In praise of diversity

Jennifer Creek

Introduction

It is a great privilege to be invited to give the first annual lecture in honour of an outstanding European occupational therapist, Hanneke van Bruggen. Several national occupational therapy associations present an annual lecture in memory of the person who is thought to have contributed most to the development of the profession in their country: Elizabeth Casson in the UK, Eleanor Clarke Slagle in the US, Muriel Driver in Australia, Vona du Toit in South Africa. As far as I am aware, Hanneke is the first occupational therapist to be so honoured by a whole continent and the first one to have a lecture dedicated to her in her lifetime.

Hanneke van Bruggen qualified as an occupational therapist in the Netherlands in 1969 and worked there for much of her career. However, her energy could not be contained within the borders of one country, or even one continent. Not only has she contributed to the development of occupational therapy education across the whole of Europe but she is now working with the African Union to harmonise higher education across sub-Saharan Africa. At her retirement symposium earlier this year, she told us that she has travelled to 50 different countries to work: I wonder how many occupational therapists in the world can match that achievement?

I first met Hanneke at the College of Occupational Therapists' annual conference, in Glasgow, in 2003, when she invited me to join an ENOTHE terminology working group. In 2000, the ENOTHE executive identified that a common terminology is a necessary aspect of harmonising occupational therapy education across Europe, so they set up the working group in 2001. From 2003 to 2009, I travelled to many European countries for meetings of the working group and ENOTHE conferences, and also to teach. These experiences gave me opportunities to observe and appreciate the diversity of our beautiful continent: diversity of landscape, architecture, people, culture, language, politics and occupational therapy.

Receiving the invitation to deliver this lecture, led me to think about how occupational therapy is recognisably the same profession in every country I have visited but it also differs in the ways that it is taught and practised, reflecting different cultural norms and expectations. Through discussions with European colleagues, I have learned to appreciate just how flexible and adaptable occupational therapy can be, when we have the confidence to set goals and deliver our services in ways that are culturally and socially appropriate. These musing led me to select the theme of this lecture: *In praise of diversity*.

In this paper, I am going to talk about diversity in occupational therapy. I will begin by discussing what diversity means and considering how important the concept has been in shaping our professional purpose and practice. I will attempt to show that the historical development of occupational therapy has resulted in an ongoing tension between our pragmatic, person-centred values and the structuralist theories that we teach to our students: while we claim to value diversity, much occupational therapy education and practice has become standardised, generalised and procedural. I will look at the influence of the human rights discourse on the principles and practice of occupational therapy. I will highlight some of the challenges that face the profession as it struggles to express its values

and principles in practice and show how these struggles affect occupational therapy education. I will finish with a summary of my argument and conclude that occupational therapists need to embrace diversity if we are to provide services that are relevant and useful for the people who need them.

What is diversity?

Diversity means difference, variety, being unlike each other (Shorter Oxford English Dictionary 2002). For example, the term *biological diversity*, or *biodiversity*, 'means the variability among living organisms from all sources… and the ecological complexes of which they are part; this includes diversity within species, between species and of ecosystems' (UN Convention on Biological Diversity 1993). We know that biodiversity is essential to life on earth because it is 'the vast array of interactions among the various components of biodiversity [that] makes the planet habitable for all species, including humans' (UN Convention on Biological Diversity 1993).

Homo sapiens is itself a very diverse species, with people differing from each other along a huge number of dimensions: gender, race, age, height, intelligence, religious beliefs, emotional resilience, sociability, creativity, ambition, energy, physical fitness, pain tolerance, health, longevity, style of dress and culture, to name just a few. For each dimension, there is a normal distribution for any particular location; for example, Belgian women tend to be shorter in height than Belgian men but taller than Bolivian men who are, in turn, taller than Bolivian women (Wikipedia 2011).

