



Joint COTEC-ENOTHE Congress

Dear colleagues,

I am very honoured to be entrusted by the ENOTHE Board to give this address. It gives me an opportunity to freely review my modest contribution to the development of Occupational Therapy, especially in the context of ENOTHE. It is also an occasion to reflect upon my views of evolutions that should take place in the relatively near future – say in the next decade, as far as some conceptual elements in OT are concerned. Long-term changes will require fresh energy – they will be up to occupational therapists who are in their mid-thirties today; we have faith in their ability to carry them out!

My views on the evolution of our profession are shaped by the specific context of a “Semi-European” Occupational Therapy school – since Switzerland is not a member of the European Union. There are three OT schools in Switzerland, and three teaching languages: German, French and Italian. To teach in Lausanne means to teach in French; it also implies being wedged between two big “neighbours”. First France, as the cradle of the French language and its somewhat imperialistic tendencies where other French-speakers are concerned; yet French OTs, including the teaching staff in OT schools, have a relatively limited access to international OT literature. Secondly Canada where OT models are systematically translated into French and clearly facilitate access to a conception of OT that is occupation-centred and client-centred.

In this my address, I will present three main challenges to the development of Occupational Therapy in the French-speaking European context, and more broadly at the international level: 1) the terminology of occupation, 2) the academic development in OT education centres, 3) the relationship between occupation and activity. I think that these issues are also relevant to many other countries.

The terminology of occupation

French-speaking OTs in France, Switzerland and Belgium, still find it difficult to use the term “*occupation*”, especially within the context of professional practice; I shall attempt to explain why I think this is so. This terminological difficulty is also present in teaching, research and in professional articles; this is unfortunate, as it does not open avenues for change. For instance, the ministerial decision issued in July 2010 that provides the definition, in France, of the OT diploma states the following: “Occupational Therapy” takes into account the interaction between person-activity-environment. The meaning of activity is here that of the English-language term “*occupation*”, i.e. “*A group of activities that has personal and socio-cultural meaning is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure.*” The definition is, of course, in French in the legal document, but it is directly taken from the text issued by the ENOTHE Terminology group. However, the conceptual framework of the Terminology Group also proposes a definition of the term “*activity*”. It is thus not appropriate to pretend that “*occupation*” can simply be translated as activity and to write: “activity is a group of activities”. Confusion reigns, since the same term refers to two different concepts within the same conceptual universe. This is a long-standing debate; however, it should be resolved once and for all in order to move forward.

French-speakers are able to avoid using the term occupation because the name of their profession is built upon the Greek root “*ergon*” (meaning work, or strength) and not upon the Latin root “*occupation*”. This however does not help us understand why and how the



international literature vehemently promotes the notion of occupation-centred occupational therapy, nor does it incite French-speaking OTs to read it.

There is more. Occupation, according to the Grand Robert French dictionary is defined as: "That to which one dedicates one's activity, one's time". Synonyms are: business, labour, employment, engagement, leisure, work, pastime, career, function, job, profession, trade... The Oxford Dictionary gives a similar definition and synonyms that are not very different: *job, profession, trade, vocation, employment, position, career, activity, leisure, hobby, entertainment, recreation, diversion...*

The problem in French is that the dictionary also references quotes that give the word occupation a negative connotation; for instance, from a Balzac novel: "his dear existence, full of pointless occupations and of occupations full of emptiness", Or Flaubert: "Smoking, having a bath, painting one's eyelids and drinking coffee, such is the sphere of occupations within which her existence revolves." Balzac and Flaubert are classical authors; their works are compulsory reading in schools. OTs, but also common sense, thus gives a meaning to the term occupation that refers to an activity without intrinsic value, a way to spend time without undue boredom that is of no interest to society at large. This is an exact opposite of the concept developed in OT.

This very negative view of occupation is also embedded in the professionalization efforts conducted by the pioneers of OT. Corinne Dallera, a Swiss historian who carried out a study in 2015, of the creation of the Lausanne OT School in 1965, showing that in the fifties and sixties occupations and work were provided to psychiatric patients in the mental hospital serving the Lausanne region; workshops were staffed by nurses or other types of personnel. Newly trained occupational therapists as well as students from the OT school were sent there on field practice from the end of the 1960s, defending their presence in this context by putting forward the idea that they were designing more specific activities, based upon individual therapeutic goals. They were thus able to distance themselves from the notion of occupation and to promote the concept of therapeutic activity.

