The Dr Elizabeth Casson Memorial Lecture 2017: Life as an occupational being

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NOTE TO SAGE: This is copy-edited for text and header levels are indicated, otherwise over to you for house style, thanks. This is the annual Casson lecture and is not a normal BJOT article, so please don't restructure headings or remove contractions. Suggest no need for statements as they are not relevant for this article. (Last year's Casson was 79(9), Wendy Bryant, if you need to compare)

The Dr Elizabeth Casson Memorial Lecture 2017: Life as an occupational being

Diane L Cox

<<IMAGE OF DIANE COX FROM CONFERENCE>>Figure 1

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<*A*>INTRODUCTION

I am delighted to present the Dr Elizabeth Casson Memorial Lecture at the 41st conference of the newly 'Royal' College of Occupational Therapists (RCOT), here at the ICC in Birmingham. Indeed I am especially delighted to be delivering the lecture in Birmingham, as this feels like coming home – I was born and bought up nine miles down the road, in Solihull. I would like to thank my nominees and the RCOT council for giving me this opportunity to present the prestigious Dr Elizabeth Casson Memorial Lecture.

No Casson Memorial Lecture should start without a reminder to its namesake, and to the importance of Elizabeth Casson's work to the profession of occupational therapy in the United Kingdom. She opened the first school of occupational therapy in the United

Kingdom (UK) at Dorset House, Clifton, Bristol in 1930. We continue to owe her a lot. While writing and researching this lecture I was struck by the opening sentence of Dr Casson's paper, published in 1941, in which she details 40 cases treated at the clinic attached to the school:

> Rehabilitation needs serious attention at present
> (Casson 1941)

I will come back to this important statement later on. But, before I start out, I am going to give you the take home message of my lecture first (e.g. my last slide first):

> Publish. Publish. Publish.

That might appear a unusual place to begin however I will go on to explain, in the course of the lecture, why that is my take home message.

During my lecture I want to consider the complexities of being an occupational therapist facilitating occupation in people's lives to allow them to maintain, restore, enhance, and/or value occupational wellbeing. In coming to my final title for this lecture I settled on 'Life as an occupational being', but in conjunction with two important themes that I want to explore:

1. Encouraging engagement and participation in occupations through activity
2. The complexity of being an occupational therapist facilitating occupation in people's lives

To address these, I have divided my lecture into several broad areas: Engagement, Assessment, Intervention and Outcome, and I hope you will be able to follow that thread. However, within these I am also going to consider some subsidiary themes: *our* Environment, *our* Impact and, *our* Output

<*A*>ASSESSMENT

The reason I am starting at the end and then telling you the story, is because we need to consider our journey – in particular, *your* journey, as occupational therapists. So your 'homework' from today's lecture will be to reflect on the profession's journey, and on the

path that you, personally, will take from today. You might feel during the course of the next 40 minutes that I'm taking you down wrong paths and not sticking to the point – however bear with me it will all come together and make sense!

<*B*>*Our* Environment

There were many titles I could have chosen for today's lecture, and here are just a few suggestions:

- Moving forward, looking back;
- Complexity in simplicity;
- An event, not a linear vision of time.

All these could illustrate what I want to talk about today. However, I wanted particularly for us to consider the complexity of being an occupational therapist, facilitating occupation in people's lives. I wanted to think about how we encourage engagement and participation in occupations through activity and, most importantly – *why*. Hence my two main thematic areas and the final short title of – Life as an occupational being.

As we start to explore this, let me 'recap' on what defines us as occupational therapists and our profession. Let me quote the 2012 World Federation of Occupational Therapists (WFOT) definition of occupational therapy, with which you will all be familiar, I'm sure:

> The primary goal of occupational therapy is to enable people to participate in activities of daily living. Occupational Therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or environment to better support their occupational engagement (WFOT 2012).

In helping people to achieve what 'they want to, need to, or are expected to do' we as occupational therapists are often perceived as the facilitators, the enablers, and the people that make things happen for the benefit of other people's wellbeing.

The Royal College of Occupational Therapists (RCOT) extends the WFOT definition further:

> Occupational therapists view people as occupational beings. As occupational beings, people are intrinsically active and creative, needing to engage in a range of activities in their daily lives in order to sustain health and wellbeing …
> The purpose of occupational therapy is [therefore] to enable people to fulfil, or to work towards fulfilling, their potential as occupational beings. …
> We believe that activity can be an effective medium for remediation, facilitating adaptation and [creating or] re-creating identity (COT 2014).

