Will occupational science facilitate or divide the practice of occupational therapy?

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Background: *Prompted by a study day at last year's European Network of Occupational Therapists in Higher Education conference, this article explores the relationship between occupational therapy and occupational science in the context of the future development of the profession.*

Content: *The authors consider some of the challenges currently being expressed within occupational therapy, particularly the move to define the profession in terms of its 'origins in social transformation', and the difficulties arising from its position in relation to a biomedical hierarchy.*

Conclusions: *The authors conclude that occupational science may have much to offer but this underpinning knowledge base is not without additional challenges for a profession which is concerned with aspects of doing.*

Key words: ■ everyday life ■ everyday life ■ occupational science ■ occupational therapy ■ rehabilitation

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The professional practice context of occupational therapy is developing and expanding. The recognition of cultural and other aspects of social diversity is driving the agenda for practitioners, educators and researchers, but the definition of occupational science, as well as the constantly evolving focus of occupational therapy, appear to generate difficulties in the symbiosis between research and its application in practice. Occupational science actually emerged from occupational therapy, when it was recognized that there was a need for 'the study of the human as an occupational being, including the need for, and capacity to engage in and orchestrate, daily occupations in the environment over the lifespan' (Yerxa et al, 1989: 6). Occupational therapy is described by its international governing body, the World Federation of Occupational Therapists (2009), as 'a profession concerned with promoting health and well being through occupation [whose] primary goal … is to enable people to participate in the activities of everyday life'. Occupational science then, has a far wider remit than occupational therapy, although the profession is able to draw on the former as a knowledge base.

The relationship between science and profession contains questions which require some critical exploration. In a conference of educators and students of occupational therapy, Jonsson (2008) was quoted as saying that 'occupational scientists research, while occupational therapists practice'. This article is the response of the authors to this statement, and our professional position on this issue of professional identity that has been concerning the field of occupational therapy for two decades. This article discusses the relationship between occupational therapy and occupational science in the context of the future development of the profession. The origins of the profession and the alliances it established are outlined before exploring some of the challenges currently being expressed within occupational therapy. The article concludes with revisiting the question posed in the title and discussing the potential contributions of an occupational perspective in developing culturally and politically savvy occupational therapists.

What is occupational science, and how does it relate to therapy?

Occupational science is essentially about studying what people do (Wilcock, 1991), an interest the emerging discipline shares with sociology, cultural studies, anthropology, psy-

chology, history and other disciplines. The study of occupation entails interdisciplinarity and its scholarship is characterized by diversity (Hocking, 2000). This can either work well, harnessing the strengths of several disciplines to the task, or work incoherently because many of the concepts they appear to share are used inconsistently. For example, Iwama (2006) has explored how occupation may not be interpreted in the same way across different cultures, and occupational therapy itself is not always clearly understood by other health and social care professions, let alone the general public. These issues have an effect on the uptake of interventions and their success in defining and meeting occupational outcomes in treatment (Wilcock, 2006).

The history of occupational therapy reveals a complex set of alliances and tensions in the evolution of the profession which centre on its relationship with medicine (Frank and Zemke, 2008). These multiple alliances can compromise occupational therapy's claim of patient-centredness. The tension between the patient's needs for activity or a specific intervention and the therapeutic programme to which patients are expected to comply, is recognized as one of the vehicles for occupational engagement (Creek, 2007). But this presents a difficulty: the skills of the occupational therapist arise through a gap between what the patients may feel they need and what may have been prescribed. Some patients, and sometimes their carers, cannot express what they may think is needed, and in any service it may be economically necessary to set a reasonable limit to the identification of their needs. The occupational therapist becomes a mediator of a practical intervention, a negotiator within a large and complex system over which neither he/she, nor the patients, nor their carers, have control (Creek, 2007; White, 2007).

