in human life, (ii) the link between mind and body, (iii) the belief that lack of occupation could lead to poor health and dysfunction, and (iv) conversely that participation in occupation could restore health and function (Kielhofner, 2004). Early occupational therapy practice was, therefore, focused on providing opportunities for people to engage in occupations. This may have involved people participating in arts and crafts while restricted to a hospital bed, or encouraging long term residents in psychiatric institutions to participate in the daily occupations of washing, cooking, and gardening.

Although the profession retained a focus on occupation for a number of decades after it was founded, the power of medicine in the middle of the 20th Century influenced occupational therapists to reduce the focus of practice to the minutia of body structures and functions. This reductionist approach fitted well with the medical model's concern for diseases of the body, and within physical rehabilitation and psychiatric settings in which many occupational therapists were working. Occupational therapists

soon came to realise, however, that a narrow focus on physical and psychological components often did not enable them to address the occupational needs of their patients and clients, particularly those with long term difficulties (Kielhofner, 2004).

Once the inadequacies of a reductionist view of humans and health were recognised, towards the end of the 20th Century (although it had always been recognised at some level) the profession began renegotiating its professional paradigm and by the start of the 21st Century it had emerged and has been named the contemporary paradigm (Kielhofner, 1992, 1997, 2004). The core assumptions of the contemporary paradigm are that (Kielhofner, 2004);

- humans have an occupational nature
- humans may experience occupational dysfunction
- occupation can be used as a therapeutic agent.

So, it is my argument that as a profession we have allowed ourselves to be blown by the prevailing winds to get us where we are today. We are the sand dunes that change depending on the wind. What makes me say that? Well to explain that we need to dissect what Kielhofner means by paradigm, and to do that we need to return to Thomas Kuhn (1996). In examining the history of science, Kuhn proposed a repeating process of paradigm formation followed by crisis, as a way in which science develops, and that is the way Kiehofner has documented the history of our profession.

Because a paradigm is “an accepted model or pattern” shared by members of the group under consideration, each time a new paradigm emerges it implies a new definition of the field by capturing the shared beliefs of those in the field, articulating the rules, standards and procedures for practice (Kuhn, 1996, p. 23). As such it requires members of the field to view their world from a particular perspective. Reviewing the history of occupational therapy it is clear to see how this has operated. During the reductionist period occupational therapists generally viewed the world from a mechanistic perspective and this guided how they understood the difficulties their clients faced and in turn how they as occupational therapists might work with their clients.

So, using this way of understanding the profession we must assume that occupational therapists view the world in the way described by the contemporary paradigm and that this guides practice (Kielhofner, 2009).

1. All occupational therapists recognise the importance of occupation to health and well-being.
2. All occupational therapists recognise the difficulties people face as occupational problems / challenges, and these are the focus for our practice.
3. All occupational therapists use occupation to improve health status.

What do you think? Are occupational therapists practising ways consistent with the contemporary paradigm?

While authors such as Kielhofner suggest that they are, I think there is sufficient evidence to question the extent to which that is actually true. There is no doubt that there is some fantastic occupation based occupational therapy going on in many places (although we might not hear much about it and perhaps we should share those examples more) but sadly there are too many examples of less than ideal practice.

For instance, I remember visiting a student at an occupational therapy department, somewhere in the world. I arrived at the department and was walking to the office to meet the student. On my way I passed a large room and witnessed an elderly woman dressed in a flowing sari pedaling a pedal fretsaw, with no wood in sight and not even a blade in the saw. The occupational therapist was standing by the client with a stopwatch and clipboard.

What is more I recently heard about one occupational therapist who was addressing the rise in mosquito numbers caused by global warming, and her intervention was to research and source the latest method for killing mosquitoes.

After having a stroke at an early age one man had this to say about occupational therapy; “The part of convalescence that I found most profoundly humiliating and depressing was occupational therapy...” (McCrum, 1998, p. 139).

