OCCUPATIONAL THERAPY AND IDEOLOGY: A CRITICAL INVESTIGATION

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Dedicated to all philosophers in/of Occupational Therapy.

Read not to contradict and confute;
nor to believe and take for granted;
nor to find talk and discourse;
but to weigh and consider.

(Francis Bacon, 1561-1626)

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The only philosophy which can be responsibly practiced in the face of despair is the attempt to contemplate all things as they would present themselves from the standpoint of redemption. Knowledge has no light but that shed on the world by redemption: all else is reconstruction, more technique. Perspectives must be fashioned that displace and estrange the world, reveal it to be with its rifts and crevices as indigent and distorted as it will appear one day in the messianic light. To gain such perspectives without velleity or violence, entirely from felt contact with its objects – this alone is the task of thought. It is the simplest of all things, because the situation calls imperatively for such knowledge, indeed because consummate negativity, once squarely faced, delineates the mirror image of its opposite. But it is also the utterly impossible thing, because it presupposes a standpoint removed, even though by a hair's breadth, from the scope of existence, whereas we well know that any possible knowledge must not only first be wrested from what is, if it shall hold good, but is also marked, for this very reason, by the same disproportion and indigence which it seeks to escape. The more passionately thought denies its conditionality for the sake of the unconditional, the more unconsciously, and so calamitously, it is delivered up to the world. Even its own impossibility it must at last comprehend for the sake of the possible. But beside the demand thus placed on thought, the question of reality or unreality of redemption itself hardly matters.

(Theodor Adorno cited in Handelman 1991: iv-v)

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Preface

> Occupational Therapy is the art and science of the use of daily activities in order to treat or prevent sickness and thus learning necessary skills, or to compensate for the loss thereof, as required for successful personal independence, work, play and recreation *(Information brochure, School for Allied Health Professions, UFS, 2003).*

A very competent and experienced practitioner in occupational therapy asked me recently what made me choose to go into the field of occupational therapy. While it is certainly an important but difficult decision to make at the age of 18, I recall that I knew I wanted to go into the 'helping business'. While studying to be a medical practitioner seemed the obvious and most prestigious choice, it was too expensive. (I will return to the aspect of prestige during the course of my theoretical analysis). Subsequently, psychology seemed to be the next best option. Nevertheless, in my mind's eye, it appeared that I would have difficulty sitting passively, 'only listening to people's problems'. Thus, I heard from one of my classmates that her sister was studying occupational therapy. Until now, I cannot remember how she defined it, but I do remember her 'definition' included working with sick/ill people and being creative in the process.

In this description, I encountered a crucial concept that would crop up many times in the following study: that of creativity. Thus, I embarked on the journey of occupational therapy. I studied for four years and was taught that occupational therapy 'equals activity'. I learned that each patient is assessed in terms of his/her five basic abilities (performance components): sensory, motor, cognitive, affective and conative. When these components are affected by disease or dysfunction, they may - when appropriate - be 'remediated'. These basic abilities enable a person to engage in 'activity performance' or performance areas e.g. personal care, interpersonal relationships, life-skills,

work, play and recreational activities. When adversely affected, these abilities may be 'rehabilitated'. I learned that our task is to strive to help our patients to become independent, have balanced occupations and as therapists, always to bring in activity as treatment.

I graduated and then worked at a private facility for people with alcohol and drug dependency problems, for a few months. The high standard of my undergraduate education and training enabled me to leave South Africa for some years to work abroad. There I became aware that the boundaries between occupational and physical therapy were a transverse division between the top and bottom half of the human body. OTs treated upper extremities and PTs the lower extremities. Overseas, I learned that unit targets had to be reached, careful documentation had to be completed every day, justifying exactly (read 'quantifying') how progress was made in strengthening the upper extremities (by means of the amount and frequency of resistance that the patient could manage with 'Thera-band' or weights). I gratefully learned how to use other physical agents such as ultra-sound, paraffin baths and so on and enjoyed the clear-cut boundaries, as well as knowing exactly what was expected.

Returning to South Africa, I realised just how much the international working experience had benefited me and I was appointed at an international company in the sector of 'Disability Management'. It was my task to review all medical records of a client and based on those, (and often including an occupational therapy report from a private OT practitioner), conclude whether a person qualified as medically unfit to continue with his/her 'own or any other occupation'. In my infrequent personal encounters with the often anxious client who was being assessed, and in accord with the practice protocol of the company, I usually explained that the occupational therapy evaluation is the last step before a final decision is made. Furthermore, I tried to clarify whether such an occupational therapy assessment mainly entailed an evaluation that gave the assessor a picture of how the person functioned in his/her everyday life.

