Part I

Background to occupational therapy, and philosophy of occupational therapy and emergence/re-emergence of occupation-focused practice

Part One of this book is designed to open up the discussion about who we have been as occupational therapists, who we are currently and what could be the core strategies and approaches to lead us into the future, building on the essential ‘fit’ between academic studies and fieldwork education in the preparation of our graduates.

As most practitioners who have graduated from an occupational therapy education programme within the past two decades know, the roots of the profession were laid within the moral treatment era of the nineteenth century. Some may also know that in the mural art of Ancient Egypt were depictions of women helping others to rid themselves of foul humours through the use of activities such as playing a lyre, working on canvas and weaving on wall looms. Wherever we each believe our profession originated, one thing we all know is that somehow somewhere in the middle of the twentieth century we seemed to lose our way. In committed attempts to fit into the medical model and the reductionist thinking of the 1970s, occupational therapy relinquished its hold on occupation, and joined the movement which focused on curing, healing and ameliorating that stemmed from the perceived importance of impairment as the central construct.

One of the initiatives that has shown particular growth is the intentional strategy of integrating fieldwork education into the academic mission rather than seeing it as something that stands alone and exists in isolation at the end of study. Some settings have organised fieldwork to occur during discrete time periods such as full semesters or within a full academic year, thus creating an isolated set of experiences rather than an integrated evolution of each student working towards competence at an entry-to-practice level.

There is a distinct commitment within the current climate to create models for occupational therapy practice that are centred around ‘occupation’ as the core construct, using client-centred and person-centred philosophies to establish partnerships between clients and therapists. There have been steps taken to move away from settings that are formed around a medical model and a few eager pioneers who have chosen to explore new territory and not be constrained by what has been or what is; they seek to uncover what can be.
Chapter 1

Emerging occupational therapy practice: Building on the foundations and seizing the opportunities

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Introduction

Several decades ago, Mary Reilly (1962, p. 3) proposed, perhaps quite boldly, that occupational therapy could be one of the great ideas of twentieth-century medicine. Although we might now argue about the way she located occupational therapy within medicine, it is probably true that many occupational therapists would agree that the sentiment of her claim was reasonable and achievable. The extent to which her prophecy has come true varies between countries, and perhaps even between different locations and organisations within countries. For example, in some countries where occupational therapy is relatively new, occupational therapists tend to work within health systems dominated by a biomedical view of humans and health, and may in some instances have their interventions directed by a medical practitioner. Even in countries where the profession is well established, some healthcare systems or organisations are so biomedical in their outlook that occupational therapy practice is narrowly focused and limited. However, there are also a growing number of examples of occupational therapy practice which are contemporary, innovative and effective at meeting the needs of individuals, groups and communities to achieve and maintain health through occupation, and this book provides a few examples of this work. Nonetheless, there is more work to be done by the occupational therapy profession until we can feel comfortable that Mary Reilly’s challenge has been fully met.

This chapter aims to set the scene for occupational therapists and occupational therapy students as they contemplate and engage in practice which is non-traditional and so might be viewed as emerging. The chapter will begin with a brief reminder of the history of occupational therapy, with a particular focus on what constitutes contemporary occupational therapy practice. This will include the suggestion that when contemplating new and emerging practice areas focus should be shifted from a concern with what role can occupational therapists play in this area to a concern for what could an occupational perspective of humans and health offer. The chapter will then move on to briefly consider some of the many changes in the world, in order to begin to understand the changing nature of the practice context. The chapter will end with a section that proposes a framework for occupational therapists and occupational therapy students when contemplating developing practice in new areas.

Contemporary occupational therapy

The history of occupational therapy is now very well documented with Kielhofner (2004) providing a particularly useful overview. Briefly, Kielhofner (2004) traced the history of the profession from the moral treatment movement in the eighteenth and nineteenth centuries to the current time. He showed how the profession has undergone a recurring process of paradigm–crisis–paradigm. For example, in the first 40 decades of the twentieth century the profession’s paradigm was one focused on occupation. This was influenced by the core constructs of the Moral Treatment Movement and recognised, for example, that occupation was essential in human life and influenced health, and that occupation could be used to restore function lost due to disease, illness or accident. A crisis occurred when the profession was pressured by medicine to develop a more scientific basis for practice. As a result, the mechanistic paradigm emerged and so practice focused on repairing or compensating for elements of the human system that were dysfunctional or absent. When the mechanistic paradigm was recognised as not meeting the needs of people with chronic conditions or permanent impairments, another crisis ensued and resulted in the emergence of what Kielhofner (2004) has called the contemporary paradigm.