This belief from the RCOT is one that I firmly share and fully sign up to. (And there are other parts to this extract from the full RCOT definition that are also important; I will get to these later.) However these activities, as we know, may be physical or social and therefore observable, or emotional, cognitive and/or psychological and not *so* observable. And most often, they are combinations of all of these – that is, complex occupations requiring complex interventions (Creek 2003, 2009, Craig et al 2008).

So far, so good. This probably all sounds quite familiar to anyone in the profession. But do we have the evidence? Before I consider that question in more detail, let's take a little time to consider the beginning of the profession and why activity and in particular purposeful activity is the corner stone of our profession: why, and how, does the focus on an occupation enable recovery from ill health?

During the American Occupational Therapy Association (AOTA) Eleanor Clark Sagle lecture in 1961, Mary Reilly remarked that:

> Man through the use of his hands, as they are energized by mind and will, can influence the state of his own health. (Reilly 1962, p.2)

Put more simply, 'what we *do* effects what we think, and what we think *affects* what we do. In thinking about that, let's look back to the beginning of occupational therapy in the UK.

<<Figure 2a and 2b HERE>>

Photographs of early occupational therapy activities show a range of activities that go beyond the simple explanation of 'being occupied'. Crafts, often in bed, and workshop activities, ADL assessments (Figure 2a) and the pleasure of having a product to take home (Figure 2b). Much of the activity depicted in images from the Dorset House archives and else where show far more than a simple explanation of 'being occupied'. They show the range of occupations has been there from the beginning. Although some of the occupations, activities and modes of delivery may have changed today, the premise of people being *occupational beings* has always been, and still is, fundamental to occupational therapy – and to you, as occupational therapists.

In 1934, Arthur J Brock MD wrote in the British Medical Journal of occupational therapy and the work of Elizabeth Casson:

> Occupation is not a secondary matter: it is the primary need of an individual's life (Brock 1934).

More recently, these opening lines by Reed and colleagues, in a 2013 paper, clearly highlight the significance of occupation:

> Occupation is as old as humanity. To survive, people have needed to eat, clothe themselves and interact with each other (Reed et al. 2013).

From this we can take that occupation is fundamental to *you* as occupational beings and also fundamental to all the people whose lives you interact with, whatever their age or whatever limitation they might have that *effects* and/or *affects* their participation in their daily occupations, activities and tasks. Occupation and social interactions are essential to a person's life.

<*A*>INTERVENTION

Continuing the story as we follow the path to *our* collective outcome as occupational therapists, and also to the future output of today's lecture, I want to tell you a little about me: my work and my approach to practice, education and research.

For most of my career I have worked with people with long-term conditions, particularly those with fatigue as a major factor in their lives (Cox 2000, 2002, 2012). Alongside my embedded occupational therapy skills my work is influenced by the biopsychosocial approach (Engel 1980), narrative reasoning (Mattingly 1991), and cognitive behaviour therapy principles (Cox 2000, Beck 1993). In my consideration of the *whole* occupational being of the person *and* their environment I have thought about ways to gain an understanding of a person's life, their experiences, their expectations and aspirations. I have been assisted in this by using narrative practice as a foundation to enable the person I am working with to tell their story through conversation. The narrative is formulated, fed back and re-formulated to ensure we are working to the same goal. An agenda is co-created, and tackled; actions are agreed, and participation in homework is encouraged (Cox 2012, Wiseman and Whiteford 2007). And my hope is that from today's lecture we, too, can co-create an agenda and agree our homework, and then continue the conversation.

A common thread in my work has been, and still is, facilitating engagement and participation in activity. This involves asking the questions – what occupations, what activities, what tasks are important to you, what do you want to be able to do?
It requires having a focus on a person's priorities, and discovering these through conversation – asking how do you define your time, prioritise your activities, balance your day, your week, your year, and have time to restore, reflect and rebalance? Many people I have worked with are in a situation where their current and future occupations and activities are different to ones they did before the long term-condition impacted on their life. Therefore, in many cases the focus of the occupational therapy will be on the formulation of the person's identity through activity in a world that has changed significantly, for them.

<*B*>Time and Energy

The WFOT definition of occupational therapy speaks of engaging people in the occupations *they want to do*, *need to or are expected to do*. So what are the differences in terms of effort, time and energy between what you *want* to do, and what you perceive you *need* to do? Does the energy used in occupations differ depending on whether they are what you *want* to do, or what you *perceive* you *need* to do (Cox 2000, 2012)?