Here I became aware of a sense of uneasiness after having to deal with clients who were able to qualify relatively easily for vocational disability, and, subsequently receiving 75% of their salary. However, they would be re-evaluated again after a period of two years; this time, with different criteria that stipulated an 'ability to work in any other occupation'. Thus, I witnessed many cases of individuals who were allowed to stop working by the system; being removed by this system from an open labour market for two years, then were expected to return to the same open labour market with little control over their responsibility for facilitating and maintaining their rehabilitation.

After having relocated, I started a private practice in the psychiatric field of occupational therapy, being privileged to work as part of a multi-disciplinary team, which included psychologists and a psychiatrist. I soon became aware again of the professional hierarchy in such multi-disciplinary teams and also of the fact that occupational therapy, although being valued, continues to be viewed as an accessory and not of cardinal importance to the treatment of a patient. Within the facility where I worked, it was occupational therapy's responsibility to orientate each group of patients to the multi-disciplinary standard programme that was followed. We would explain to the patients that there were different role players in the multi-disciplinary health team. We would usually explain that the psychiatrist is the primary therapist or 'gate-keeper', who ensures that they receive the correct medication for specific diagnoses. The psychologist would speak to them about their inner worlds and the inner dynamics that had contributed to their current states, while the occupational therapist would teach them skills that would empower them for the future, such as self assertiveness, for example.

At the present time, I am privileged to have taught occupational therapy for a few years at a university (UFS). However, after all the learning processes and experiences that I have recounted above, the following burning question is for me, more prevalent than ever: "Why does occupational therapy continue to have identity problems?"

When informally discussing these questions with a colleague, it was remarked: "But are you not outside the boundaries of occupational therapy already, when asking such a question?" Upon reflection, it seems that the latter remark is both right and wrong; right, because the themes referred to above are indeed not part of 'ordinary, everyday' occupational therapy, but wrong, because they are an inherent part of the underlying philosophy of occupational therapy. It is with a view to the partial and tentative exploration of these central and indeed foundational issues, that the following study was undertaken.

SYNOPSIS

Occupational Therapy's (henceforth referred to as OT) self-concept apparently remains, for all practical purposes, not well defined. While the complexity of the OT profession's definition and their subsequent difficulty of articulating this might point to the very unique character of the OT profession, it does not follow from this that its future relevancy is therefore ensured. It is furthermore contended that due to the ongoing self-definition of the profession, there is a globally increased focus on occupational therapy's values and philosophy about our relationships with not only those to whom we render a service, but also the environmental realities we form part of.

An inevitable link is indicated between critical reflection in OT practice, and the profession's identity. While research on reflexive practice may be associated with the critical theoretical framework or critical social theory, this type of research in OT appears to be relatively scarce, and is mostly associated with research topics pertaining to clinical reasoning.

In order to explore one possible path through these complex problems, this study turns to the core field of philosophy, which is that discipline that studies essentially the foundations of disciplines (among other things). The present study will avail itself of a specific philosophical and sociological tool namely ideology theory. Currently, little or nothing is known about the presence of specific ideologies in the field of OT. Ideology theory is closely related to critique and self-reflection.

The *main aim* of this study is to perform a critical analysis of the presence of ideology in the profession of OT, by applying a three-dimensional ideology analysis. In order to meet this aim, an innovative approach had to be followed during which a unique methodology is argued. This study is subsequently typified as a (so-called) *non-empirical* type of research, based on a *critical* theoretical framework, using *philosophical analysis* as a study design, specifically applying *ideology critique* as a method of analysis.

In accordance with existing approaches in ideology theory, this study focuses on three levels of analysis in its own model of ideology critique: the socio-historical analysis of concrete contexts of domination (Chapters 2 & 3 and 5) the formal-structural analysis of the theory (model) of ideology critique that is used (Chapter 4), and finally, a creative end-interpretation of these analyses (Epilogue) with suggested perspectives for the ‘de-idolized’ future of OT.

The ideology critique model (Ideology Typography of Modernity or ITM) applied in this study revealed a systematic identification of ideologies that are present in the OT profession. These analyses show that ideology critique may serve as a methodical tool for critical self-reflection, offering a limited but penetrating perspective on the ‘deep structure’ of OT discourse.

SINOPSIS

Die self-konsep van Arbeidsterapie (voortaan AT) bly klaarblyklik vir alle praktiese doeleindes nie goed gedefinieerd nie. Terwyl die kompleksiteit van die AT professie se definisie en die feit dat hul dit moeilik vind om dit te artikuleer dalk juis mag dui op die unieke karakter van die AT professie, kan dit nie afgelei word dat die beroep noodwendig relevant sal bly in die toekoms nie. Weens die beroep se voortgaande self-definisie word daar verder aangevoer dat globaal meer gefokus word of AT se waardes en filosofie oor hul verhoudings met die mense aan wie hul ‘n diens lewer sowel as die omgewingsrealiteite waarvan hul ook deel vorm.