Diversity is essential to human survival and wellbeing because it is the differences between people that drive development, innovation and adaptation, not their similarities. Article 1 of the UNESCO (2002) *Universal Declaration on Cultural Diversity* states:

> As a source of exchange, innovation and creativity, cultural diversity is as necessary for humankind as biodiversity is for nature. In this sense, it is the common heritage of humanity and should be recognized and affirmed for the benefit of present and future generations.

The commonalities we share with others contribute to the fulfilment of a deep need for belonging and community, but it is the differences between people that give us our sense of personal identity and agency. We desire acceptance from others but not at the expense of being recognised and valued as individuals. Each of us needs to know that we can make a unique and valuable contribution to the development and wellbeing of our communities (Nixon, in press).

The development of occupational therapy

When the profession of occupational therapy was founded, at the beginning of the twentieth century, the concept of diversity did not appear in the literature, although an implicit acceptance of human differences can be inferred from the writings of the first practitioners. For example, a paper on occupational therapy, delivered at the Glasgow Royal Mental Hospital in 1924, suggested that 'instead of thinking in groups, we must develop a more individual touch than has ever previously characterized mental hospital organization' (Henderson 1925, p. 64). Elizabeth Casson, who started a school of occupational therapy in England, in 1930 (Paterson 2010), wrote that 'even in cases of physical illness [occupational

therapy] is primarily psychological' (Casson & Foulds 1955, p. 113) and, as such, 'must be applied to each patient as an individual' (p. 123).

A practice that is tailored to the needs of the individual accommodates diversity, even when the therapist is not consciously aware that this is what she is doing. I remember in the early 1990s attending a job interview where I was asked, for the first time, how I would respond to diversity in the client population. I did not understand the question because, from my perspective, occupational therapy is essentially person-centred, individualised and context-specific: there is no other way of practising authentic occupational therapy.

Many of the beliefs and values espoused by occupational therapists come from two philosophical movements that were influential at the time when the profession was founded: pragmatism and the arts and crafts movement. Both these philosophies stress the importance of acknowledging individual experience and human agency.

Pragmatism 'presupposes humans are agentic by nature and knowledge is tentative and created within particular contexts' (Hooper & Wood 2002, p. 40). 'Knowledge and truth [are] constantly being revised, and interpretation of reality is influenced by individual and collaborative experience' (Breines 1986, p. x). A pragmatic worldview leads to practice in which 'clients' experiences and knowledge are [seen as] central and carry authority within the client-professional partnership' (Canadian Association of Occupational Therapists 1993, p. 5). This philosophy celebrates and accommodates diversity.

The arts and crafts movement was based on the ideas of two British writers, John Ruskin and William Morris, who were, in turn, influenced by the philosophy of Karl Marx. Ruskin and Morris felt that factory work took away the knowledge and dignity once found in work, and alienated the worker from the product of his labours. They thought that 'workers should be free to fulfil their potential as creative, emotionally expressive and autonomous individuals' (Hocking 2008a, p. 148). Their goal was to restore dignity to the worker by giving him control over the process and quality of his work (Paterson 2010).

In its early days, the occupational therapy profession could articulate a clear set of values and principles, derived from its founding philosophies, but it did not have its own theory base. Practitioners worked under the direction of medical staff although their practice was informed directly by their humanistic beliefs, without the mediation of formal theories, models or frames of reference.

The new profession was given a boost by two world wars, during which occupational therapy practitioners were able to demonstrate the effectiveness of their interventions in the rehabilitation of injured soldiers. Their success led to a demand for more occupational therapists to be trained. Two American writers, Hooper and Wood, have suggested that:

> the early occupational therapists had a moral imperative to train more practitioners but no knowledge base of their own with which to educate them or much of any status or expertise with which to argue for particular educational practices. This vacuum was largely filled by deference to medical authorities… under the strong influence of physicians, basic medical sciences and applied medical lectures occupied more of the field's core curricula over ensuing decades. (Hooper & Wood 2002, p. 46)

While the principles and values of occupational therapy were derived from pragmatic philosophy and the arts and crafts movement, the medical curriculum is based on a structuralist epistemology. Structuralism is concerned with the underlying structures that are shared by phenomena, rather than with individual difference and context-dependent action (Hooper & Wood 2002). Embracing a structuralist epistemology led occupational therapists to 'concentrate on aspects of performance that could be quantified and manipulated' (Hocking 2008b, p. 231), to standardise their interventions and to seek uniform outcomes.