These are a few rather sobering examples that what is happening in practice might not be entirely in tune with the contemporary paradigm. Another way of exploring the extent to which occupational therapy is within the contemporary paradigm is to consider what is seen as the expertise of occupational therapy. After all, a paradigm includes a profession’s expertise, and our current paradigm is all about occupation and health. As a slight aside, I actually think it is well worth pondering what our expertise is, given that, according to Mosey (1996, p. 10) in order to be “recognised as a profession a group must have “expertise in assisting people to resolve specified practical problems”. So then, what is the expertise of occupational therapists?

In reflecting on the expertise that occupational therapy has we need to add in one contextual factor that must inform our answer to that question. In the current financial climate it is not sufficient, in the eyes of budget holders at least, to propose an area of expertise that is not unique. The argument that “Yes, I know <insert name of another group> can do that too, but occupational therapists do it better” is not going to save jobs. So in reflecting on the issue of unique expertise, I want to consider two commonly proposed areas. The first is equipment.

Many occupational therapists are of the opinion that our expertise lies in our knowledge of assistive devices and home modifications. Some occupational therapists will argue until they are blue in the face that nobody else on the planet can determine what piece of equipment is best nor install that equipment safely. Note that my concern here is not that occupational therapists are not good at ‘doing equipment’ but I question if that is what we want to sell as our unique contribution to society? I am not saying that equipment and modifications are not potentially risky, but when it is merely about the provision of the equipment then that is not

occupational therapy. There are too many examples of a host of companies and individuals who, with the right training and supervision, can and in fact do assess for and install equipment and home modifications.

Consider this real life example from York, where I lived in the UK. This piece in the local newspaper described a scheme in which residents were being trained to use a defibrillator so that they could administer advanced first aid while waiting for the emergency services to reach their remote village. Given this example as just one of many, are we really saying that it requires a four-year degree in order to fit a raised toilet seat? Now before some of you storm the stage and tie me to a stake... hang in there, I do have a caveat to this but you will have to wait.

Secondly, let's turn to what in some countries are called physical modalities. That is the use of wax, electrotherapy devices, splinting, massage, or soft tissue techniques. I find it very hard to consider how occupational therapists can start to argue that as a profession we have expertise in most of these types of interventions. They are not taught in many occupational therapy courses and yet other professions spend large amounts of their entry-level courses devoted to such methods. Now I know that it is possible to take courses after graduation and so some therapists do develop skills and knowledge in a whole range of areas, but just because an occupational therapist can do it, does not mean it is occupational therapy.

So if you have developed skills in an area, why should I feel so strongly about what you do? The answer is that if you are calling it occupational therapy then it is a problem for two reasons.

The first problem with this situation is that it confuses the clients and patients we work with as well as the people who fund our services. Take for example one occupational therapist whose sister was a journalist investigating a range of different health professionals for a magazine story (Gray, 1998). The journalist reported back to her occupational therapist sister that she could see little if any difference between occupational therapy and physiotherapy. Thinking back to when I worked in hospitals or community services, when I visited students on placements, or from just speaking with students about their experiences I can completely understand why the journalist was confused. Sometimes what an occupational therapist does can easily look like physiotherapy, nursing, social work or psychology, for example. Furthermore, sometimes it doesn't just *look* like another profession, it could very well *be* physiotherapy, nursing, social work or psychology.

The second problem is that because occupation and health is an idea whose time has come, pretty soon there is going to be a great deal of work for occupational therapists to do. However, there are not that many of us, and so each one of us has a lot to do if we are to make sure that as many people as possible benefit from our skills and knowledge. Occupation for health is such a powerful idea that all sorts of people are going to be lining up to make sure they get some occupational therapy! So the problem is that while some of us are off doing something that another profession

could do, and in some cases might even do better, there are a huge number of people missing out on occupational therapy.

Now for my caveat... and pay attention because I am going to try and trick you.

You might be sitting thinking that I deserve the title bestowed upon me in the UK many years ago by suggesting that occupational therapists should not be involved in equipment / modifications or a range of very specific and focused treatment methods. I am not suggesting that we should never do those things, but that we should not do them if they are the be all and end all of our services.