In fact, I have little information on which to ascertain that activities proposed by the OTs were actually more "therapeutic" than the occupations organised in the hospital's workshops; this is because the first curricula for OT training at the Lausanne school do not provide any specific operational principles for OT interventions (dia). The courses offered at the time enabled students to master a broad range of craft and creative techniques and to acquire skills in the organisation and implementation of group activities. However, while the classes in these applied disciplines are juxtaposed to courses in medicine, including in psychiatry - the relationships between the two fields does not emerge. An affirmation that "therapy" was being conducted made sense in the medical world and seems to have been sufficient to install a division of labour allowing OT to secure its place.

Over the years, professionalizing OT will come to mean gradually specifying the therapeutic value of activities and designing methods to implement it. It then entails transmitting this theoretical, scientific and methodological knowledge to generations of students. This endeavour necessitates examining the structural characteristics of activities as well as activity demands. More specifically, the time and space activities necessitate, the stages they include as well as the objects they require have to be analysed in order to determine the body functions and the skills necessary for their implementation. This conception of activity, that is well suited to medical approaches, will enable OTs to adapt activities and propose them to patients according to the type of effort they require, and thus to use them as exercises or training (dia).



This lengthy, patient and never completed work leading to the development of activity grading, sequencing, to setting adjustments and measured elaboration of the instructions meant to guide the performance of the client has represented the professional technology of OT; it represents it today and will represent it tomorrow. Recognition by other professionals who work alongside OTs as well as by the public and by the media is in large part dependent of these methodological achievements. Numerous specific models and conceptual frameworks make use of these constructs; the development of many disciplines of reference, such as the neurosciences, provides opportunities to deepen this body of knowledge. In fact, this knowledge is so firmly embedded into professional practice that one sometimes forgets that it should be seen as a prowess in the realm of applied science.

Achieving this theoretical, methodological, pedagogical and discursive tall order – as OT must also be explained to outsiders – tends to lead, in the French-speaking context, to the eviction of the term *occupation*, seen as too vague and too depreciative, from the language of OT. Once again, French-speakers – as opposed to English-speakers – do not have to question why the very name of their profession contains a term not used in their practice; thus there is nothing, apart from reading the international literature that might incite them to keep the term *occupation* in their vocabulary. This rejection also seems legitimate if one takes into account the following definition from 2016 Grand Robert: “Occupational therapy has very broad uses. It takes place in a hospital context, is more or less systematically carried out and may take on a wide range of appearances”. It does not exactly turn you on...

In short, when one talks about occupation in French, one enters a minefield; it is as though one was defending not occupation-centred OT as put forward in the international literature, but rather obsolete practices against which OTs have been fighting. To change this perception is to conduct a difficult academic process within one's own profession. The process and the effort it requires have not yet been accepted.

Academic development

OT in Switzerland, but also in France or in French-speaking Belgium, is far from having achieved full professionalization. OT education, like that of nurses and physical therapists, only achieved university-level status at the beginning of the 21st century, and even then this recognition was grudging in Switzerland; it stemmed from the impact of the Bologna Declaration, as a result of which OT trained abroad and coming to work in Switzerland would have had higher qualifications than locally trained professionals. This would have been inconceivable in a country that states proudly that its raw materials are its brain power!

Switzerland has not integrated the educational programs in the field of nursing and allied health professions, social work, the arts, administration or engineering into its universities; like some other European countries, it created Universities of Applied Sciences. These are a kind of professional university, to which the very broad autonomy awarded to “real” universities has not been granted, so that they can be made to better serve the requirements of the market (dia).