This importance of the negotiation process is something which has recently been given new emphasis in occupational therapy literature, with the concern that occupational therapists need to develop their capability and credibility to fulfill this mediation role more effectively (e.g. Kronenberg and Pollard, 2005a, 2005b; Lawson Porter and Pollard, 2006a, 2006b; Pollard et al, 2008a, 2008b). However, occupational scientists, such as Wilcock (2002, 2006) and Hocking and Nicholson (2007) have discussed how the profession lost its sense of purpose as it tried to meet biomedical directives; others have reported the difficulties of developing and sustaining evidence for interventions given the highly individual and pragmatic nature of occupational outcomes, and the need to work with available resources. The consequences are that while there are ethical standards of practice, what is actually possible may be difficult for the profession to effectively express (Creek, 2009).

Pollard et al (2008b) argued that many factors compromise the ability of the profession to exercise the power required to facilitate and enable service users, and also the profession itself. They give examples such as its perception as a feminine profession, and so less empowered in the male dominated health and social care hegemonies; the lack of focus and consequent impact on expressing professional identity – dilution, isolation and erosion of the profession through generic pressures, and the survival tactic of 'fitting in', sometimes resulting in a perception of occupational therapists as unskilled. For all of these claims there will be many valid counter-assertions, but the intention of this discussion is to query, rather than be self-congratulatory. Many occupational therapists are concerned with working to reposition the profession to better recognize its role in preventative health, wider social needs such as vocational rehabilitation and community-based rehabilitation, and to better realize the occupational paradigm at its core.

ALLIANCES AND ASSUMPTIONS IN OCCUPATIONAL THERAPY

Occupational science authors often point to occupational therapy's origins in social transformation in the first two decades of the previous century. Frank and Zemke (2008) however, trace how the profession came to neglect its activism quite early on as Eleanor Clarke Slagle campaigned for its acceptance in the health services. They point out the influences of Jane Addams, a founder of Hull House, Julia Lathrop, a prominent charity worker, and the psychiatrist and neurologist Adolf Meyer – all social reformers who appear to be Slagle's mentors (Frank and Zemke, 2008). However, the use of occupation as a rehabilitation medium was the central idea that emerged to shape practice, shorn of its links to a social reform agenda. The pioneers of the new discipline and orthopaedic surgeons recognized the potential and need for occupational therapy to contribute to the rapidly evolving military demands for the rehabilitation of combatants during America's entry into the First World War. According to Frank and Zemke (2008), Slagle was able to position herself to make the most of political opportunities to

advocate for the new profession and to develop it within the US health care context of the interwar years.

Frank and Zemke (2008) point to a significant event after the war, when the Vocational Rehabilitation Act of 1920 put into law the outcome of a dispute between the US Surgeon General and the Federal Board for Vocational Education. This had the effect of 'drawing a sharp line between 'medical' and 'vocational' rehabilitation' (Frank and Zemke, 2008: 125). It seems that as the profession sought to clarify official recognition and legitimacy in the early 1920s alliances were developed with the powerful but conservative medical profession. Frank and Zemke (2008) suggest that the social reform agenda was consistently opposed by the American Medical Association, and consequently the approach to occupational therapy which was mostly exported to the rest of the world was restricted in its scope to rehabilitation.

However, occupational therapists have described themselves as advocates for their patients, creating therapeutic spaces away from the busy acute environment, and have assumed a mantle of patient centeredness. While Pollard et al (2008b: 29) have called for an 'alliance with patients', this was something the pioneers of occupational therapy had already engaged with at the beginning of the last century (Frank and Zemke, 2008). While Hammell (2007) queries the avowal of patient-centeredness because of the limitations imposed on it through restricted resources, other investigators have discovered that some occupational therapists lack insight into patients' physical treatment needs, bringing both the assumption of patient-centeredness and their clinical reasoning into question (Rassafiani et al, 2008a). A principle factor in the ability to determine appropriate interventions is the level of clinical experience (Rassafiani et al, 2008b).