- If we are merely installing equipment so that a person can transfer on and off the toilet and that is all we are concerned about then no we shouldn't be doing it.
- If we are merely doing some joint manipulations just to improve range of motion and that is all we are concerned about then no we shouldn't be doing it.
- If we are merely sitting on soft chairs talking about a client's problems doing cognitive behavioural therapy just so they learn some skills and that is all we are concerned about then no we shouldn't be doing it.

All of these could be done equally well, perhaps even better, and probably more cheaply by others.

The only time that any of those tasks, and many other activities should happen within occupational therapy is when they are just one part of an occupational therapy programme. Just one part of an occupational therapy programme that starts with a concern for the client's occupational difficulties, and has as its goal some sort of improvement in or maintenance of occupational performance and engagement. So occupational therapists can do what they want as long as they start by assessing a client's occupational difficulties and plan their intervention with an occupationally focussed outcome in mind.

Agreed? Well not quite!

Around the world many occupational therapists who have been trying to reconnect with occupation have engaged in discussions about the means and ends of occupational therapy. Is it enough to say that as long as our goal is occupational then we can do what we want in therapy? No. I am of the opinion that occupational therapy is defined by the use of occupation to achieve an occupational outcome. Indeed, to use Gray's (1998) terms, it is by using occupation as means *and* ends that we can distinguish ourselves from other health and social care professionals.

One of the mistakes the profession has made is to try to justify the use of any treatment method by arguing that as long as we are aiming at an occupational outcome then it is occupational therapy. This is problematic because in the era of the *International Classification of Functioning and Disability* (World Health Organisation, 2001) many, if not all, professions are being encouraged to focus on participation, activity and health. For example, the Physiotherapists Board of New Zealand

(2009) include the following statement in their explanation of physiotherapy;

Physiotherapy provides services to individuals and populations to develop, maintain, restore and optimise health and function throughout the lifespan. This includes providing services to people compromised by ageing, injury, disease or environmental factors. Physiotherapy identifies and maximises quality of life and movement potential.... This encompasses physical, psychological, emotional, and social well being. (p. 8)

Let's look at that definition a bit. Some of it looks quite familiar – function, impact of environmental factors, quality of life, physical, psychological, emotional and social well-being. They are all concepts, which if you asked some occupational therapists to define occupational therapy would get a mention. So we must recognise that occupational therapy is not alone in our concern with what people do and how that impacts on their health.

Indeed there has been research by some outside of occupational therapy that clearly shows the impact of occupation on health, and this research is not new. In the world of the ICF it is no longer enough to say we focus on participation, function and so on, in order to distinguish ourselves from others. However, the positive side of this is that it is strong evidence that occupation and health is indeed an idea whose time has come. We just need to make sure that we are the ones leading on it.

So here we are with a curious situation.

1. As occupational therapists we define ourselves as experts in the use of occupation to improve / maintain health and wellbeing.
2. There is evidence that many members of the profession around the world are not working in ways that are occupation focused.
3. And yet there is a growing recognition of the significance of what we call occupation for health.

There is evidence that we are not truly within the contemporary paradigm – occupational therapists do not share a view of the world, the difficulties their clients face, and the nature of practice, which is grounded in occupation. How have we as a profession allowed this to happen? What has caused us to be so easily influenced by others? In her seminal work *An Occupational Perspective of Health*, Wilcock (1998) proposed that the fundamental reason that occupational therapy has struggled with its relationship with occupation and health is due to our relationship with medicine. She has outlined several particular features of this.

1. Prescription

As we know from the history of the profession there was a time (and in some countries around the world it is still the case) that occupational therapy could only be provided following prescription by a medical practitioner. It has been suggested that occupational therapists at the time were entirely committed

to the idea of medical prescription because it gave acceptance, purpose, status and pride (Wilcock, 2002). One implication of this is that, Wilcock suggests, for a long time occupational therapy did not need to give much attention to the conceptual or theoretical underpinnings of practice – there was no need to – we just did as we were told.