Graduate education: a difficult path

Universities of Applied Sciences are subjected to a close control by government agencies, though this direct control may be decreasing. They are primarily mandated to conduct professional education at the Bachelor level and they have had – and continue to have to fight for the right to set up Master's programs. Where these exist, they do not primarily have the goal of raising the level of qualification required to enter the job market; rather, they are designed to offer some Bachelor-level professionals a postgraduate qualification enabling them to carry out more complex tasks or to take on supervisory



positions. This spring, the Swiss parliament refused to integrate Master's programs into health profession legislation, stating that it has not been demonstrated that the health system requires OT, nursing or PT professionals trained at Master's level for good patient care. Master's programs are thus being developed against a backdrop of criticism and of expressed doubts about the need for graduate curricula, as well as about the legitimacy of our schools to set them up.

Furthermore, employers have expressed concerns about raising educational levels for fear that it would lead to claims for salary increases. Politicians, mostly those from the political right, but probably a majority of elected officials in all parties, associate higher academic requirements with the production of knowledge they view as disconnected from the interests of professional practice, and thus with the training of professionals who would be incompetent in their work. In the realm of health professions, politicians still imagine that doctors make all decisions and prescribe the acts to be executed by other types of personnel. It is thus quite difficult to promote actualised practices based upon research in the field of OT, since such an approach corresponds neither to the politician's values nor to their understanding of the issue – despite all the lobbying efforts deployed by professional associations.

Let us underline, however, that there is one undeniable advantage to the current limited access of OTs to a Master's program: nobody is questioning the ability of OTs who hold a Bachelor-level qualification to work in private practice and bill health insurance or other social insurance programs, as long as treatments are prescribed by a physician. This is true in all fields of OT, including in community health. The conditions offered for private practice are thus much more favourable in Switzerland than in France or in French-speaking Belgium. However, in the long-term, we may have to think about the relationship between educational levels and autonomy in professional practice and we may find that the competencies acquired at Bachelor-level may not be altogether sufficient for independent private practice. Yet this issue is not on the agenda right now - and may not be for quite a while.

A Doctorate (Ph.D.) in occupational science – a request met with a refusal

However, whilst we need to train OTs at Master's level in order to take on leadership roles within teams, to implement evidence-based practices, to develop clinical projects, to produce new knowledge, to intensify inter-professional collaboration and for positions in the University of Applied Sciences and research units, we also need access to a higher level of postgraduate studies. By this I mean access to a Doctorate (Ph.D.) for persons who hold a Master's in OT and who wish to acquire further specialisation in occupational science and gain the ability to produce new knowledge through research. These professionals will be better equipped to develop new OT knowledge and to further occupational science, as well as to publish their results. They will also be better placed to obtain research funding through open calls and will be awarded the social recognition associated with the Doctorate (Ph.D.) qualification.

Yet the idea of a Doctorate (Ph.D.) makes all kinds of partners shake in their boots; moreover, the Universities of Applied Sciences are not allowed to introduce Doctorate (Ph.D.) programs. At best, they can attempt to secure agreements with Universities. Increasing the academic character of training for health professions is still seen as an abomination. As a result, Swiss OT schools have to hire highly qualified teaching staff trained abroad in our specific field, or else to recruit persons who have Doctorates (Ph.D.'s) in other fields, such as psychology or education, but often have little specific knowledge of, and engagement in, occupational science or OT. To my knowledge, the situation is not very different in France or in French-speaking Belgium.



This lack of higher-level academic training has meant that we do not have the capacities for research and development that would enable us to adequately contribute to the production of knowledge in our discipline and to compete with the British, the Australians, the Canadians or the Swedes. OT schools also experience difficulty in obtaining sufficient financial resources to set up appropriately staffed research units. Finally, existing open calls for research projects focus far more on the disciplines that have an established place in Universities than in Universities of Applied Sciences. Level of qualification, research personnel and focus of available research funding constitute a vicious cycle that proves rather difficult to transform into a virtuous one. However our schools do have one strong point worth mentioning: a strong connection with professional practice that facilitates access to the field for research projects.