The contemporary paradigm includes a number of core constructs which at face value seem clear to occupational therapists, but which may be difficult to operationalise. The three core constructs of the contemporary paradigm are that humans have an occupational nature, the difficulties humans have in participating in occupations are the focus of occupational therapy and the defining feature of occupational therapy practice is that “engagement in occupation is the basic dynamic and core of therapy” (Kielhofner, 2004, p. 68). Although a cursory comparison of the paradigm of occupation and the contemporary paradigm might lead one to believe that there has not been much change, this would be incorrect. Indeed in some ways, this is the root of many of the problems occupational therapy faces; the “change may appear subtle, but its significance is not to be underestimated” (Molineux, 2004, p. 3).

The current paradigm reminds occupational therapists that we see the world differently from others, and therein lies our uniqueness. This is particularly important to recognise, as the world we live in is dominated by the biomedical perspective. In fact, the biomedical perspective has become so dominant, perhaps without some people realising, that it is the folk view of humans and health (Engel, 1977). Of course, the biomedical perspective is extremely useful and has been, and continues to be, of enormous benefit to humans. The advances in the diagnosis, treatment and prevention of many diseases have improved the lives of many throughout history. Wade and Halligan (2004) have usefully summarised the assumptions which are generally characteristic of a biomedical perspective:

- Illness/disease is due to an underlying abnormality of the structure or function of the body
- Health is the absence of disease
- The patient is a passive and ideally cooperative recipient of treatment.

Although the medical field is beginning to recognise some of the problems inherent in this perspective, it continues to dominate health care systems and the professions
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which work within them. Of concern in the context of discussions about occupational
therapy is the extent to which occupational therapists acknowledge the subtle and perhaps
unrecognised influence a biomedical view of humans and health has on the development
of the profession. After all, it has been recognised for some time now that the biomedical
perspective is at odds with the way occupational therapists view humans and health
(Rogers, 1982), and that this close alliance with medicine has been detrimental to the
development of occupational therapy practice and the knowledge which underpins it
(Wilcock, 1998). It is also responsible for the dilemma faced by many occupational
therapists in practice, that is, being “torn between a concern to ‘treat the whole person’
and a concern to be credible within a medical world” that requires services to be defined
within biomedical terms (Mattingly & Fleming, 1994, p. 296). Given that the outward
manifestations of paradigms are inherently difficult to explicate and observe, a clear
articulation of how practice might be different continues to be difficult, although there are
examples in the literature.

Some might suggest that despite working within systems dominated by biomedicine it
is possible to superimpose an occupational perspective. For example, Spencer et al. (1996)
have provided an example of how one might overlay an occupational perspective onto a
biomedical one. They suggest that following the onset of disability or illness “persons
must consider which occupations they can continue to perform as they have in the past,
those they can continue to perform but in new ways, and those that they may not be able
to perform at all” (Spencer et al., 1996, p. 531). Although this is a useful framework and
goes some way towards ensuring that an occupational perspective can be operationalised,
it is nonetheless problematic. Despite recognition of changing occupational performance
and engagement, the proposed framework has as its central organising construct disability
and the underlying impairment. As such, it runs the risk of adopting a deficit orientation
and may not recognise the way in which challenges such as illness and disability can bring
positive benefits for some people and their carers (e.g. Schwartzberg, 1996; Heward et al.,
2006). Nonetheless, it is one way that some occupational therapists might find useful,
particularly perhaps when working in hospital environments.

The Well Elderly Study conducted by occupational therapy and occupational science
researchers at the University of Southern California is an example of how an occupational
perspective might be translated into practice. In this project the intervention group received
a nine-month programme of individual and group sessions delivered by an occupational
therapist (Clark et al., 1997; Jackson et al., 1998; Mandel et al., 1999). The participants
were a group of culturally diverse older adults living in the community, and so from the
start the focus was not on people with disability, but on maximising health. Furthermore,
the initial modules of the programme focused on facilitating the participants to understand
themselves as occupational beings and the relationship between occupational engagement
and their health. Although the programme did include some techniques that might be seen
as traditional occupational therapy, one of the key reasons proposed for the programme’s
effectiveness was that it explicitly adopted an occupational perspective (Clark et al., 2004).
One simple example of this is that a module within the programme was called ‘dining as an
occupation’. A more traditional programme might have focused on the nutritional aspects
of eating and perhaps the practicalities of cooking, including energy conservation and the
use of assistive devices. In the Well Elderly Study, this module, as the title suggests, took a
much broader view to include all the associated tasks and also the myriad of meanings that cooking can have for people and how these are expressed during all stages of preparing for, engaging in, finishing and reflecting on a dining experience.