2. The feminine gender bias

I realise that as a man standing before a room of predominantly women I am in danger of being heckled off the stage, but my cop out is that I am just reporting what a female occupational therapist has said. So don't shoot the messenger! It is fairly well documented in the professional literature that occupational therapy has suffered from the now outdated view of the nature of caring work, and the associated views of women within the male dominated health systems and culture. Indeed, male doctors early in the history of our profession were very clear that occupational therapy was "women's work" (Wilcock, 2002).

3. Striving for professionalism

While there is no doubt that the increasing professionalisation of occupational therapy has brought with it some clear benefits, such as the establishment of educational programmes, it has also been problematic. For example, in the 1960s and 1970s we equated *being professional* to *being scientific*, and so turned our focus to the biomedical perspective at the expense of our unique occupational base.

While it is easy to criticise all of these aspects of our profession's history, each of them has provided some benefit to us. However, I am not sure that enough occupational therapists realise the impact they have all had on our professional psyche – the way we see ourselves and the way that we present ourselves to the world. To move the discussion forward I want to outline a fantastic paper by Tracey Fortune (2000), which in my view summarises what our history has resulted in at the level of practice, and why I am clear that we are not actually in the contemporary paradigm.

Fortune interviewed occupational therapists working in child and adolescent psychiatry in the United Kingdom. In her research she first asked participants to describe the most unique aspect of occupational therapy in their current service, and then presented occupational therapists with a scenario that required them to consider and describe the potential role of occupational therapy in what could be seen as a non-traditional work situation.

She found that the occupational therapists described their potential role in ways that suggested they were filling a gap, and that their practice was devoid of any philosophical touchstone. Their decisions about how they might contribute in the hypothetical situation were dependent on the makeup of the team, the exact nature of the service, and were not related to the occupational therapy profession. To me, this is a perfect example of how we sometimes sink into the quicksand of trying to fit in and feel good about what we contribute.

To rephrase Fortune (2000), it is *paradigm-independent practice* which is the cause of the mismatch between current practice and the history of the profession. A key driver in filling the gaps

seemed to be the sense of identity it gave therapists – they were the ones who did ‘x’. So strong was this need for identity that some occupational therapists seemed to be willing to “take on anything” (Fortune, p. 228). While this role as gap fillers does provide occupational therapists with personal and professional identity within each work environment, it does place the profession in a very uncertain situation. In contrast to paradigm-independent practice is paradigm-dependent practice, that is asserting a professional identity that continually reflects the profession’s core beliefs (Fortune).

And so we finally get to that great phrase – ontological security. Now apart from anything else you get out of my presentation, you will at least get a phrase that you can use anytime you want to bamboozle someone. The sociologist Giddens (1991) coined this term when presenting his view of society. It is based on the idea that in order to feel safe and secure humans need to have a certain level of trust in how we perceive the world and how we respond to it. When responding to situations, in order to ensure that we are responding appropriately we must have a “shared framework of reality.” (Giddens, p. 36). These frameworks provide a “protective cocoon” which allows people to deal with life on a daily basis” (Brown, 2000, p. 63).

There are several ways to achieve ontological security, including what we might call reflective practice, but also through the use of what Giddens called rules, and here I think you can see the link back to Kielhofner’s paradigms. Rules are procedures that form part of our knowledge, which can be generalized, and so used to help guide our action (Turner, 1986). However, rules are not set in stone, and so as much as they provide a common connection between members of a group and guide their interactions, they can be “created, changed, and recombined into different forms.” (Turner, 1986, p. 972)

So here we have an idea, that in my view, has much to offer occupational therapists and hence my question to readers of the *May OT Insight* magazine – how ontologically secure are you (Molineux, 2010)? Do you have a way of seeing your clients, their difficulties and what you can offer them, which you trust and in which you are confident, and is shared with other occupational therapists? Here are some questions to test you.