OT as a discipline: a status met with denial

Value issues must be added to objective problems associated with the Swiss educational system. This system establishes a hierarchy between knowledge historically developed and taught in Universities and disciplines more recently devolved to University of Applied Sciences. This hierarchy is reproduced in our own schools, and reinforced by the fact that professors have Doctorates (Ph.D.'s) in other disciplines and also conduct research in these disciplines. For instance, when I speak of OT as a professional discipline and of occupational science as a science, I am either ridiculed or viewed with condescension: clearly, disciplines are limited to the University context, and thus there is no such thing as occupational science. This argument only holds, however, if one limits one's scope to Switzerland or if one uses Germany and its "Fachhochschulen" as a sole comparison – Germany remaining, for Swiss Germans, i.e. the majority of the Swiss population, the great next-door neighbour to turn to for guidance.

The worst part is that this symbolic hierarchy is not only reproduced by persons who have reoriented their career towards academic pursuits established in Universities, but that it is also present in our immediate environment. Thus, quoting Max Weber is preferable to quoting Kielhofner. Yet as a professor of OT, it is more crucial that I know the work of Kielhofner than the writings of Weber. Another example has stuck in my mind; when I became dean of the OT school, the dean of the nursing program in our own University of Applied Sciences asked me what subjects I taught. Hearing my answer he replied – and he was not joking in any way "Oh, so there are concepts in OT?" So we must not only develop the discipline but also combat enemies on the inside, though they themselves are experiencing the same legitimacy issues as OTs. The demonstration that must be carried out does entail explaining concepts, but it is also symbolic in nature. Thus, having been chosen for this address at the ENOTHE conference is an act of recognition that shows colleagues within our department that our own professional field is organised, that it has structures for promoting international cooperation and recognizing qualifications, and that we are engaged and have a valued place within these structures.

Developing Master's and Doctorate (Ph.D.) level training programs undeniably contributes to ensuring that the next generation of teaching staff are well trained and allows for raising standards in research and discipline development. However, we must remain vigilant to make sure that the vital transfer of new knowledge to clinical practice does take place. Professionals in the fields that we might call the traditional practice areas of OT are keen on acquiring new technological knowledge and on being provided with skill-centred models that give them indications of "what to do" with clients in view of their medical diagnoses. They do not necessarily seem to have a marked interest in an occupational approach to interventions, nor in the scientific evidence associated with it. A major effort is thus required to disseminate knowledge outside the academic publication channels, using



less prestigious but widely available professional journals that are read by practitioners and published in their own language.

The relationship between occupation and activity

My contribution to the development of OT is relatively limited. With the exception of a few research projects, most my professional activities have been devoted to the dissemination of knowledge, particularly with the writing of handbooks that have turned out to be quite successful. It must be said that there is only a small number of manuals available in French; as a result, the few existing handbooks remain the literature of choice for many years and may perpetuate information that should have been superseded by new concepts or research results.

The experience of the terminology group

My participation in ENOTHE has had an important impact on the evolution of my ideas, my teaching and my writings. The network presents a challenge in terms of language; this because while English is the international language that carries the concepts of OT and thus is most easily used for our exchanges, it does not mean that we are all fluent in English – at least I am not! Thus we often have to resort to talking to each other in an approximate, pidgin version of English, a “European *sabir* “. The term “*sabir*” refers to a linguistic mix restricted to a few grammatical rules and a limited vocabulary (...) born of contacts between communities speaking very different languages and used as a supplementary means of communication. Nice definition and a good fit with the configuration of the terminology group ENOTHE, even though the origin of the term “*sabir*” has nothing to do with English.

To be a member of ENOTHE, and even more of its terminology group, has been a huge opportunity for exchanges and debates with colleagues who read the same documents, who encountered similar definitional and translation problems and who taught the same subjects to students who, in the European contexts, are rather similar. Hours and hours have been spent assembling definitions and discussing them, in order to finally build a common conceptual framework and to formalise it in written form. This led to a 2010 publication in English by Jennifer Creek, and another one in French, by myself, in 2013. The conceptual framework is also used in the fifth edition of “*Creek’s occupational therapy in mental health*”. The French version will also be presented again in the new version of Morel-Bracq’s “*Modèles conceptuels en ergothérapie*”. Unfortunately, we have not been able to publish in German, Spanish, Flemish or Portuguese beyond a lexicon of the definitions themselves.