‘n Onvermydelike aansluiting word aangedui tussen kritiese refleksie in AT praktyk en die beroep se identiteit. Terwyl reflektiewe praktyk geassosieerd mag wees met die kritiese teoretiese verwysingsraamwerk of kritiese sosiale teorie, blyk hierdie tipe navorsing in AT taamlik skaars te wees en word meestal met navorsingstemas oor kliniese beredenering verbind.

Ten einde om een moontlike weg deur hierdie komplekse probleme te verken, draai hierdie studie na die kernveld van filosofie – die dissipline wat essensieel die grondslag van alle dissiplines bestudeer (onder andere). Die huidige studie gaan die geleentheid te baat neem om ‘n spesifieke filosofiese en sosiologiese hulpmiddel naamlik ideologieteorie te gebruik. Tans is daar min of niks te wete oor die teenwoordigheid van spesifieke ideologieë in die veld van Arbeidsterapie nie. Ideologie teorie hou strykelings verband met kritiek en self-refleksie.

Die *hoofdoelwit* van hierdie studie is om ‘n kritiese analise van die teenwoordigheid van ideologieë in die AT beroep uit te voer, deur ‘n drie-dimensionele ideologie analise toe te pas. Ten einde hierdie doelwit te bereik, moes ‘n innoverende benadering gevolg word waartydens ‘n unieke metodologie beredeneer is. Hierdie studie word dus getipeer as (sogenaamde) *non-empiriese* tipe navorsing, gegrond op ‘n *kritiese* teoretiese

verwysingsraamwerk, met die gebruik van *filosofiese analise* as ‘n studie ontwerp, en waartydens spesifiek *ideologiekritiek* as metode van analise toegepas word.

In ooreenstemming met bestaande benaderings in ideologiekritiek, fokus die huidige studie op drie vlakke van analise binne die studie se eie model van ideologiekritiek: die sosio-historiese analise binne die konkrete kontekste van dominasie (Hoofstukke 2 & 3 en 5), die formeel-strukturele analise van die teorie (model) van ideologiekritiek wat gebruik word (Hoofstuk 4) en eindelik, ‘n kreatiewe eindinterpretaise van hierdie analises (Epiloog) met voorgestelde perspektiewe vir die ‘gedeïdeologiseerde’ toekoms van AT.

Die model vir ideologiekritiek (“Ideology Typography of Modernity”, of ITM) wat in hierdie studie toegepas word, onthul ‘n sistematiese identifisering van ideologieë wat teenwoordig mag wees in die AT professie. Die analises dui daarop aan dat ideologiekritiek mag dien as ‘n metodiese hulpmiddel vir kritiese self-refleksie, wat ‘n beperkte maar deurdringende perspektief bied van die ‘diep struktuur’ van AT diskoers.

INTRODUCTION AND OVERVIEW

> *Citizens who cultivate their humanity need, further, an ability to see themselves not simply as citizens of some local region or group but also, and above all, as human beings bound to all other human beings by ties of recognition and concern. The world around us is inescapably international* (Nussbaum 1997:10).

1. A Question of Being Relevant: The Occupational Therapy Identity

Imagine if we lived in a reality where occupational therapy (henceforth OT) is not only a concept that everyone knows and thinks of as synonymous with the human rights of health and well-being, but where it is also regarded globally as essential in realising these rights (OHCHR 1996: 4). This would be a world where OT is seen as fundamental to global humanitarian relief programmes, and where the true potential of this profession may be appreciated by every human being. This would be a reality where OT practitioners fully recognise the complexity of the twin themes of meaningful occupation and health (Wilcock 2000:81) and where occupational therapists (henceforth referred to as OTs) fully understand the relations between the philosophical base of the profession and its theory and practice (Ikuigu & Rosso 2003). A reality where OT is in a position to contribute to political and administrative decision-making to ensure occupational justice for all humans (WFOT 2006; Wilcock 2001:5).

Given that the OT profession is less than one-hundred years old, it is not surprising that this profession continues to make significant advances in theory

and practice; a fact that some take as a confirmation of the remarkable and innate characteristic of the profession's adaptability. On the other hand, other matters that also have become part of the profession's 'character' are more problematic. These issues have not dissipated since the founding of the profession, or at least it seems that not enough has been said or done for generally accepted resolutions to be achieved. One such concern is the identity problems of OT (Blair & Robinson 2005; Creek, Ilott, Cook & Munday 2005; Fisher 2003; Ikuigu & Rosso 2003; Ikuigu & Schultz 2006; Hooper & Wood 2002; Watson 2006).

Chevalier (1997:540) states that after scrutinising many issues in relevant OT journals, his long-standing impression is confirmed that OT as a profession is still in the process of defining itself and still in search of its own, ultimate meaning. This resonates with De Witt's (2002:2-3) presentation on the theme of "Pathways" during the 19th Vona du Toit Memorial Lecture, in which she also discusses, for example, the many ambiguous views and definitions of the concept of 'occupation'. She further states:

> *Consensus around key terms is important for dialogue with-in and outside the profession and for the development of coherent models and tools for practice.....there is an urgent need for the profession to address and get consensus on its professional language*.