1. Outside that door is a person, who you have never met, who is going to come in and sit in front of you. Your task is to understand them as an occupational being, identify what (if any) occupational issues they have, and devise an occupation based treatment programme. How confident do you feel that you could make a pretty good attempt at it?

2. You are sitting in a ward round or case conference, and the

doctor turns to you and asks you to explain your work with the client. How confident are you that you could explain your view of your client, his/her difficulties and your planned intervention, drawing on occupation focused theory?

3. If I was to randomly pick 12 of you out of the audience and said we are going to the infamous Christmas Island off the coast of Western Australia to develop an occupational therapy service for people detained there, how confident are you that you could devise a service that was paradigm-dependent and not one that was merely filling the gaps?

I hope you can see that the idea of ontological security is one that might be useful for us a way of stepping back and reflecting on our profession. But then some of you may be sitting there thinking I have lost myself in the sand. However, I think this concept summarises very neatly the problem facing occupational therapy. That is, collectively and individually we lack ontological security. We either do not have a shared view of the world that we can continually fall back on to frame what we do, or we do not trust it, or both. However the answer, to all our problems is easy!

Standing firm on shifting sands

I recently went back to the UK to visit my partner and we spent one weekend in Liverpool. After we had done lots of shopping and eating, we thought we should go further afield and so we headed out of town to see an art installation by the sculptor Antony Gormley. He is known for using his own form in his work, and in the piece now at Crosby Beach outside Liverpool he has created 100 pieces and placed them all over the beach and in the water, stretching for quite some distance along the coast and into the sea. Apart from being quite impressive to see, while on holiday I could not help but draw some parallels between these and the issues facing our profession.



First and foremost, what all of these had in common was a firm and solid foundation that enabled them to weather the waves, tides, and shifting sands around them. For us this is our philosophy. The profession must recognise the need to articulate our professional philosophy and then use that to guide what we do. Drawing on the work of Doris Sym in Scotland, Wilcock (1999) has suggested that once we articulate and commit to a professional philosophy – and her suggestion is ‘occupation for health’ – then we would be empowered to;

Take ‘a long cool look at our particular skills’

Knowing what it was we were about we could take stock of all the various knowledge and skills that we currently try to stuff into many occupational therapy courses or into our continuing professional development activities, and identify what are the

skills and knowledge required to make our unique contribution to society? Do we all need to know the various tracts of the spinal cord, cognitive behavioural therapy, or soft tissue manipulation?

'Concentrate on limited areas'

Being clear about our philosophy it should be so much easier for all occupational therapists to articulate exactly what are the boundaries of our practice. This would put a stop to us adding or discarding areas to our practice based purely on "fashion or self-consciousness" (Wilcock, 1999, p. 193).

'Skillful pruning [would lead] to controlled development'

While some might see some of these outcomes of adopting a professional identity as stifling, that is not the case. In fact, a professional philosophy would allow growth and development, but in a reasoned way. This would address, in my opinion, the problem of paradigm-independent practice. When faced with a new possibility, we could consider what we might offer based on the philosophy, rather than the contextual issues of what is missing, what others are doing, and what might make us feel valued.

So the Gormley figures got me thinking about a professional philosophy, and that would mean a certain degree of uniformity. While some may see that as limiting, I do not, as touched on before. First because I think it might bring an end to every occupational therapist working in different areas of practice, seeing themselves as unique, and describing themselves differently. Are we not / should we all not describe ourselves as 'occupational therapists who are concerned with enabling our clients to achieve and maintain health through the use of occupation'? Wouldn't that increase our sense of belonging and with it our ontological security? Wouldn't that help others better appreciate what we do and why we do it?

That is of course not to say that we would all be carbon copies of each other, just like the Gormley figures. Although each one is a representation of the sculptor's body, he actually used 17 different casts to create them – so there is variation at that level. Furthermore, each one is individually numbered, and so is completely unique. As occupational therapists each client is different, and the contexts within which we work require us to do things *slightly* differently. So let's recognise this diversity but do so with the security of something shared.