Let's take this lecture, even though everyone in the audience may *want* to be here, the energy each of us is taking to complete the activity or occupation will be different. For some, there may be a low energy commitment, for others medium energy and for me, giving the lecture, I can assure you it's taking high energy.

But some questions arise. For instance, what impact will the use of the energy have on the remainder of my day and the activities I want to take part in, or on other things that I *want* to do? Does one change the energy input in order to get a desired output? How often do we spend time thinking about an activity and then, by the time we've come to do it, find we have have run out of the required energy to complete the task?

We know that occupation is fundamental to people's lives. What we, as occupational therapists, *do* when working with a client is to *re-frame* and *re-consider* the activities that give balance back to a person, putting them back in control. In my own work, for each question in practice I have encountered, I have endeavoured to describe, evaluate and research to help me to find reliable answers and solutions, and clearly set out what it is as occupational therapists we do. In addition, over the years it has been my privilege to work with many occupational therapists – in practice, education and research – and that has opened up to me alternative ways of thinking, and a consideration of the wider aspects of our understanding of occupation.

Many of the people we as occupational therapists work with will experience disruption in their occupational lives: disruption to their routines, patterns and schedules (Pemberton and Cox 2011, 2014, 2015). With this in mind, have we lost sight of certain aspects of human life that are vital – such as our concept of time? Time and time use were fundamental in the early aspects of our profession (Meyer 1977, originally published 1922). However, how often are we stuck in 'clock time' rather than 'event time' (focusing on the activity or event, and not being ruled by an imposed schedule or timetable) (Pemberton and Cox 2011, 2014, 2015). Sometimes it seems as if meeting the demands of clock time has become the defining factor in our lives, rather than focusing on the occupation or activity. Have we lost sight of 'being in the moment' and the sense of achievement in completing an activity? Please don't misunderstand me, since I do realise that certain activities, such as this lecture, benefit from having a time limit!

<*B*>Communicating complexity

In my research, I try to portray the complexity of what we as occupational therapists can achieve for people's occupational wellbeing, and to highlight where we *still* need to write, evaluate and research to be able to communicate what we do. In our work we consider all aspects of human behaviour, form and function – people's customs, purpose, meaning, roles, and more – to facilitate the people we work with in being the occupational beings they want, need or are expected to be. As occupational therapists, these are the components that we take into account in all the interactions we have. However, do we always clearly state, describe, and communicate this?

Let us consider the parts of the RCOT definition of occupational therapy that I haven't yet discussed:

> People shape, and are shaped by, their experiences and interaction with their environments. They create identity, purpose and meaning through what they do and have the capacity to transform themselves through conscious and autonomous action. …
>
> Occupational therapists promote activity, quality of life and the realisation of potential in people who are experiencing occupational disruption, deprivation, imbalance or isolation.
>
> (COT 2014)

Occupations enable targeted changes in a person's life, through focused decision-making, consciousness and repetition (Carlson et al 2014). But think for a moment about what *you* mean by the occupational therapy *you* do. Consider how you define your treatment or therapy ingredients. What is your cookbook or toolbox?

I offer a proposition to help us clearly define what we do – my proposal is the development of occupational therapy manuals and guidance. Perhaps we have not always considered constructing therapy manuals as the right way forward. The development of a therapy manual can seem daunting and you may feel that they are not always relevant to your practice and that they are only useful for research and evaluation. However, I would argue that the construction and development of occupational therapy manuals or guidance is a more evidenced descriptive approach to our occupational therapy toolbox, and can enable us to evaluate and research our interventions.

On the positive side, the manual, or toolbox, gives a clear indication of what we are doing and why. The limitation of a manual is that you cannot simply follow it as A to Z set of instructions, since it is *not* a book of instructions – it is a descriptive portrayal, of the complexity of the occupational therapy that *you* do, in *your* setting, with the people *you* work with (Cox et al 2013, Hart 2009). In addition, people as occupational beings are complex; more often than not when using a manual you might start at H and go to B, then N and Z, and then back to A. It is about knowing your practice and following the approaches that will work to the benefit of that individual; using a defined approach that is individualised for each person. So if we write it down and say what we do, then and only then can we consider the reliability and trustworthiness of our occupational therapy practice, and others will be able to see the evidence of what we do. This is evidence built on description, exploration, and evaluation.