Sometimes, perhaps in consequence of factors like these, the occupational therapy role has been more about enacting the restriction than facilitating the patient (Pollard et al, 2008a). In response, Frank and Zemke (2008) have called on occupational therapists to recognize the complexities of social transformation and to seize the power of occupation to work for change. Hammell (2009), however, is in the process of setting out challenges to many of the assumptions that underpin occupational therapy and occupational science. These suggest that the power of 'occupation' has to be critically re-examined from perspectives othre than its narrow 'middle-class' base. Occupational therapists are outnumbered by people on lower incomes than themselves, whose aspects of their daily lives, such as work and where they live, carry a strong certainty of industrial illness and related disability. They may have 'a meaningful and purposeful occupation', but they will also have very different perspectives on the power of occupation for health or social change. Creek (2009) argues that the expert occupational therapist is capable of reaching across such social divides because of his/her ability to incorporate patients' perspectives, but that the profession has a tendency to seek general formulae to explain itself in convenient models and theories. These are divorced from practical contexts and belie their complexity.

BARRIERS TO OCCUPATIONAL SCIENCE AND IDENTITY CONFUSION

Occupational therapy has been criticized for its uncritical sense of professional obligation to meet the demands of a dominant orthodoxy, whether this is biomedical (Wilcock, 2002), financial restriction (Hammell, 2007) or from within its own ranks, with, for example, the protestations of all-encompassing patient-centredness (Hammell, 2009). Occupational therapy has not struggled to find a role so much as struggled to keep its borders, e.g. present demand for generic work on the one hand, a rise in specialization on the other.

This concern of the profession with itself belies its stated aims of patient-centeredness. The rediscovery of social transformation as a core principle of the profession may be another symptom of self-preservation: occupational therapists can argue that a society of social isolation, occupational deprivation and injustices and poverty, requires the development of social capital through occupation. Social capital is part of a number of concepts including knowledge and cultural capital describing assets which can relate to economic position, but also depend on individual capacities for networking and cooperation with others – doing, being, becoming and belonging (Wilcock, 2006).

A key core around which occupational therapy and occupational science could maintain a complementary dynamic is the exploration of political strategies and tactics to facilitate the development of social capital through opportunities for occupation (Pollard et al, 2008c). But many service users lack social capital. Occupational therapists could try and develop

an agenda by which practitioners (and educators) articulate the need for forms of occupation which will promote local projects to benefit communities and enhance the social capital of marginalized groups. Many occupational therapists are already doing this, but even this has to be proposed in ways that allow cost saving targets to be achieved. Occupations that are self-sustaining and health giving are justifiable because they are less costly than other forms of intervention. Achieving human dignity through occupation, the old patriarchal adage of moral therapy, appears good because it is cheap. This might be a timely issue since, according to the recent Wanless Report (2007), despite investment and increases in both private practice and the range of agencies operating in care around the National Health Service (NHS), its productivity is reduced.

Even in the pursuit of social transformation, occupational therapists are cautious about how they advocate change, fitting it into the dominant agenda. This is partly because the lack of theoretical scholarship in the profession has not equipped it to mount robust arguments for change (Hammell, 2009), while the pursuit of models, theories and procedural approaches appears to have led practitioners to doubt their own practical expertise and fail to appreciate its complexity (Creek, 2009). In the UK particularly, the climate of change in the NHS has also fed a leviathan of conservatism in occupational therapy, in which people want to stick to practices they know because they offer security – a defensive attitude noted across the NHS (Cortvreind, 2004). Some, though by no means all, practitioners try to persuade new entrants to be clones of themselves rather than be agents of change. It is understandable – there has been too much apparently faddish and 'decontextualised' change without regard to the real needs of patients or understanding of the purpose of occupational interventions, driven through 'mechanistic' central policy-led initiatives (Creek, 2009: 47). These have resulted in significant and chronic demoralization among clinicians, and there is a general culture of risk aversion stifling practice innovation across the service (Hewison and Griffiths, 2004; Morgan, 2007). This could stand in the way of allowing new people coming through, to develop the profession through their networks in the community to facilitate change, rather than replicate existing practice.

Creek (2009) argues for clarity in all this muddle. She demands a profession that is focused on its purposeful and practical core, and which builds transformative situations with its patients. She asks for these situations to be developed in ways that are sustainable through the exchange and transfer of skills. Even though, in present circumstances, they are buried under a fog of problems, Creek (2009) asserts that occupational therapy is able to take account of the abilities patients may have and enable them to realize their capacities.