Mary Reilly, the occupational therapy programme leader at the University of Southern California during the 1960s and 1970s, became concerned that the profession was too much under the influence of the medical model and urged her fellow occupational therapists to revisit the ideas and beliefs of the profession's founders. She argued that the profession needed to put the occupation back into occupational therapy, in order to avoid reductionist thinking and to understand the real meaning of occupation in people's lives. (Reilly 1971)

Under Reilly's leadership, occupational therapists began to develop theories of occupation and occupation-focused practice. An occupation-focused practice necessarily adapts itself to diverse needs and contexts because it recognises that occupation 'is complex and multifaceted, incorporating physical, social, psychological, emotional and spiritual dimensions [and that] the occupations people engage in have social, cultural, symbolic and spiritual significance for them' (Creek 2003, pp. 32-33).

Despite a growing awareness that occupations are shaped by social and cultural contexts, the occupational therapy curriculum continued to move away from 'teaching the application of occupations… to the healing, rehabilitation, and adaptation of persons with disabilities' (Cole 2010, p. 78) and focused increasingly on teaching biomedical and other scientific theories, including structuralist theories of occupation. A Canadian occupational therapist, Karen Whalley Hammell (2009, p. 11), has pointed out that 'despite the occupational therapy profession's declared allegiance to client-centredness, there has been little effort to enable the perspectives of diverse client groups to infiltrate theories of occupation.' Today, throughout the world, occupational therapy students are taught theories, models, processes and techniques that, it is claimed, can be employed with any client in any setting. Many occupational therapists in Europe accept theories and models from other parts of the world without critical evaluation of their social and cultural relevance.

Epistemological tension

The outcome of this historical development is that occupational therapists at the beginning of the twenty-first century have a pragmatic view of human beings, derived from the profession's founding philosophies, and a structuralist approach to knowledge, arising from our long dependence on medicine. Hooper and Wood (2002) claimed that these two cultural discourses are incompatible and that, by espousing both of them, occupational therapy has cultivated 'a basic and problematic incompatibility' (p. 46). These 'epistemological tensions' within the profession have been identified as 'a major contributor to eroding [occupational therapists'] confidence in and articulation of their practice' (Wilding & Whiteford 2007, p. 187).

Practitioners, educators and researchers deal with epistemological tension in different ways. Some feel comfortable with the principles of pragmatism and attempt to apply them in their work, often without realising that this is what they are doing. For example, a letter in the *British Journal of Occupational Therapy* described how one department came to adopt a pragmatic approach to intervention:

> Having gone through a … frustrating process to base our service on one model of practice, we concluded that in practice this is often unworkable… after considerable discussion and trials, we concluded that as the clients we work with in the community are diverse, with different needs, priorities, culture, value systems and attitudes to health care, reliance on a one-therapy approach would be avoided. We strive to work in a client-centred and holistic way and did not want to be obliged to fit our clients into one way of thinking and one style of working. (Murphy 2009, p. 42)

This occupational therapy team has found a way of incorporating diversity into their daily practice. However, modern health services are organised to 'support medicine's emphasis on the treatment of disease' (Townsend 1998, p. 11) and occupational therapists often struggle to find ways of enacting their humanistic principles and values within the biomedical settings where we work. Hence, structuralism remains the dominant discourse within the profession at the present time. For example, an article in the *British Journal of Occupational Therapy* described how an occupational therapy service manager decided to introduce her chosen model for practice across the whole service:

> The impetus… to choose a service-wide model was in part driven by the need for the profession to establish its identity and clarify its contribution in the current healthcare marketplace… advances in the profession sometimes require a more collective or corporate approach, in which professional members come to use a shared language along with a common toolbox of structured assessment tools and intervention resources. (Wimpenny et al 2009, p. 514)

This manager is using the language of business - marketplace, corporate approach, common toolbox – and appears to have made the assumption that the adoption of a business model requires a single approach and a rejection of diversity. In opposition to this view, the Nobel prize winning economist, Joseph Stiglitz (2010, p. 46), argued that:

> we need a variety of alternative forms of economic organisation. We… have focussed too long on one particular model.