<*B*>Being an 'occupational being' today

While the core premise of occupational therapy in the use of engagement and participation in occupations through activity is the same today, in the early 21st century, as it was in the early 20th century, perhaps we need to consider the modes of delivery, and what it is to be an *occupational being* today.

We are entering what some call the Fourth Industrial Revolution (when digital technology will be so integrated in our lives and work that we live and work completely differently. The World Economic Forum (January 2016) considered how developments in genetics, artificial intelligence, robotics and biotechnology will lay the foundation for a revolution that could never have been considered by Elizabeth Casson in 1930, when she founded the first school of occupational therapy in the UK. The WEF report identified the job skills that it predicts will be required of the future workforce (Figure 3).

<<Figure 3 HERE>>

These are the skills required by all jobs, but to me – whether we consider the 2015 or 2020 list – these, are all occupational therapy skills. In particular, our abilities in problem solving, creativity and, critical thinking in regard to a person's wants, needs and expectations. As a profession we need to evolve with this revolution and consider our

modes of delivery through smart technology and systems – in our homes, industries, cities and in our interventions (Steel et al 2011). How many of you are now using your smartphone, your tablet, or videoconferencing regularly at work, and for how many of you is this now the norm? As occupational therapists we are 'problem solvers' – we see the solutions or guide people towards seeing the solution for themselves.

Our approach echoes the sentiment of John Ford's famous dictum, 'don't find fault, find a remedy; anyone can complain'. In our role, rather than complain, criticise, moan, or protest, let us instead find remedies, recommend, and acclaim what we do – and more importantly the complexity of how we do it. But we should also bear in mind the words often attributed to another famous thinker, Einstein, that 'We cannot solve our problems with the same thinking we used when we created them'

We need to consider how others perceive what we do. Are we doing enough? And is all that we do described, evaluated, researched – can you say what you do and how what you do impacts and influences a person's life, or the wider community in which you work? Whenever I am asked what I do, I always change my response to describe not what I do, but who I *am* – I am an occupational therapist. My current academic role is as a director of research in a university; however, I articulate occupation and occupational therapy in everything I do. If I were a stick of seaside rock, it would say not 'Blackpool' but 'occupational therapist' right through the middle! All through my career, I have asked these kinds of questions. We, as a professional collective 'we', need to continue to ask those questions, and influence. You all need to consider the questions that still need to be answered.

The WEF report that I referred to above, goes on to state that, as industry adjusts, some jobs will be threatened by redundancy and some will require a fundamental transformation. How might that affect us as occupational therapists?

At the same time of reading the forum report I caught sight of a twitter link to an article in the *Sunday Times* (2017), where occupational therapy was listed as at least risk of jobs likely to be subject to computerisation based on a paper by and Osborne (2017).

As we know, occupational therapy is defined as a complex intervention (Creek 2003, 2009), requiring consideration of the individual within their life network, with all its accompanying complexity of physical, emotional, cognitive, and social interactions. We know individuals are complex and therefore need a complex problem-solving, solution-

focused intervention. We provide that by simplifying the complex, using occupation, activity and tasks of the person's daily life to enable them to retain, restore, or recover. However unlikely, there is truth behind the article: it points to the complexity of the skills required by the profession, and how difficult they would be to automate.

So, what is it to be an occupational therapist in the 21st century? Has our practice changed? *Should* it change? The modes of delivery might be different today from the earliest days of the profession, but I argue that we still do occupational therapy using the same guiding principles. Perhaps sometimes we forget or lose sight of these fundamental core skills as we focus on the clock, rather than the event.

We must use our knowledge and skills to facilitate and encourage participation through physical, cognitive and emotional activity, whatever the context, age or situation of that person.

<*B*>Our Impact

So let me start to bring us back to my take home message from the beginning of my lecture. Do we know how we impact on or influence the communities in which we work? How do we measure participation and the difference we make? We need evidence to answer such questions. And if we want more evidence, we need to create that evidence: we need to set the questions and lead the studies. In outlining the steps of evidence-based medicine Sackett et al (1996) suggested that we need to:

1. Ask the right question
2. Search the evidence
3. Appraise the evidence
4. Act on the evidence

And also you need to:

5. *Evaluate your practice &*
6. *Publish the evidence*

The PICO model suggests four elements that form the basis of developing a good-evidenced based question, useful for both searching the evidence and formulating a researchable question. This model is used widely in research, and many funding bodies use

this formulation to clarify the issues in practice and to decide if a problem merits research (Figure 4):

<<Figure 4>>

<*B*>Describe what we, as occupational therapists, do.