In addition to the return to placing occupation at the centre of occupational therapy practice, occupational therapy and occupational science have introduced new concepts that also provide a guide to developing future practice. Occupational justice is one such concept that broadens the potential scope of occupational therapy practice, but perhaps more importantly shifts the focus away from the need and desire for occupational therapists *per se* to have a role, towards a recognition that the ideas inherent in an occupational perspective of humans and health are valuable perhaps without any direct intervention by occupational therapists.

Occupational justice was developed by Wilcock and Townsend (e.g. Wilcock & Townsend, 2000; Townsend & Wilcock, 2004) and has received much attention in the literature. Grounded on a recognition of humans as occupational beings, occupational justice is “the promotion of social and economic change to increase individual, community, and political awareness, resources, and equitable opportunities which enable people to meet their potential and experience well-being” through occupational engagement (Wilcock, 1998, p. 257). Put simply, occupational justice is concerned with creating a world in which all people have the opportunities they need to meet their needs to achieve and maintain health through occupation. Importantly, it is not about all people having the same occupational experiences. It is rather a “justice of difference that enables the prerequisites of life to be obtained according to needs, matches meaning with competence, and value with capacity and opportunity” (Wilcock, 2006, p. 247). Although this may seem a significant shift of focus for many occupational therapists, it is worth remembering that in fact the early profession was concerned with broader social issues and so this is a returning to our roots (Wood et al., 2005). Although the precise ways in which occupational justice can be translated/incorporated into practice are still being explored there are some examples (Townsend & Wilcock, 2004; Nilsson & Townsend, 2010). It is the case, however, that working in this way requires therapists to engage in broader dialogues and consider working at different levels of social systems.

In summary, currently occupational therapy finds itself within the contemporary paradigm with a growing recognition of the importance of occupational justice, and therefore must reflect on what this means for practice. A review of the underlying assumptions hint at a subtle yet significant change that brings occupation back as the central concern of occupational therapists and therefore as the organising concept for all aspects of practice. As such, it is not just a tool to be used in practice, but a whole new way of seeing the world. Indeed, it may require “a re-education into the new world view” so that occupational therapists “come to see the world with a ‘new gestalt’” (Kuhn, 1970, p. 112).

**The current world of health and social care**

Being an occupational therapist in the twenty-first century is a challenge for a range of reasons. Although not the focus here, the pressures of daily practice are just one example of what occupational therapists must contend with, and unfortunately these
Emerging occupational therapy practice may mask the bigger picture. To be an occupational therapist, and indeed any type of professional, requires a recognition of the complexity of the world within which practice occurs (Whiteford et al., 2005). More than merely recognising this complexity, however, it is necessary for occupational therapists individually and collectively to scan the practice horizon regularly to identify emerging issues that may impact on practice. This may reveal signs that a particular approach to practice might become less appropriate, as was the case when, for example, the trend in acute health care systems was for shorter hospital admissions. This required occupational therapists to review practice, as it was no longer realistic to rely on an extended period of inpatient intervention with clients before they were discharged into the community. What is more exciting are the new opportunities that might present themselves as society changes.

In order to be responsive to the changing context of practice, it is necessary to be aware of trends and developments within society. 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. Given the complexity of the issues and diversity of views, it is inappropriate to attempt to provide a comprehensive overview here. Rather, a taste of different views will be presented in an attempt to raise awareness about how important it is for occupational therapists to remain abreast of socio-cultural developments and trends.

Reporting on the most recent McKinsey global survey, Beinhocker et al. (2009) highlight a number of trends and how the recent global financial crisis has impacted on them. Although many have recognised for a long time that globalisation is a driving force in many aspects of human experience, the McKinsey survey suggests that this may not be as clear cut as previously thought. For example, it is thought that although the globalisation of goods and services will continue it is likely to stall due to the reduction in international trade, and this will also be the case for the previously mobile workforce if governments tighten immigration (Beinhocker et al., 2009). It is almost certain that boundaries will be placed on financial globalisation, given the vulnerabilities highlighted during the global financial crisis (Beinhocker et al., 2009). Related trends identified include a reducing trust in big corporations resulting in greater control and loss of flexibility of businesses, thus demanding increased government involvement in business (Beinhocker et al., 2009). Others have identified other trends to include the rise of the power of spirituality, capitalism with a conscience, consumers driven by values and the importance of social responsibility (Aburdene, 2005).