Occupational therapists can adapt to working within healthcare settings that employ a business model without compromising our person-centred orientation or the diversity of our approaches. My own view is that the dualistic perspective within occupational therapy is an essential aspect of our professional identity and only becomes a problem when we fail to acknowledge it. The American anthropologist, Cheryl Mattingly, described occupational therapy as 'a two-body practice' because it 'tends to deal with functional problems that fall nicely within biomedicine [treating physical injuries with specific treatment techniques], as well as problems going far beyond the physical body, encompassing social, cultural, and psychological issues that concern the meaning of illness or injury to a person's life' (1994, p. 37). When we are aware that this is what we do, we can move smoothly between addressing 'the physiological problems of dysfunction… and helping the patient cope with the illness experience, for example, with the fear of returning home, or of never being able to return to work' (op cit, p. 38).

The American occupational therapy historian, Ruth Levine Schemm, also saw the two incompatible epistemologies on which occupational therapy is based as a potential strength. Writing in 1993, she observed that:

> Occupational therapists have bridged two contradictory value systems for more than 75 years. The ability to combine the biomedical aspects of patient illnesses with the humanistic values of the Arts and Crafts Movement requires complex patterns of integrative treatment planning. This skill is an asset in today's healthcare arena where the limitations of scientific medicine encourage practitioners to emphasize the art of patient care. Occupational therapists who have struggled with ways to balance the scientific and artful aspects of practice can guide other professionals to develop more integrative health services. (Schemm 1994, pp. 1086-1087)

So far, I have argued that occupational therapists appear to be unsure of whether our remit is to treat illness or to enable people to build rich lives through occupation. I now want to consider the impact of human rights legislation on occupational therapy's domain of concern.

Human rights

Following the Second World War, the publication of the United Nations' *Universal Declaration of Human Rights* (United Nations 1948) led to a more overt acknowledgement of the need to recognise and appreciate diversity. Article 2 of the Declaration states that:

> Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

In other words, diversity, whether of race, colour, language, religion, opinion, origin, wealth, birth, nationality or other status, does not exclude anyone from enjoying the same rights and freedoms as every other person in the world. Many governments have enshrined the principles of the *Universal Declaration of Human Rights* in law so that there is not only

recognition but also protection of the rights of women, children, disabled people and other groups.

Over the past 60 years, the language of human rights has permeated society, including the education, health and social care systems of many countries. Health and social care personnel are expected to work within a human rights framework that includes respect for all persons. For example, the World Federation of Occupational Therapists' (WFOT) *Code of Ethics* requires that: 'Occupational therapists shall not discriminate against [the people receiving their services] on the basis of race, colour, impairment, disability, national origin, age, gender, sexual preference, religion, political beliefs or status in society' (WFOT 2005). This language sits comfortably within the pragmatic discourse of occupational therapy.

In 2010, the W.F.O.T. published a position paper on diversity and culture, which acknowledges 'that every person is unique in the way they combine the dynamic interplay between cultural, social, psychological, biological, financial, political and spiritual elements in their personal occupational performance and participation in society'. To acknowledge that every person is unique 'implies that we acknowledge that a diversity of people represents a diversity in values [and suggests] a deep responsibility at the *heart* of occupational therapy, which entails the practice of respect for people's differences' (Kronenberg et al 2011, p. 2).