Can *you* define what you do, describe what you do – could what you do be replicated? I remember hearing a programme on BBC Radio 2 (Simon Mayo *Drivetime*, June 2016) where someone who was obviously an occupational therapist was referred to by the family of the client as a nurse. Based on the amount of Twitter and other social media activity that resulted, many listeners realised that this was an occupational therapist, although that was not said. This was followed up next day by an interview with another occupational therapist, who explained in simple terms the complexity of occupational therapy. She clearly described the importance of participation in activities and our understanding of the importance of daily routines and engagement in occupation for occupational wellbeing. It *can* be done: we can explain what occupational therapy is, and what we do.

In this world of sound bites and, for those using Twitter, 140 characters or less we find we have to describe things in brief . Or, to put it another way: you've heard of *speed dating*, well what about *speed describing*? Perhaps some people here may have heard of, or even taken part in, the three-minute thesis, and idea which originated at the University of Queensland (Queensland University, 2017) and has now been adopted in the UK through Vitae (VITAE, 2017). Could you describe your work in three minutes?

During the course of today take some time to try this out, using the PICO model, with a colleague, or perhaps use the PICO in your next group meeting at work, as an opportunity to participate in an activity. If we can describe what we do through using a PICO model, we can search the available evidence, formulate new questions, and start to answer through evaluation and research the questions raised, moving towards establishing a stronger evidence base.

Consider the nuances and intricacy of *your* occupational therapy. The short description you create is the start, but after that comes the need write and explain more

through evidenced descriptions and evaluation, using all methodological approaches across the qualitative and quantitative spectrum.

Occupational therapy can sometimes seem like a swan – above the water calm and composed, but beneath a lot of power, paddling like fury. As occupational therapists, all our input and output appears to happen seamlessly, or the observation or participation in an activity appears far less complex than it is. The complexity is perhaps not obvious to others.

<<FIGURE 5 – swan>>

I could have used a picture of an iceberg, too – to indicate that about 90% of what we do is unobservable: below the waterline, as it were. But I haven't taken a photograph of an iceberg, yet. To go back to the idea of writing manuals or guidance – these are the part 'under the waterline', that will clearly explain and describe the ingredients of occupational therapy in all our different areas of practice. The swan analogy points to the power of our interventions, and the iceberg to the non-observable aspects of occupational therapy's complex interventions (Creek 2003, 2009).

So, returning to that observation by Elizabeth Casson in her 1941 paper: 'Rehabilitation needs serious attention at present' (Casson 1941). How much has changed, today? That message is as relevant today, in 2017, as it was in 1941. Some of us may not use the term 'rehabilitation' in our practice today, for others it will be quite familiar. Whatever the terminology you use, it is down to us to ensure that enough attention is paid to, and, enough is known to ensure the continuation of rehabilitation, reablement, recovery and facilitating the lives of people as occupational beings.

We cannot keep the results of occupational therapy in practice, education and research to ourselves, within our own community. Others will always question what it is that occupational therapy *is* and what we *do* – and we must tell them. Because the only way we will influence policy and practice is through an evidence base of, and for, occupational therapy. We as occupational therapists need to drive this.

We need to ask ourselves: What to do? What could be done, and how can occupational therapy assist? In practice, education and research, we need to consider and reflect on the questions we have answered, and those we have still to answer. Are we influencing these questions from a research perspective? Think about the PICO model.

What we do as occupational therapists is not always observable and we need to communicate to others how we change the lives of the people we work with in a manner that is clear, observable and evidenced. We make the complex *seem* simple. That is, we need others to understand the complexity, communicating it in terms that are understandable and explained as simply as possible. How to do this? It is about knowing *why* you do what you do; about how you know it's the right approach; and about how others know what you as an occupational therapist do, and what occupational therapy can do for others.

For all those presenting their research or practice here at the RCOT conference, I suggest your action plan is now to write it up. Consider for a moment what the effect would be if everyone presenting research or practice agreed to write one article per year and submit it for publication in a peer reviewed journal or a professional publication. And let's imagine that every single one of these articles was accepted for publication! That would be some *1,500* pieces of occupational therapy evidence out there, with more evidence of our profession's ability to change people's lives and show the value of occupational therapy. Consider contributing to opportunities, such as the RCOT (then COT)'s 'Improving Lives, Saving Money' campaign (COT 2017).