Two concepts

During the course of its discussion, the terminology group has made several decisions. One decision has been, in contrast to the position of some authors, to develop the concept of occupation and that of activity as two different constructs, the use of which should be differentiated in the therapeutic context.

Occupation is: “*A group of activities that has personal and socio-cultural meaning is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure.*”

Activity is: “*A structured series of actions or tasks that contribute to occupations.*”

These two definitions do require, however, tackling a perennial problem; students, for instance, often want to know whether something one is doing” is an occupation or an activity. In 2004, Polatajko and her colleagues opted for the elaboration of a taxonomy going from voluntary movement to occupation, built upon the taxonomic criterion of complexity. An



occupation is thus more complex than an activity. This approach, however, only solves the problem in specific situational contexts. For instance if I say “having breakfast” is an occupation, then “drinking one’s coffee” is an activity “and carrying the cup to one’s lips” becomes a skill. However, when “drinking” means “swallowing a liquid” it is a skill, whilst if “drinking” means to be an alcoholic”, it is an occupation. In other words, concepts relating to the taxonomy of occupation should not be confused with the “actions” they designate – actions that would then become reified. “Drinking” may be an occupation, an activity, a task, a skill, a habit or a routine; it all depends on the concept that we have to mobilise in order to grasp what it is that interests us in “drinking” at a specific time and in a given context. Once students have understood this point, using these concepts becomes easier.

This relationship between the concepts of activity and occupation contributes to the ability to explain client-centred practices while simultaneously reducing the level of complexity of interventions. In my view, in most situations in which OTs encourage clients to do something in order to develop a skill or train for a performance – getting dressed, washing the dishes, playing cards, getting around in a wheelchair – the operational concept is that of activity, and it would be wrong not to bring this to light.

The complexity of occupation

When the terminology project of ENOTHE started in 2001, the concept of occupation had already been redefined as the central concept of OT. Since then, numerous theoretical and scientific works have enriched a complex understanding of occupation. Publications to be cited include, for instance, Hitch, Pépin and Stagniti (2014) de Kuo, (2011), Aldrich & Laliberté Rudman (2016), Cutchin & Dickie (2013), Hooper (2006) – and there are many others.

Occupations are thus what people do, whether regularly or exceptionally. We know occupations are both meaningful and purposeful, that they may be individual, shared or collective, that they confer an identity for ourselves and for others, that they take up time and organise life, that they evolve and transform themselves, that they focus our attention, that they require skills and reinforce them, that they modify the environment and are influenced by it, that they preserve as well as alter our well-being, that they guarantee survival but may also make it impossible, that they contribute to society and transmit culture, that they represent experiences, that they are dependent on the context. Finally, through them, individuals, families and communities act, exist, grow and belong to their world.

These theoretical and scientific works have greatly improved our conception of occupation, and intense efforts are deployed to transmit it to OT students, so that they become more occupation-centred in their future professional practice. This will – or should – translate into OT practice through the implementation, to use Fisher’s concepts (2013), of occupation-based or occupation-focused interventions. But are we truly certain that these therapeutic occupations really are “*occupations*”, especially in the field of rehabilitation? To my mind, they actually may be *activities* carried out in the specific context of therapeutic interventions that are of interest and have value because they go some way towards meeting the veritable occupations that clients have to, wish to or need to accomplish.

Activity-based interventions

When Fisher specifically portrays occupation-based practices, “task performance” and “task demands” are described. The American framework uses the terminology of activity demands alongside that of occupation demands. In other words, for the purpose of designing interventions, OTs often have to reduce the concept of occupation to that of activity, or of task. This is hardly a scoop and nobody will be surprised to hear me say this. What does



surprise me is that there is little analysis in the literature about the potential of this reduction. Most often, only its risks are described: remaining within the bio-medical model, being overly focused on physical functions, forgetting the central concept of the profession, neglecting the occupational goal of interventions, proposing activities that are not perceived as meaningful by clients because they do not relate to their daily lives. In my view, this is an error because activities are not merely meaningless exercises.