One problem with the United Nations' and the W.F.O.T. positions on human differences is that they emphasise the **right** of all people to full participation in society rather than stressing the vital **necessity** of maintaining and fostering diversity. We tend to think that inclusivity is to the benefit of disadvantaged people without recognising that it benefits all of us equally. As occupational therapists, we accept our responsibility to 'incorporate diversity and culture in [our] daily practices… educational programmes, occupational therapy research and the W.F.O.T.' (Kinebanian & Stompf 2009, p. 18) but we do not seem to understand that diversity is essential to our survival and wellbeing, both as professionals and as human beings. Diversity is not a problem to be solved, or even a right to be upheld, but an essential component of human survival and wellbeing. As I have already said, it is the differences between people that drive development, innovation and adaptation, not their commonalities.

The physical and social environments in which we live consist of a multiplicity of complex, dynamic systems that change over time, in relation to each other. In order to survive and thrive, people need a changing battery of knowledge, skills and characteristics that will enable them to adapt continuously. No one person can contain all the knowledge and skills necessary for survival in the modern world but a community that is characterised by diversity will include people who, between them, share all the knowledge and skills that they need.

Challenges for occupational therapy

One of the keynote speakers at the 2010 W.F.O.T. congress in Chile, the Brazilian occupational therapist Sandra Galheigo (2011, p. 62), spoke of 'the risk of producing conformity, instead of emancipation'. The greatest risk to occupational therapy at the present time is that we will become so conformist we lose the capacity to adapt to rapidly changing social, political and economic conditions. In many countries throughout the world, the practice of occupational therapy is already falling short of what it could be and there is a

danger that occupational therapy will not survive as a profession unless we remain true to our values.

The beliefs, values and principles of occupational therapy reflect a humanistic, person-centred, non-discriminatory ethos that grew from our founding philosophies and continues to absorb new influences, including a human rights perspective. This has enabled us, for over a hundred years, to match our services to the needs of the populations we serve. Some occupational therapists are critical of the profession's adaptability, suggesting that we have had to give up our ideals and principles in order to conform to the requirements of service settings (Wilding & Whiteford 2007). I would argue that to give up our core commitments would rather demonstrate a **lack** of adaptability. If we reject conformity and embrace diversity within the profession, we can find ways to adapt to a range of service models without losing any of our unique features.

How diverse are occupational therapists? The first practitioners were young, educated, white women from relatively affluent families (Paterson 2010), not representative of most of the populations they served. Does the present composition of the profession better reflect local demographic profiles or do we select students to be as much like ourselves as possible: mostly young, educated, predominantly white, mainly female and relatively affluent? Hanneke herself has written that:

> Students of different migrant or ethnic minority backgrounds often feel excluded by teachers and fellow students and not attracted to occupational therapy programmes. Furthermore, there is a high dropout rate… It is quite difficult to find good practice about successfully implemented diversity policy in occupational therapy practice and education. (van Bruggen 2009, p. xv)

The Sullivan Commission, on minorities in the health professions in the United States, concluded that 'increasing diversity in the healthcare professions… will improve health care access and quality for minority patients and assure [an equitable] healthcare system for all' (Sullivan 2004, cited in van Bruggen 2009, p. xv). If we are to accommodate a wider range of client needs, the profile of the occupational therapy workforce should better represent the age and gender of the populations with whom we work, their social, cultural and linguistic backgrounds, their contexts and their interests.

Our remit is to work with people who are occupationally disadvantaged by impairment, disability, poverty, displacement or exclusion but how many occupational therapists have experienced and overcome such disadvantages in their own lives? We say that we help our clients to find ways of meeting life's challenges, but how willing are we to challenge the status quo in our profession?