OT's self-concept apparently remains, for all practical purposes, not well defined. While the complexity of the OT profession's definition and our subsequent difficulty of articulating this (De Witt 2002:3) might point to the very unique character of OT (Creek 1994:23), it does not follow from this that our future relevancy is therefore ensured (Joubert 2003:3; De Witt 2002:6). It is also contended that due to the ongoing self-definition of the profession, there is an increased focus on OT's values worldwide and its relationships with not only those to whom they render a service, but also the environmental realities that

they form part of (Kronenberg & Pollard 2005:1). It is further argued that because of the very growth of the OT profession, it is increasingly challenged to shift the now less adequate boundaries and definitions of what has previously been viewed as ‘holistic’ (Kronenberg, Simó Algado & Pollard (eds.) 2005:56).

Many explanations may be proposed for the profession’s identity problems. One line of reasoning is that of the tensions within the theoretical paradigm of the profession, as well as the conflict between OT philosophy and practice. Incongruent philosophical paradigms such as pragmatism and structuralism are recognised as having had significant influences on the professional stance of OT (Hooper and Wood 2002; Ikiugu & Schultz 2006; Wilcock 1998:178-179; Wilcock 2002:41-44). It is therefore apparent that a continuous dialectic exists between the OT profession’s philosophy of health associated with the medical model and its deep and central allegiance to occupation (Wilcock 2000). This dialectic appears to inform the profession’s search for a balance between concepts, such as ‘art’ and ‘science’, ‘holistic’ and ‘functional’ and ‘body’ and ‘mind’ (Mattingly & Flemming 1994:302; Peloquin 2005). Moreover, similar discrepancies are echoed in discussions of the field of research in the OT profession:

> *A consequent dissonance is evident between ontological assumptions, ways of generating knowledge and practice within occupational therapy* (Blair and Robinson 2005:269).

In the same vein, Hagedorn (1992:3-4) points to two main and “incompatible” views in the philosophy of the OT profession: that of the reductionist and the holistic perspectives.

Wilcock (2000:1) proposes that one of the ways of consolidating such tensions and developing a uniform OT identity, is to build “a personal, professional, and educational philosophy grounded in the association between occupation and health”. Some argue for pragmatism as such a philosophy, since this is supposed

to be the closest to the ontological assumptions of the OT profession (Breines 1986; Hooper and Wood 2002; Ikiugu 2004; Ikiugu & Schultz 2006;). Conversely, Blair & Robertson (2005:275) conclude that "[o]ccupational therapy lies on a medical/social fault line and, as such, is theoretically eclectic and epistemologically pluralistic".

Another line of argumentation that offers an explanation for the identity problems of the OT profession is the one about the very complexity of OT as such. This notion acknowledges that the OT process *per se* is individualised and unique to every client. The process is described as being complex and contingent as it is shaped by many 'variables', such as the therapist and the client within his/her own environment, context, worldview and experience history, and what individuals perceive as 'meaningful occupation' (Creek, Illot, Cook & Munday 2005:281-284; Whiteford, Klomp & Wright-St Clair 2005: 3-15).

Ruth Watson (2006) corroborates this line of reasoning by arguing that it is important to appreciate the cultural identity ("essence") of the OT profession. She points to the fact that while the OT profession might share a global philosophical/theoretical basis, OT practice as such, *cannot* be uniform. The reason for this is that the occupations, which are the vehicles for therapeutic means, are indeed very culturally-specific and should be, if occupation is to impact on people's lives for health and well-being purposes (Watson 2006; WFOT 1999:6).

The above rough sketch of the 'state of the art' in OT is meant to provide an initial image of the issues that motivated me to undertake this study. I wanted to bring some perspective to the above-mentioned problems that plague the profession. I also realised that one could not address these issues haphazardly, reflecting on them one by one, and by trusting one's own 'gut-feelings'.

Therefore, I chose to turn to a philosophical/sociological theory that I had become acquainted with; a certain model of ideology theory called the Ideological Typography of Modernity (ITM). I wanted to see how OT would come out from a 'confrontation' with this theory, which deals in a very specific way with value, power and domination. This confrontation (of diagnostic analysis) would be between the model of ideology (ITM) and OT discourse, to probe the possible ideology content of this discourse and practice, as well as between this model and the culture and society in which OT finds itself. With reference to the latter and for the purposes of this study, I shall take this culture to be that of *modernity* in its broadest sense - defining 'modernity' as Western culture since approximately the 17th/18th century. However, this model does not hold that development and progress have to be Western to count as such – that would be regarded as Eurocentric. Even in developing countries such as South Africa, other cultural contexts are very much interwoven with the culture of modernity. All of this is closely related to critique and self-reflection.