Interestingly, the Institute for the Future (2007) has documented how some of these trends might manifest at the level of individuals. For example, in the area of health and sustainability, people might use public transport more, participate in community health and well-being projects, recycle and buy recycled goods. In the health economy, people might seek out the health benefits in a range of goods and services, including food, clothing, furniture, outdoor spaces and holidays. Living a healthy lifestyle might mean having a clean home, spending time with friends and family, spending time outdoors and avoiding stress and maximising mental health. In what the Institute for the Future labels ‘extended self’ lies powerful insights into the beliefs people have about themselves and others. For example, personal networks might include hundreds of people spread throughout the world, people might redefine life stages as more than a chronology, and
that people need to process larger amounts of information more quickly in order to interact effectively. Although only a taste of what might be, these few examples open up a number of opportunities for using an occupational perspective to support people in these new ways of living.

From this cursory overview of just a few sources and merely from living in the world ourselves, it is clear that both the pace and magnitude of change are great. Although we should continue to be aware of what futurists and others (in fields well beyond occupational therapy and health care) have to say about our changing world, as a profession occupational therapy must be clear about what it has to offer the society and to explore frameworks to guide the development of the profession and the practice of individuals to ensure it can meet the ever-changing needs of individuals, groups and communities.

Bringing it together

People respond to change in different ways, and so for some the changes in the world, and health and social care may appear daunting. However, these changes offer huge potential for occupational therapy to break out of the confines of traditional health and social care and finally be one of the world’s great ideas and so rise to the challenge set by Reilly (1962). In order to move towards this future it is necessary for occupational therapists to recognise that they are members of a profession, and to reflect on what that means. A profession is a group “recognised by society as having expertise in assisting people in resolving specific practical problems” (Mosey, 1996, p. 10). In this, it is implicit that the practice of the profession is based on largely intellectual operations for which the individual professional has responsibility, practice is based on science and learning and has a practical and definite end that is of benefit to society (Flexner, 2001).

What then is the focus of occupational therapy’s contribution to society? Although all occupational therapists could no doubt describe the fine detail of their practice, it is noteworthy that apart from the work of the Canadian Association of Occupational Therapists over the years (Canadian Association of Occupational Therapists, 1991; Townsend & Polatajko, 2007) there is no “simple generic occupational therapy philosophical statement that everyone in the profession learns and uses” (Wilcock, 2000, p. 82). This means that at times the profession may appear fragmented and disjointed and this has been accentuated over the years as therapists move into increasingly specialised areas of practice. Although some may argue this is not a problem for practitioners in more traditional settings (although many of those practitioners will recognise it is a problem for them as well), this situation is particularly problematic when it comes to exploring new and emerging areas of practice. For example, how would an occupational therapist determine the scope and boundaries of practice in a novel practice area?

Fortune (2000) explored this in her study exploring the extent to which occupational therapy practice in child and adolescent mental health was occupation focused. One part of her interviews with occupational therapists included asking them to respond to a hypothetical scenario about what they might offer if working in a community youth centre. One of the findings from the study was that for some participants their response to this
hypothetical scenario was “devoid of a philosophical reference to occupation” (Fortune, 2000, p. 227). These therapists suggested that their contribution to the team would be dependent on their colleagues, their clients and the practice context. This study provides a powerful example of the problems (Wilcock, 1999) identified by occupational therapy not having a professional philosophy.

In her paper, Wilcock (1999) highlighted that occupational therapy did not have a shared professional philosophy and that this caused three problems. First, without a philosophy it is not possible to identify the core skills required to practice occupational therapy and what are peripheral, or perhaps even inappropriate, skills and techniques for occupational therapist to employ. Second, because of a lack of shared understanding of the boundaries of practice, what occupational therapists do and the way they describe their practice tends to be quite concrete and focused at the impairment level. Because of this it could be difficult to see how a therapist working with someone following a hand injury is similar to another therapist working with someone who is a refugee. Although the practicalities of therapy might be very different, use of a common language arising from a professional philosophy would enable the shared focus on achieving and maintaining health through occupation to be recognised. Third, without a professional philosophy the future development of the profession runs the risk of being ad hoc, disjointed and lacking in coherence. All these problems mean that working in new and emerging areas in response to a changing world and the emerging needs of individuals, groups and communities can seem daunting. Wilcock (1999) suggested, not surprisingly, that the philosophy of occupational therapy should be one of occupation for health. She also provided a framework which can be used to consider what contribution an occupational perspective of humans and health can offer in any setting.