As occupational therapists we tend to be quite practical and now some of you might be sitting there thinking "so what can I do?" In conclusion, I want to make some suggestions as to what we can do, individually and collectively, to move towards a day when as occupational therapists we recognise our professional paradigm, are able to articulate it, are able to put it into practice, so that we can stand firm on the shifting

sands around us, safe in the knowledge that we have a strong foundation on which to practice and develop into the future, for the benefit of the people we serve. To achieve this end I would like to present you with three challenges I have presented to the profession elsewhere (Molineux, 2001);

First, demonstrate your commitment to occupationally focused research, education, and practice.

Occupation should permeate all that we do – we must walk the walk; educational courses must be underpinned by occupation, research conducted by members of the profession must include a focus on occupation, and most importantly what we do in practice must be occupationally focused (Molineux, 2001). Now for some, and I know it was the case for me some years ago, it will mean spending time reconnecting with the history, philosophy and growing evidence of occupational science and occupational therapy. However, if we do not have that knowledge, and associated skills, then we will not be able to practice in ways that are occupationally focused.

It is important to acknowledge that part of this may involve educating others about alternative ways of evaluating effectiveness and of delivering services, but these too are vital if our work is to be taken seriously. In addition, when we discuss all of these activities we must use the language of occupation. (Molineux, 2001, p. 94)

This one is not to be underestimated and I have seen the changes in practice, confidence, and perceptions of others this can have.

This may seem an odd challenge, but my experience is that we are too often our worst enemies. Too much of our practice, research and education occurs in areas out of the profession's domain of

concern, and we are often afraid of words like occupation; this must not continue. (Molineux, 2001, p. 94)



Second, reframe all non-occupational therapy examples of occupation into occupational terms.

There are many examples of how occupation can enhance health and well-being in academic and popular literature, and in our own day-to-day experiences. However, it is important to remember that many non-occupational therapists, and indeed some members of our own profession, will not appreciate this and so we must make sure we reframe these into occupational terms. It is only through educating others that we can achieve the wider recognition that occupation deserves. (Molineux, 2001, p. 94)

What some of you will notice, if you haven't already, is that once people 'get it' they really do see the value of occupation, and some of your colleagues may even start to use the language. For example, I know a palliative medicine consultant who has been well educated about occupation, and so has been known to turn to the occupational therapist and say "Can you see this man please, I think he is occupationally deprived?" This is a powerful example of how helping others to understand occupation, can result in greater recognition of the profession of occupational therapy.

Finally, embrace and encourage the wider recognition of the importance of occupation in the lives of humans.

If we start from a base firmly grounded in occupation, as suggested in my first challenge, then we can acknowledge and not feel threatened by the interest being shown in occupation from outside our own profession. We need to hold on to the fact that a wider acceptance of occupation has the potential to benefit society more generally, far beyond the boundaries of health and social care.... We must therefore encourage other disciplines to consider the occupational nature of human beings, and how this may inform their own practice and research. (Molineux, 2001, p. 95)

However, this does not minimise our strength in being experts in both understanding occupation and its impact on health, and how to use occupation to improve or maintain health. Sharing our expertise with others will mark us out as a truly mature profession.

The aim of a keynote is to motivate people and often that motivation can be fuelled by two things. I hope that what I have done for some of you at least is to encourage you and give you a shot in the arm that this is a fantastic profession and we are at a key point in our history with opportunities to make huge leaps forward. Some of you might, however, disagree with what I have said and so you may be motivated to prove me wrong or start a debate. Either way, I hope I have given you all a few things to think about for this last day of the conference, and into the future.

To summarise, occupational therapy has so much to offer and we must make Mary Reilly's claim come true. Let's make occupational therapy one of the greatest ideas of the 21st Century. To do that, we need to recognise that unless we stand firm on the shifting sands around us, then meeting that challenge will be difficult.

The only way that we can do this is to articulate our professional philosophy and put it into practice. Are you up to the challenge?

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