2. The OT Identity and Critical Self-Reflection: Choosing and Articulating a Suitable Epistemology

Much is being said nowadays about reflective and reflexive practice in OT. While these two terms are often used as synonyms, some authors however, make a distinction. Finlay (2002:532-533) differentiates between these terms in the sense of referring to *reflective* practice as a concept that entails the contemplation about something external from the practitioner that occurred in the past. Additionally, she describes *reflexive* practice as a continuous process that occurs more internally and entails a "subjective self-awareness". Blair and Robinson's (2005:270) analysis of these terms are similar and add that reflexive practice is "about subjecting your own knowledge claims to critical scrutiny". Whether one chooses to perceive these terms as being synonymous or not in day-to-day practice, critical reflection has become a crucial principle in health

care practice (Gamble, Chan & Davey 2001; Whiteford 2005:45) and is stated by WFOT (World Federation for Occupational Therapists) as one of the skills required by an OT for competent practice (WFOT 1999:8).

Whiteford (2005:44-46) also indicates an inevitable link between critical reflection in OT practice and the profession's identity. Critical reflection is regarded as the basis of the "craft knowledge" of a profession, and it appears that this skill (critical reflection) indeed resonates with the 'artistry' feature of the definition of OT. However, for a profession to remain relevant in an "era of accountability", it needs to be able to clearly articulate its epistemological ("how it comes to know" (Henning 2004:15)) foundations (Whiteford 2005:46). The latter is a point of contentiousness, as reflexive practice is generally associated with much subjectivity and lack of 'evidence' (Finlay 2002).

The following diagram may be argued as illustrating the above relations:

Diagram I. The Circular Relations between Critical Reflection, Professional Craft Knowledge, Professional Epistemology and Professional Identity.

Research on reflexive practice may be associated with the critical theoretical framework (Henning 2004:23) or critical social theory. (Detailed argumentation will be further outlined in Chapter 1.) This type of research in OT appears to be relatively scarce, and is mostly associated with research topics pertaining to clinical reasoning (Blair & Robinson 2005:274).

In one other study (using critical social theory), Mackey (2006) contends that a Foucaultian analysis of the oppressing powers of theoretical constructs and discourse in the OT profession, may assist the OT profession in creating a new, dynamic and authentic identity. Mackey (2006:5) points to Foucault's argument for analysis entailing:

> *practice of the reflexive, ethical self [in which] mature judgement rests on the reflexive examination of contradictory possibilities and power relations within the professional discourses*.

3. The OT Profession Engaging in Systematic Self-Clarification: Investigating Ideology Theory as a Means of Critical Self-Reflection

In view of OT's identity-dilemma and its links with reflexive practice, it may be said that contributions to define, clarify and argue the theoretical base of OT, are invaluable to the philosophical discourse of this profession. It is apparent from the OT literature that different and specific angles have been used to serve as means of such self-reflection. Compare frameworks such as those of structuralism, pragmatism, complexity theory etc. As mentioned above, my own contribution to this debate is to explore *one* encompassing sociological and philosophical tool for the purpose of professional critical self-reflection: that of ideology critique.

The ideology tool (as outlined in detail in Chapter 4) that this study will implement, seeks to analyse both conceptual distortions (relations of conceptual domination) and social relations of domination. An example of the former is the technocratic management of illness, where technological considerations may come to distort or dominate ethical norms, authentic communication, principles of patient care, and so on. An example of social ideology may be found in relations of domination that may function within institutions such as universities or hospitals or the families from which patients come. Such relations may be centred on various indicators such as class, gender, race, age, etc. Ideology analysis also aims at analysing possible links between conceptual distortions and relations of domination.

In this introductory context, I wish to point to two main characteristics of ideology:

- It has an aura of exclusiveness where the nature of certain ideas, judgements and perceptions are viewed as non-negotiable.

- When criticised, ideology cultivates the fabrication of enemy-images, serving as a shield for the self-appointed privilege to deflect criticism at its own convenience (Schoeman 2000:14-15).

As for the pervasiveness of ideology, I can only refer to Schoeman's remark: "it adversely affects every mode of human existence, every aspect of human culture, and every structure in society" (Schoeman 2000:12).

However, little or nothing is known about the presence of specific ideologies on the development of occupational therapy as a profession. This could be one of the reasons why this profession, along with other professions such as nursing, is viewed as secondary and restricted to the realm of medical science and is therefore, mainly the business of treating illness. In exploring the global history of

the medical and related professions, it becomes clear that one form of ideology, namely patriarchy (the domination of 'male-ness'), has shaped their development, which in turn, explains why occupational therapists (for example), which is a female dominated profession, are considered as merely assistants of doctors (Capra 1983:121-122).

Consequently, the *premise* of this study is that ideology has had and still has an influence on the professional standing of occupational therapy, and might therefore, to some degree, account for the identity problems of this profession.