ADJUSTING OCCUPATIONAL THERAPY'S VIEWPOINT

The evidence for practice changes could come through occupational science to future-proof and to realize an occupational vision, facilitating new graduates' energy and motivation to move in to new fields. A critical occupational science could enable occupational therapists to realize their claim to being agents for social change. Models of service delivery based in a critical re-examination of concepts such as occupational justice alongside people with experiences of disability, or even other forms of exclusion, could be of benefit to a wider range of people than those who are currently served. Occupational science may be able to provide some of the basis for negotiating a philosophy of engagement in social change. Despite occupational therapy's narrow class culture and gender base, it still has an asset of diversity in practice, which has the potential to position it well in arguing for such an agenda. But effective arguments must address the strong tendency for complacency, or as Hammell (2009: 11) has highlighted, a negative 'entrenchment' in its tenets which merely replicate rather than challenge assumptions.

However, as Creek (2009: 48) warns with regard to university curricula, there are dangers in introducing yet more apparently impressive ideas if they are to detract from the core combination of 'pragmatism' (a focused approach to problem solving which arises through active, experiential learning) with 'structuralist epistolomologies'. As a new human science, occupational science appears to draw from the established and accepted concepts provided by psychology, sociology, history, anthropology, human biology and cultural theories, among others. It could be argued that occupational science has developed in lieu of a wider understanding of these broad disciplines. Not only that, but part of its attraction is the appearance of uniqueness to the field of occupation, which matches occupational therapy's assumptions of a professional uniqueness. But this

actually rests on the tacit acceptance of all these underpinning structuralist epistemologies in order to uphold occupation, rather than finding a new vocabulary to challenge them (Creek, 2009).

Another way to read this might be that such beauty is only skin deep; the avowal of holism in practice and vision demands to be rigorously tested. To adequately reflect the breadth of knowledge contained in the occupational science hold-all would require the capacities of a true renaissance figure, i.e. someone who knows all it is possible to know. Since occupational therapy frequently refers to maximizing human potential, the outcome of such an enabling drive should perhaps be the development of a polymathematical understanding and universal applicability of practice. Clearly this is impractical for a profession based on a three-year BSc or a two-year pre-registration MSc programme, and would be unsustainable across a service.

One of the key challenges of a profession entrenched in 'ableism' is to meet the critiques of health and inclusive rhetorics from the positions offered by disability studies; while the risks in mixing engagement with people who are service users and research can result in the outcomes being ignored by the academic community, and so 'not counting' as evidence (Goodley and Moore, 2000). So far, this is a discussion which has only just begun. It also frequently appears that a similar issue in building links with potential allies arises in relation to working across cultures, given that the profession in the UK has a very narrow profile in terms of cultural origin. The profession has only recently begun to develop responses to cultural differences in approach to the place of occupation in different societies, largely in reaction to Iwama's Kawa Model (2006). Perhaps the action of engagement is more significant; through working together the viewpoint will move on and it will become possible to determine how the story should be told (Pollard and Sakellariou, 2008). The knowledge base of occupational therapy is frequently ignored by the dominant forces in the biomedical hierarchy (Creek, 2009), yet the concern of the profession with the evidence base demanded by the power structures within which it operates often prevents it from recognizing the importance of experiential narrative.

OCCUPATIONAL THERAPY AND SCIENCE IN TODAY'S WORLD

The baby boom of the post-war years is beginning to produce its first retirees, and the number of older adults in many countries is increasing faster than the availability of services to meet their needs (Walker, 2002; Robine et al, 2007). These people are expected to be in need of care for longer than previous groups of older adults, because they are anticipated to be living longer.