Through clearly identifying the differences between the concepts of occupation and of activity, it should be possible to distinguish, in therapy, between two types of moments: those during which OTs refer to occupations that are their clients' own, or will be an integral part of their daily life on the one hand, and on the other hand moments in which activities are used explicitly, because they are aspects of an occupation that can be isolated and targeted in order to be practiced. This activity, requiring specific efforts from the client as well as skills, and implies choosing, organising and carrying out activities in interaction with the environment, is what the terminology group's framework calls activity performance. Of course, if the intervention is occupation-focused, then the activity will be seen as meaningful by clients because it is related to one or several occupations of their daily lives.

Therapy as occupation

Activities that do not have a direct link (or a tenuous one) with the occupations of patients' daily life are widely used in the traditional sectors of OT practice that are dominated by the bio-medical model, be they hospital-based or ambulatory. These interventions are efficient in terms of improvements in physical functioning, skill acquisition and performance, thanks in part to the use of specific objectives associated with particular tasks, such as hooking up 8 clothespins on a vertical stem in one minute. The occupational perspective remains difficult to discern because the therapy room is an unusual environment, because specialised devices are being used and because the setting is organised in a particular way. These sectors of OT are numerous and comprise a high proportion of field practice placements; they are also generally fields in which financial coverage of OT interventions is established. They cannot simply be excluded without losing professional opportunities as well as clients.

OTs who are not very occupation-centred or who propose intervention activities that have little to do with their clients' daily lives, for instance craft activities or rote exercises, do not experience greater difficulties than other OTs in engaging their clients to participate in interventions. Certainly, when one sees on the web countless photos taken in OT sessions that show smiling clients concentrating on tasks that, to my mind and to yours may seem silly and unconnected to real life, we perceive the absence of the concept of occupation. Yet these practices continue to exist because they work. The question that needs to be asked is thus: why? Of course the question can be sidestepped and we may pretend that these practices are not OT, but doing so would be abandoning the field.

Alongside these traditional practices of OT, numerous works in occupational science, particularly those by Eklund, show how or in what way individuals reinvest, transform or recreate occupations within the context of a chronic invalidating condition or when they have had to move, for instance to a nursing home. Some researchers in the tradition of Mattingly have also focused on meaning-making within the field of mental health. Their results could also help us understand, from an occupational perspective, how interventions in a traditional practice context can be meaningful.

In fact, these practices could also be read using an occupational viewpoint, as long as one asks the question of what occupation we are talking about, notably by relying on characteristics built into the very concept of occupation: they have meaning within a culture,



are named and are influenced by the environment. My thesis is that therapy, rehabilitation or living in hospital are actually occupations.

Thus, “spending two months in hospital” is an occupation that takes on as much meaning as “spending a three week vacation at the seaside, or visiting New York” – even though it is less fun. But occupations are not necessarily pleasant (Ikiugu, *et al.*, 2015). This hospital activities, among them evaluations, rote exercises, training and even passive preparation activities proposed by OTs have meaning in this physical, social and symbolic context. This is a fortunate state of affairs, because otherwise who would agree to going to the bathroom, to wash oneself and to display their scars in front of a stranger. Following a therapeutic regime also means living special experiences to which individuals give meaning, for instance because they feel it will enable them regain their physical or mental functions. Making use of special therapeutic devices endowed with the aura of the latest technological innovations may also give clients the feeling that they belong to a privileged group benefitting from high-level treatment protocols carried out by a very highly specialised professional called an OT (dia).

Of course, we must also continue to extend the practices and the client groups of OT to populations and communities who experience occupational problems that are neither caused nor associated with bodily injuries or dysfunctions as defined by the ICF. We should not throw away the baby with the bathwater and cease to acknowledge and develop the potential of the concept of activity, using as a pretext the fact that it has eclipsed that of occupation for the past 30 years.

Conclusion

Having reached the end of my address, I propose keeping the following three elements in mind:

1. We should adopt the concept of occupation without linguistic reservations and we should dare give the word, within our profession, the meaning we wish it to have.
2. We should clearly distinguish occupation and activity in order to reap full benefits from both, and extend the scope of OT without delegitimizing traditional interventions.
3. We should continue to pursue the process towards higher-level academic qualifications in OT that is already under way, and make sure those who are further ahead on this path look kindly upon those who are still struggling in this regard.