Occupational therapists claim to work with anyone who has occupational needs (Creek 2003) but, in reality, we discriminate in the ways that we ration our services.
For example, earlier this year, I read a paper reflecting on the experience of an occupational therapy support worker following the suicide of a service user (OT News 2011). The client worked with the support worker for about two months but his attendance became increasingly erratic and he eventually stopped attending. The support worker informed the client's key worker, who tried to contact the man. When these attempts were unsuccessful, the client was discharged from the service, without being seen, and he committed suicide a week later. Subsequently, the support worker asked himself if he had done enough in his practice to safeguard the client. His reflections were as follows:

> … after examining my practice I believe I acted to the best of my ability and followed procedure. This gave me a sense of wellbeing in myself… my duties towards the customer were fulfilled, except on this occasion it was a sad conclusion. I am glad I safeguarded my own wellbeing by following good practice. (OT News 2011, p. 29)

Note the support worker's use of the word 'customer' to describe his client. This implies that the man had actively chosen to seek the help of the mental health services and, therefore, could actively decide to stop using them. When the patient or client is a customer, it is considered good practice to provide the service he wants, even if this means providing no service.

But a person who is ill enough to need mental health services is not in the same position as a customer deciding where to shop for the things he wants. What really happened in this case was that the community mental health team rationed its services by providing care only to those people who could comply with the procedures set out for service delivery. In practice, this means giving a service to the people who are well enough to keep appointments and respond to messages. When someone is too ill to attend sessions or return phone calls, he can be discharged without follow-up because he is a customer who has decided not to use the service any longer.

It would be interesting to explore how many ways occupational therapists have found to ration their services, thus discriminating against certain groups of people, without being aware that this is what we are doing. I am not arguing that there should be no rationing of services – our resources are not infinite – but that discrimination occurs when we fail to think through the consequences of our criteria for exclusion.

About 20 years ago, a colleague of mine left occupational therapy. She had been working with disabled primary school children, helping them to develop skills that would facilitate their integration into mainstream education. As a cost-cutting measure, her managers decided that occupational therapy intervention should be limited to a maximum of three months for every child. My colleague, realising that to follow this rule would mean disadvantaging those children who needed longer periods of intervention in order for their development to catch up, could not tolerate working within a system that discriminated against the most disabled children. She left her job, turned her back on the profession and now works as a teacher in a secondary school.

What I find especially interesting in the occupational therapy support worker's account is his statement that following procedure gave him a sense of wellbeing, even though the procedure failed to prevent the client's death. A South African occupational therapist, Lindsey Nicholls (2007), has written that 'the culture of an institution, which can inform the policy and procedures of that institution and influence its primary task, may be established as a defence against the primitive unconscious anxieties that arise from the workers' direct contact with clients' (p. 72). Perhaps the occupational therapy support worker is using procedure as a defence against the anxiety arising from working with people who are ill enough to want to take their own lives. Perhaps my colleague walked away from the anxiety of knowing that she would inevitably fail the children who needed her most.

The rhetoric of occupational therapy says that we are 'not just concerned with impairment or diagnosis but with the meaning and purpose that clients place on activities and occupations and with the impact of illness or disability on their ability to carry them out'

(Creek 2003, p. 31). Yet, hearing how our clients feel about the impact of illness or disability on their lives can be anxiety-provoking and it is not surprising that we look for ways to protect ourselves.

A few years ago, I attended an interdisciplinary conference on narrative based medicine. One of the presentations was entitled *Locating the narratives of psychiatry* (Kirmayer 2001). The speaker identified narrative as a movement against evidence-based medicine, which is controlled by the big drug companies. He said that some truths, as defined by the dominant medical discourse, protect the clinician but damage the patient. For example, every psychiatrist has a checklist in his head when he listens to a patient: this checklist contains the information that he needs to make his diagnosis. Every time the patient says something that matches an item on the checklist, the psychiatrist makes a mental tick: 'I wake up very early in the morning and can't get back to sleep' – tick; 'My clothes are getting loose because I'm not interested in food' – tick; 'I think my family would be better off without me' – tick. Anything the patient says that is not relevant to the checklist is ignored or simply not heard, becoming a lost narrative.