<*A*>OUTCOME

As we come towards the end our journey, I'll have a look back at those 'alternative' titles that I thought about for this lecture. Perhaps we have covered them all, along the way, and can now 'Move forward after looking back', and have considered the 'Complexity in our simplicity', or – I would argue more strongly – the 'Simplicity in our complexity'. Perhaps you may also now consider the event more than just the clock time that passed while we were here together.

<*B*>Our Shared Occupation

In Conclusion for *our output*; some occupations we do alone, some we do together as individuals, some are joint occupations, some we do as a group, and some are shared occupations –

I put it to you that publishing is our next *shared occupation* and is part of you being an occupational being. Let's create the next occupational therapy revolution for the 21st

Century. As occupational therapy researchers and professionals in your field, consider writing that one piece that expands the evidence for occupational therapy each year, and find a place to publish – whether you are a researcher aiming at a journal or a practitioner, writing about your innovations in practice for a professional magazine, blog or newsletter. So here's my message to you all:

Publish, Publish, Publish

It's part of your life as an occupational being!

Note to Sage: issue numbers are in where they exist, if any not there it is because the journal concerned doesn't use them

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FIGURES

Image exported separately

Figure 1: Diane Cox urges us to 'Publish, publish, publish' at her enthusiastically received Casson Lecture (Image: Royal College of Occupational Therapists)

Images exported separately

Figure 2a: Bath assessment

Figure 2b: Going home with a product

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2020

1. Complex Problem Solving
2. Critical Thinking

2015

1. Complex Problem Solving
2. Coordinating with Others

3. Creativity	3. People Management
4. People Management	4. Critical Thinking
5. Coordinating with Others	5. Negotiation
6. Emotional Intelligence	6. Quality Control
7. Judgment and Decision Making	7. Service Orientation
8. Service Orientation	8. Judgment and Decision Making
9. Negotiation	9. Active Listening
10. Cognitive Flexibility	10. Creativity

Figure 3: Top 10 Skills, 2020 compared to 2015, as predicted by the World Economic Forum (WEF 2016)

- *Patient/* Person/Problem – The person or the problem being addressed,
- Intervention – The intervention to be considered,
- Comparison – The comparison intervention when relevant and
- Outcome – The outcome of interest

Figure 4: The P.I.C.O. Model for Clinical Questions (Centre for Evidence Based Medicine, Oxford 2017)

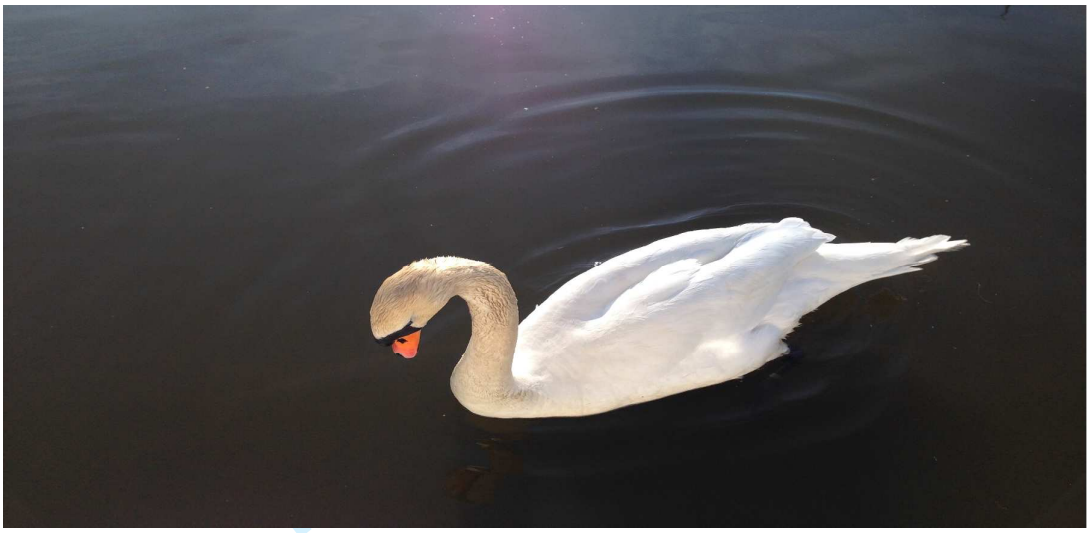

Figure 5: A swan's unobserved 'below the surface' power is a good analogy for occupational therapy (Image: author's own)

377x266mm (300 x 300 DPI)

115x85mm (300 x 300 DPI)

91x145mm (300 x 300 DPI)