The term 'flexible economy' described the change from heavy industry to a service economy in the 1980s and 1990s, which required that people moved to be where the jobs were, away from parents and grandparents. These people are now more dependent on the care they can buy, than on the care traditionally provided by family. For those wealthy enough, there is an insurance industry to support these needs (AXA Foundation, 2009), but many of the people in the UK have not invested enough in planning for social care, and are seriously confused about how to do so, and that is if they are in the minority of people who feel they should (Price Waterhouse Cooper, 2009). There is a greater tendency for people to live alone (Office of National Statistics, 2002), with fewer long-standing social contacts (Macvarish, 2006), to invest more time in work and the community around work, and less in the community in which they live. Often, the community in which they work has little to do with, and is even physically separated from the community in which it is situated. To protect these business communities and their interests, a plethora of policing and other security measures have been developed while social divisions have increased (Minton, 2006).

Mary Reilly (1962) said that occupation was 'one of the greatest ideas of the 20th century'. Despite the numerous times this statement has been cited in occupational therapy literature, somehow the profession has not paid much attention. It has been concerned about who gets to hand out the adaptions, and whether anyone has been assessed properly. It has been concerned with risk assessment, but research on risk, and therefore perception of risk, tends to be strongly weighted towards professional or employing organizations' considerations than those of service users or even carers (Mitchell and Glendinning, 2007). It has been concerned with defending the occupational nature of the profession against the idea that occupational therapists have not had enough resources to do research.

But, while all this has been going on, the idea of occupation as a right is drifting into dangerous territory. As Wilcock (2006) discusses, an idea of occupational justice, which entails that people have equity in being enabled to express

themselves through meaningful and purposeful doing, is difficult to mediate for all. People engage in meaningful occupations unaware of the effect these activities have on the ability of others to fulfil their occupational goals. Many of our daily activities have been carried out in an unsustainable way for centuries, since they have encouraged some people to consume the planet's resources without being aware, or in spite of being aware, of the impact on other communities (Minton, 2006; Ikiugu, 2008; Hammell, 2009). Indeed, the idea of occupation as doing has become confused with the idea of physical occupation, or colonization, of environmental spaces in which 'to do'.

FREEING THE RESTRICTIONS ON PRACTICE WITH NEW PERSPECTIVES

Occupational therapists have, for a number of years now, been discussing alternatives to careers in the health system and social services, for example with charities and social enterprises working with people who are increasingly finding themselves excluded from the progressively homogenized urban spaces, or else trapped in the confines between them, for example people who are homeless, or the long-term unemployed. Part of the attraction of these roles is that while professionals are often not employed as 'occupational therapists', the roles they have are more 'occupation' focused. Their paradox is that these roles give occupational therapists a clearer sense of identity through the development of roles with people whose identity is negatively constructed. The profession's inherent ableism arises through the stigmas associated with forms of disability or difference.

What individual people do is affected and facilitated by the social, political and economic environment. The laboratory for the scientific exploration of what people do may be found in the emergent practices of occupational therapists, but the science they produce will only be valid if it takes account of the experiences and expertise of people with disabilities, as well as a critical perspective of the normalizing social agendas worldwide, with their aversion to difference. The self-perpetuating and uncritical assertions of the value of meaningful occupation will have to be cast aside to make progress on the assertion of a right connected with doing.

Perhaps there is more at stake. Therapeutic outcomes don't end at the hospital gates, and compliance with interventions often depends on social circumstances and the ability and facility to maintain gains in the community (Creek, 2007; 2009). If so, occupational therapists and occupational scientists have to critically engage with their fellow allied health professionals and their consultants to argue in new terms. 'Therapeutic' and 'compliance' are words that still retain the power imbalance, the notion that the patients' circumstances are to be interpreted and a solution offered. Is not this the purpose of health professionals? By arguing in new terms, would the need for such professionals be removed?

There appears to be a real risk that, in a competitive health market in which occupational therapy has to demonstrate value for money but is often misunderstood or misrecognized, the value for money it represents is not always visible. In mental health, it might mean maintaining people in the community who might otherwise be presenting themselves to their GPs and psychiatrists. Or, such patients might be sufficiently motivated that they are still presenting to their GPs, but with physical problems in addition to the psychiatric issues they have, because activity enables them to recognise these occupational limitations. People have historically found it difficult to recruit occupational therapists who are trained in smaller numbers than, for example nurses and social workers, and instead advertised posts as general ones so that they will be filled. It has often been assumed that other professions are more versatile (because of their legal powers and capacity for physical care, or administering drugs). As a consequence of the mistaken belief that there is no need for an occupational therapist in a health service, many patients are not engaged in the richer lives they could otherwise be living.