Occupational therapists have a different checklist in our heads but I suspect that much of the client's narrative is still lost to us because we are looking for specific information rather than trying to hear her or his real concerns. We think that we want to hear what the client has to say but, in reality, we fear that we will not be able understand or cope with a diversity of needs. It is safer to carry out a procedure or fill in a checklist than to confront our own inadequacy in the face of another's distress; safer to follow prescriptions than to acknowledge that we have choices (Freire 1972).

In his 2006 Casson Memorial Lecture, Graeme Smith (2006) said:

> If we allow our professional narratives to be constrained by tests and formal procedures, we will not be able to get close to our clients. Some practitioners feel safer keeping the professional boundaries intact: they may choose to go into areas of work where they are protected by badges, uniforms and technical expertise (p. 305)… Practitioners fear uncertainty, which feels unsafe, and aspire to certainty, which gives the illusion of safety, of knowing where we are going (p. 306).

Approaches to education

The Brazilian educationalist, Paulo Freire (1972), wrote that having freedom means giving up the illusion of certainty and being able to imagine alternative futures. Some people prefer to believe that the way we do things now is the right way, or the only way, and should therefore be adopted by everyone; creating uniformity not diversity. Freire (1972) wrote that choosing the security of conformity leads people to become imprisoned in circles of certainty and to feel threatened if their truth is questioned: 'Thus, each considers anything that is not "his" truth a lie' (p. 18).

Those occupational therapists who seek certainty in their work want models of practice, tools and procedures that will reveal the truth about their clients' problems and lead to the right way of addressing them. Some occupational therapy academics are skilled at promoting their particular version of the truth through publications and presentations, often travelling widely to spread their message. In an editorial in the *British Journal of Occupational Therapy*, Duncan and Bannigan (2009) claimed that these gurus 'often tell their

audience what they want to hear and capitalise on professional uncertainty or disaffection… a guru's views, beliefs and ideas become tied up with the person, and those who ascribe to his or her views seem neither to want nor to be able to engage critically with the ideas presented' (op cit, p. 423).

Freire (1972, p. 46) described this as 'the "banking" concept of education', in which the teacher's task is 'to "fill" the students by making deposits of information which he considers constitute true knowledge' (p.49). These teachers are driven by the need to know and to control knowledge. Banking education imposes a passive role, discourages critical thinking, minimises creativity and encourages students to adapt to the world as it is, rather than seeking to transform it. An occupational therapy programme that employs the banking model of education presents theories, models and approaches to practice as though they are both true and universally applicable. Tutors may pay lip service to teaching critical appraisal but they discourage any real challenge to their professional authority.

In the early 1980s, practitioners in the UK were just beginning to use occupational therapy models for practice. I read about the latest one in the *American Journal of Occupational Therapy* and identified some flaws in its conceptual foundations. When a two-day workshop on the model was advertised at my local university, I booked a place and went along prepared to engage in a productive discussion with the author. The first time I asked a critical question, he told me that I was there to listen and learn, not to criticise.

More recently, I attended a European conference where another new model was presented. Again, I had read about the model and identified some gaps in the author's reasoning, so I went along to the workshop prepared to engage in a critical dialogue. This time, the presenter talked for 90 minutes without pause, leaving no time for questions or discussion.

When we teach our students, we not only deposit knowledge but also transmit our beliefs, values, principles and ways of doing things. If we treat students as passive recipients of knowledge, they learn to treat their clients as passive recipients of the occupational therapist's expertise. Employing a banking model of education, teaching students to follow models and processes rather than thinking through the complexity of each client's situation, produces therapists who conform and clients who comply.

Those occupational therapists who want to be told how to think and what to do can always find a guru, but there are other ways of teaching and learning. Our professional rhetoric proclaims that 'client-centred occupational therapy is a partnership between the client and the therapist in which both participate actively, thus increasing the client's responsibility, choice, autonomy and control' (Creek 2003, p. 30). If this is what we really believe, then occupational therapy education should be a partnership between the teacher and student in which both participate actively, thus increasing the student's responsibility, choice, autonomy and control.