In the first edition of her seminal work An Occupational Perspective of Health, Wilcock (1998) proposed two triangles to understand the occupational factors that lead to health/well-being and ill health. The triangles demonstrate how disease, disability and death (Figure 1.1) and health and well-being (Figure 1.2) can be understood by exploring the underlying occupational influences. The strength of these frameworks is that they make it possible to move beyond the level of the individual person (the second highest level on each triangle) to consider the range of institutions and factors which act to influence an individual’s state of health or ill health. Viewing health issues in this way, occupational therapists can, perhaps for the first time, begin to consider the ways legislation, fiscal policies, the media, and the structure of health and education systems influence occupational engagement and therefore health. Further still, they bring attention to the way underlying occupational factors such as the type of economy, national policies and priorities, and cultural values give rise to particular occupational institutions that then shape occupational engagement.

Many occupational therapists continue to be located within health and social care systems and so mostly only work with people once they are experiencing a health disorder (the second highest level in Figure 1.1). Using Wilcock’s triangles, therapists in these situations can reflect on their clients’ experiences and contexts to gain a deeper understanding of the forces which have led the client to require support from health and social services. As such, it can only strengthen the therapist’s ability to work in a client-centred way and thereby maximise the beneficial outcome of the therapeutic partnership.
More exciting, however, is how seeing health in this way opens up a myriad of new opportunities for occupational therapists to influence the health of not only individuals but whole communities, regions and even countries. For example, imagine the impact an occupational therapist could have by working with, or even within, popular media to shape the messages conveyed through advertising. The result might be an advertising campaign which sends the message of the health benefits of occupational engagement. It might also mean a change to advertising and broadcasting standards to ensure that diversity is represented more often and more positively, so that prevailing stereotypes are
challenged and stigma reduced. Similarly, in countries with financial benefit programmes for people who are unemployed what might an occupational perspective bring? People with low incomes are at risk of occupational deprivation due to the costs associated with many occupations in capitalist societies, and so an occupational perspective might lead to an increase in benefits, a greater range of free or discounted occupational opportunities, or more occupationally orientated vocational training and support programmes.
The power of an occupational perspective in addressing the broader social issues facing the world has been recognised within occupational therapy, but the focus on ill health and the limits of a biomedical perspective have restricted the profession developing into non-traditional areas. This has begun to change. For example, several books provide many examples of how adopting an occupational perspective can open up opportunities for enhancing health through occupation (Kronenberg et al., 2004; Pollard et al., 2008). Similarly there is a small, but growing amount of research which explores and documents the impact of an occupational perspective with a wider range of individuals such as young people at risk of gang involvement (Snyder et al., 1998) and older people living independently in the community (Jackson et al., 1998; Mountain et al., 2008). More recently, a special issue of the *American Journal of Occupational Therapy* focused on social justice and health disparities and demonstrated a range of innovative ways an occupational perspective can be applied. For example, in their paper Blakeney and Marshall (2009) examined water quality. Although the occupational implications of water quality might not be immediately apparent, this study showed that poor water quality resulted in residents experiencing occupational imbalance, occupational deprivation and occupational alienation. Research such as this opens the doors for contributing an occupational perspective towards work on achieving the United Nations’s (2008) Millennium Development Goals, which includes access to safe drinking water within the targets of one goal.

Ultimately, unless the profession of occupational therapy takes a stance on viewing changes in the world and the impact of these on health and well-being, occupational therapy will continue to follow studiously in the shadow of the other professions. If this is the case then the promise of occupational therapy will not be realised. Through articulating, implementing and sharing the unique occupational perspective with the aim of achieving occupational justice the profession can contribute positively to society.

**Conclusion**

This chapter has provided a broad overview of occupational therapy in the context of the changing world that the profession and individual occupational therapists exist within. For many years now, and for many more to come, occupational therapy will be influenced by a whole range of social, cultural, political and financial pressures (just to name a few). Although some may see this ever-changing world as threatening, it needs to be recast as a time of great possibility. Although there are, without doubt, some very real threats to the profession and the potential contribution it can make, we must turn to our unique professional perspective for security. It is only by engaging with an occupational perspective of humans and health, and then translating that into the vast array of practice opportunities that are out there can we meet the challenge set by one of the profession’s leaders. To paraphrase Reilly (1962), occupational therapy *must* be one of the great ideas of the twenty-first century. It is our professional responsibility to make sure it is, simply because there are so many individuals, groups and communities who experience occupational injustice, and so many more who are at risk.
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References


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