The *main aim* of this study is to perform a critical analysis of the presence of ideology on the profession of occupational therapy by applying a three-dimensional ideology analysis (Thompson 1990:307-313), as discussed in detail in the following chapters. A secondary purpose is to establish and outline an appropriate research methodology (Chapter 1) that can accommodate the stated aim. This calls for an innovative approach that, to my knowledge, has not been attempted previously in the OT profession.

The *value and significance* of this study lies in demonstrating the importance of ideology critique as a tool for critical self-reflection in OT's quest for creating a clear and sustainable professional identity. There is a vital link between OT's critical self-reflection and ideology critique: that is the search for 'truth'; the truth, or authenticity of OT as a profession. However, having said this, it has to be recognised that pure and complete truth in this regard is hardly attainable in the human life-world. The reason for this is that human access to unadulterated reality is always limited and distorted.

It is limited because human beings are just that: human, and therefore structurally shaped by our evolutionary history to have only a very specific kind of access to all of reality that is 'out there'. It is distorted, because all individuals (including the researcher), are subjected to their unique worldviews, histories and

perceptions. These are always tainted by false impressions, even though we are unaware of them. It is important to note though, that these very considerations that caution us to be realistic in our attempts to root out the ideologies in our world and in our profession, are part of ideology critique itself.

Hopefully this study will also illustrate the importance of owning basic knowledge about ideology critique, thus empowering members of the health profession to gain an accountable and insightful sensitivity toward cultural differences, as well as truly comprehending their own worldview and subconscious frame of reference when dealing with members from other cultures, which is so relevant and necessary in Africa.

4. Clarification of Terminology Often Used

Since this study is a focused ideology critique of the OT profession, the following concepts are *contextually explained in detail in the following chapters*. However, at this stage, a brief summary of certain technical terms might be useful:

- **Ideology**: The negative phenomena of when a power (in a conceptual or social form) is used for domination and which leads to distortion thereof e.g. techno-scientism, positivism, racism, elitism etc. For the purposes of this study it is understood not in the neutral sense of a ‘worldview’, but in the negative sense of distortion and domination, e.g. the idolisation of technology, or patriarchal domination.

- **Ideology theory**: Refers to the model of ideology that will be used in this study namely the Ideological Typography of Modernity (ITM - as outlined systematically in Chapter 4). ITM includes the two levels of domination, namely, conceptual/value/discourse domination (e.g. techno-scientism) and social domination (e.g. patriarchy or racism). The level of

conceptual/value/discourse domination progressively outlined in Chapter 4 from its macro to micro points, culminating in a depiction accordingly (Diagram 4.4, p. 111).

- **Ideology critique:** The practical application of ideology theory, for example (as in this study), to the profession of Occupational Therapy. Ideology critique may thus be defined as a critical awareness of when and how power is distorted.

- **ITM:** "Ideological Typography of Modernity". The specific model of ideology theory that is utilised for the ideology critique of OT.

- **Hypernormalise:** The absolutisation (idolisation) of one value above other equally important values or aims, to the point that the former dominates the latter. Various ideologies are defined by various hypernormalisations – for example, in techno-scientism, we find a hypernormalised technology.

- **Hypernorm:** While the verb for ideological dominations may be referred to as 'hypernormalise', the noun for the same concept may be used as 'hypernorm'. Synonymous to the latter is *'hypervalue'*. While I will refer to the act of ideological absolutisation as the hypernormalising of something, the resulting idolised form of that something will frequently be referred to as a hypernorm. For example, technology is obviously something that is necessary and useful, but in an ideological context it becomes a hypernorm.

5. Overview of this Study

Chapter 1, The Nature of This Study: A Journey Between Two Paradigms. This chapter entails a detailed explanation of, and argument for the type of research and methodology that has been employed in this study. A differentiation is made between empirical and non-empirical *types of research* and three different *theoretical frameworks* in research are explained. Based on the argumentation of the methodology, the researcher outlines the *study design* and *method of analysis* – the latter which includes criteria for trustworthiness. This chapter also includes the *ethical aspects* relevant to the type of study. Finally, there is some reflection on the importance of being critically aware of possible ideological distortions in research as such, strengthening the argumentation of the specific methodology in the present study.

Chapter 2, Identity and Ideology (Part I): A Brief Contextual History of Occupational Therapy in the Western World. This chapter involves a critical ideology analysis of the historical profile of the OT profession. Since human occupation is the central part of the profession's paradigm, the historical context of occupation going back to ancient and classical times, is taken into consideration. The time line is continued up to the Age of Enlightenment and further to include Moral Treatment - a significant period for the profession. The ideology analysis continues to the birth of the profession in the early 20th century, and its formative period up to the end of World War I, which indirectly led to the commencement of OT as a profession.