However, before health professionals start worrying about being seen as redundent, and subsequent dismissal, a reflective 'common sense' moment is needed. Doing, being, becoming and belonging are common sense, generally understood, and pragmatic elements of an occupational narrative. The constant prefix of occupational science and occupational therapy: 'occupational' signifies the importance of doing as engagement. This has been described as 'productivity' (Creek, 2003), but in everyday language a lack of occupation, or boredom, is described as having 'nothing to do', while its expression suggests that there is a tacit acceptance that meaningful occupation is a right and should be within everyone's capacity. Social, political and economic factors contribute resources to the idea that health can be promoted through occupation, but in an ageing

society the capacity for health is finite; the principle that occupation is productivity is one of diminishing returns; occupation could become more complex; or it could simply be just given up.

CONCLUSION

Occupational science can potentially address the complex social basis of occupational need through an occupational focus which asks questions about how people are enabled to do, be, become and belong. A wider awareness and application of occupation science might inform policy, for example to do with environmental changes. An occupational science, especially one which has just reached the end of its adolescence, must be far more concerned with doing something to facilitate arguments for people's future rights to engagement in everyday life. IJTR

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KEY POINTS

- Occupational science needs to develop a substantial body of knowledge in human occupation in order to justify its existence.
- Occupational science can be an important ally of occupational therapy.
- There is a need for more depth in the critical perspectives of human occupation in both occupational science and occupational therapy.
- Both occupational therapists and occupational scientists have to do more to assert rights to opportunities for meaningful doing in an ageing society.
- Health professions need to adapt to changing socio-political circumstances.

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COMMENTARY

During the 2009 Occupational Therapy Australia Queensland State conference, the keynote speaker Professor Gail Whiteford spoke about this period of economic downturn, where people are 'having less', but 'doing' more'. People may be having fewer restaurant meals, but are doing more everyday activities, such as spending time cooking or baking together as a family. Occupational science is about studying what people do (Wilcock, 1991). This current article, that reminds therapists of the use of self-sustaining and health giving occupations as the form of intervention, is indeed timely.

From an occupational science viewpoint, it is important to analyse the impact of international and global issues on the value of activity. As the authors have correctly pointed out, social, political and economic factors affect the perspectives on how health can be promoted through occupation. With the rise in healthcare cost, the authors discussed how occupations are considered justifiable because they are less costly than other forms of intervention. Helping our clients achieve their potential in performing everyday activities that they choose to engage in, need not be expensive. At the same time, this act of improving their capacity to engage in meaningful occupations can restore human dignity.

The use of an occupational science perspective can also broaden the scope of occupational therapy practice. With the view that meaningful occupation is a human right, occupational therapists have extended the work beyond individuals to communities (Hasselkus, 2006). Occupational therapists are increasingly working in situations where everyday occupation is strictly constrained (e.g. in prisons), where the term occupation deprivation applies. Occupational science provides us with the knowledge and tools to work in conditions such as poverty, stigma, homelessness, violence and other social circumstances, such as institutionalization. It brings our scope of work beyond the medical model, and beyond the traditional occupational categories of work, leisure and self-maintenance (Hasselkus, 2006).

This article has made reference to the aging population. Another area where occupational science is advancing is with the paediatric population. Humphry and Wakeford (2008) described about the Processes Transforming Occupation (PTO) model that focuses on the societal investment in children's activities, interpersonal influences on activity and the dynamics of doing an activity. Price and Miner (2007) used a case example to argue for a more complex and inclusive understanding of occupation-based practice. They argue that occupation-based practices extend beyond the use of occupation as an intervention in clients' natural context.

In summary, as stated in this article, occupational science is complex, but has the potential for occupational therapists to draw on as a knowledge base to further develop the profession.

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