Freire (1972, p. 19) described this as 'a dialogical and problem-posing education', in which the teacher and students learn in dialogue with each other and are jointly responsible for the process. The teacher 'does not regard [knowledge] as his private property, but as the object of reflection by himself and the students' (op cit, p. 54). An occupational therapy educator who espouses the problem-posing model of education presents real problems 'to the students for their consideration, and re-examines his earlier considerations as the students express their own' (op cit, p. 54).

Duncan and Bannigan (2009, p. 423) wrote that 'occupational therapy needs leaders who can develop innovative approaches to interventions that are open to challenge and critique; who can work with clients in new ways, spot opportunities and develop services'. These leaders are driven by curiosity, they enjoy exploring and challenging received knowledge and they promote critical exploration in their students: they are seekers. Seekers do not attempt to control how others use the theories and frameworks that they help to develop; they trust in people's ability to think independently, to know what they want and to understand the world for themselves (Freire 1972).

When we invite our students to bring their own knowledge and expertise into the learning situation and to share it so that all can learn from each other, we are modelling a way of working that engages our clients as active partners in the process of intervention.

Summary and conclusion

In this paper, I have attempted to show how the historical development of occupational therapy has left us with an unresolved tension between our pragmatic, person-centred values and the structuralist epistemology that underpins our knowledge base and curriculum. In occupational therapy practice and education, this tension is sometimes expressed as a choice between embracing diversity and seeking uniformity.

I have identified some of the challenges that face the profession as it struggles to express its values and principles in practice. I argued that, in order to continue providing services that people need and value, we have to:

- Find innovative ways of adapting to rapidly changing social, political and economic conditions without compromising our pragmatic orientation, our extensive knowledge base or our practical skills;
- Build a more diverse occupational therapy workforce that better represents the populations with whom we work;
- Embrace a wide variety of theories, approaches, media and techniques, in order to meet changing needs and accommodate a diversity of clients;
- Deliver more equitable services by finding ways to allocate resources that do not discriminate against particular groups or individuals;
- Address the anxiety produced by the uncertainty inherent in working with vulnerable people, without allowing our clients' narratives to be silenced by formal procedures, badges, uniforms and technical expertise;
- Engage critically with the ideas of our professional leaders and challenge any theories or models that claim to represent the truth;
- Employ a range of teaching approaches and methods that will accommodate a greater diversity of student occupational therapists;
- Develop in our students a critical curiosity, an ability to think independently and the confidence to articulate what occupational therapists can do better than anyone else.

The profession of occupational therapy has a choice. We can continue to cling to the illusion of certainty produced by conforming to the dominant structuralist discourse or we can choose to embrace a diversity of theories, practice, education and research that will allow us to envision and create our own future. Gandhi, the great Indian political and civil rights leader, said that we must be the change we want to see in the world. Think about what kind

of profession you want occupational therapy to be, now change yourself to become part of that vision.

In this talk, I hope that I have succeeded in presenting myself as a seeker: an occupational therapist who is curious, critical and dialogical. But I can see some of you wondering if I had Hanneke in mind when describing those professional leaders who are skilled at promoting their particular version of the truth and who travel widely to spread their message.

Hanneke van Bruggen is a powerful woman who sets high standards and expects others to adhere to them. However, she is a seeker not a guru: she challenges people to think for themselves and work out the most appropriate responses to the demands of their own settings. She does not travel around the world in order to gain fame and recognition, or to push her own agenda, but to explore, to share and to learn.

I recently had the opportunity to observe Hanneke's lack of egocentricity when we met up at the seventh congress of the Occupational Therapy African Regional Group in Zambia. I told Hanneke that I had been invited to deliver this lecture and she seemed surprised but moderately pleased. A few days later, she asked which conference I would be attending next. I said, 'The ENOTHE conference'. Hanneke was a bit taken aback: 'Are you going to the ENOTHE conference this year?' she asked. 'Yes', I said, 'I will be giving the Hanneke van Bruggen lecture'. Hanneke had completely forgotten that ENOTHE has chosen to honour her with an annual lecture!

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