Chapter 3, Identity and Ideology (Part II): A Brief Contextual History of Occupational Therapy in the Western World. In this chapter the socio-historical ideology analysis of the OT profession continues from the 1920s up to the end of the 20th century. The ideologies that have been identified through the entire historical analysis, are summarised in table form. Since the researcher is

South African, a very brief account (due to the lack of suitable documentation) of the history of the OT profession in this country is included.

Chapter 4, Ideology and Occupational Therapy: A Systematic Perspective. Here the researcher presents a systematic analysis of the tool (ITM model) that is used for ideology critique in the present study. The analysis first explores the different levels and spheres of the discursive realm, relating each of these levels of ideology domination to the discipline of OT in general. It then moves to the social realm of ITM, using the same method of analysis.

Chapter 5, Occupational Therapy and Ideology Theory: The Practical Issues. This chapter demonstrates how the ideological 'landscape' concretely affects the lives of practising OTs. This is done by interviewing four experts in the profession, representative of four different fields in OT. This chapter aims to *illustrate* the premise of the study: the presence and influence of ideology in the lives of OT practitioners, as well as in the identity perception of the profession.

An ***Epilogue***, concludes the study. This entails a final, creative interpretation of all the forgoing systematic and socio-cultural analyses, and also suggests some perspectives for the 'de-ideolised' future of OT.

CHAPTER 1

The Nature of This Study: A Journey Between Two Paradigms

1.1 Introduction

The idea for this study originated between two partners, one being an occupational therapist (the researcher), and the other a philosopher (my husband), at a national occupational therapy conference in South Africa when we presented a paper entitled "What is in a name? Defining Occupational Therapy".[1] The title obviously sounded rather presumptuous, but was chosen deliberately in an attempt to re-open the debate about some existential-problematic issues in the OT profession.

Over the following few years the idea evolved into a topic for research.[2] The project came to be seen as an investigation of the 'ideological profile' of OT. A research proposal had to be constructed for the purpose of obtaining the Faculty of Health Sciences' approval in order to register the title. The proposal was submitted to a thorough process of clarification in accord with good academic and ethical practice. However, it was clear from the beginning that this attempt did not conform to the traditional structure of studies usually conducted within the faculty. One of the reasons for this was that the present study's main aim was not to gather 'data' in the traditional sense where the involvement of 'research participants' in one way or another is automatically viewed as part of the research process.

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[1] Occupational Therapy Association of South Africa national conference at the University of the Free State (UFS), in Bloemfontein, South Africa, 23-25 September 2002.

[2] There have always been attempts to 'define' concepts like 'research' in and of themselves, quite apart from actual research programmes in which they are functioning. For example, while research is defined as "to know", epistemology as the "philosophy of how we come to know", methodology is defined as the "practice of epistemology" (Henning 2004:15).

Moreover, in spite of rigorous explanations about the nature of ideology critique, substantiated by reputable social and philosophical resources, much collective confusion about the type of research continued to exist within the sub-structures of the faculty. Even at the point of being approved and 'recognised' (on the level of the School of Allied Health Professions of the UFS) as a non-empirical type of basic research in the shared disciplines of occupational therapy and philosophy, the proposal was still submitted to the Ethical Committee of the faculty, which in turn required as a prerequisite, a letter of endorsement from the Biostatistics Department before the protocol could be submitted for approval on a faculty level.[3] Interestingly, the input of Biostatistics was also required at the presentation of the proposal, this notwithstanding the fact that no statistical data would be involved in the study. 'Ethical' considerations which are usually accepted as standard practice (in contrast to, for example, requirements in the Faculty of Humanities) had to be adapted in an attempt to conform to the prescribed structure of a protocol.

The problem behind getting the proposal for this study approved, probably did not lie in an ineffective process, or in wilful misunderstandings or in agendas that might have been malevolent – my experience was actually to the contrary. The dilemma here appeared to be an "unbridgeable chasm" (Usher 1997:5) between two paradigms in research – the so-called empirical and the non-empirical paradigms.

As a faculty member in OT with interests in Philosophy, I was asking: How is it possible that in the same University within the 'universitas' (unity) of learning, such a chasm of incomprehension between two mountains of epistemology can

[3] Actually, the above use of the term 'empirical' often reflects the kind of ideological influence that is the object of this study. At issue here is a positivist worldview (I will return to this theme in later contexts) that links 'the empirical' to criteria such as case studies, interviews, numbers, graphs, etc. But the 'reality' to which 'empirical' refers, is after all, much wider than these extremely (empiricistically) narrowed-down aspects of reality. It could be argued that *all* disciplines and their theories are 'empirical' in nature – also ideology theory (and its perspectives in OT). There are many aspects to empirical reality. However, for present purposes, I will make (some) use of the term 'empirical' in its more traditional sense.

exist?[4] On the other hand, I am sure that my experience is not that rare. The basic problem here is the "incommensurability" (Kuhn 1970:150) of paradigms.

Of course, in this situation I was confronted by the valid question as to why this study should qualify for formal registration within the discipline of Occupational Therapy, considering that the 'methodology' (I was going to use ideology theory) is situated within the disciplines of sociology and philosophy.[5] A few arguments may be presented here.

Firstly, while OT is regarded as an applied science, does this imply that one may not ask research questions other than those that will provide 'yes' or 'no' answers? And if this were to be the case, how have the theoretical foundations of the discipline (or any discipline for that matter) then been established? May we not rather say that all academic disciplines are born out of 'non-empirical research'; that is, questions and perspectives *preceding* data gathering? In this sense, 'theory' actually precedes observation (Popper 1965; Popper 1972: 81, 258).

Secondly, when asking the really deep and therefore philosophical 'why' questions in any discipline, it does not automatically render the research as being in the discipline of philosophy. The purpose of this study is to explore some of the identity problems of occupational therapy with the hypothesis that ideological theory might shed some light on them. But similar questions may be asked in any discipline without the raising or the answering of the questions taking leave of the discipline in which they are asked.

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[4] Epistemology deriving from the Greek word *episteme*, directly translated as "knowledge" and in its applied sense means "how we come to know" (Henning 2004:15) or "authentic / truthful knowledge" (Mouton 2001:138).

[5] For some, methodology is defined by the theory of knowledge while research methods are the 'techniques and strategies' to execute the research (Hammell & Carpenter 2004:9).

The third and main argument however, is that the object (purpose) of any field of research question indicates the methodology.[6] In other words, methodology is subordinated to the subject/object of research and not the other way around. The object of research should indeed determine the methodology. Methodology is not a primary concept but a secondary one; there is not a 'discipline' of methodology as compared to epistemic disciplines such as history, linguistics, economics or even OT.[7] Nor should methodology be *defining* of OT. One of the five principles that are said to constitute the ethos of OT is that OT is as much a science as it is an art and that being prescriptive about certain types of research, especially the positivistic kind, may be damaging to health professions such as OT (Peloquin 2005:613-619). Rather, the latter concerns itself with the human being in multiple contexts and who, in recent times, only started clarifying "its own unique epistemological foundation of occupation" (Whiteford 2005:41).

Being in awe of a 'methodology' separated from the actual goal of a research programme, may be compared to producing and sharpening a knife endlessly without starting from a clear idea of what particular use to which the knife is suited.

The present chapter will therefore focus on the "argument of methodology" or "methodological reasoning" as it is referred to by Henning (2004: ix).

In many ways, the methodology of the present study is an attempt to remain true to the 'artistic' part of OT's definition, while acknowledging the 'scientific' aspect of it (Peloquin 2005: 613, 616-619). This is especially so if the 'scientific' aspect is equated with the way things are done in the natural sciences.

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[6] Harvey (1990:1) attempts to define methodology as "the point at which method, theory and epistemology coalesce."

[7] 'Epistemic' is defined by some as "the scientific study of knowledge, as opposed to the philosophical theory of knowledge, which is known as Epistemology" (Bullock & Trombly (eds.) 1999:279).

It should be noted that some of the subtitles of this chapter will be familiar and in accordance with the generic structure of a traditional chapter on methodology with respect to applied research in OT. Other traditional subtitles will be omitted because of their irrelevance/inappropriateness to this type of research, though the issue itself will receive attention throughout.[8]

In terms of one possible methodological approach, the present study will qualify as a (so-called) non-empirical *type of research*, based on a critical theoretical *framework*, using philosophical analysis as a *study design*, specifically applying ideology critique as a *method of analysis* (Henning 2004:23; Mouton 2001:178). Given that this description of research might appear unfamiliar and indeed quite 'untraditional' within the positivist epistemological framework, which is regarded as traditional within the Health Sciences, I will now attempt to explicate these concepts in a logical and orderly way.

I shall start with defining the type of research engaged in, illustrating why and how it differs from a traditional empirical study that requires positivist parameters. Following this, a distinction will be made between the three epistemological frameworks, once again exemplifying how the epistemological framework of this study differs from a positivist or an interpretive framework, which usually makes use of quantitative and qualitative study designs, respectively. Finally, I will return to the subtitles 'study design' and 'method of analysis', in describing these concepts according to the nature and type of this study.

[8] It needs to be mentioned that the rationale, as well as the aim, and value and significance of the study have been fully covered in the Introduction and Overview.

1.2 Type of Research

The term ‘research’ is derived from the Latin word, which means 'to know'. Although many textbook ‘Introductions’ make much of the etymological origin of terms, such definitions *per se*, do not provide satisfactory explanations. It is important to remember that linguistically, contemporary contexts determine the meaning and use of words. The interpretation of the word ‘research’ also varies from different perspectives and even from different frameworks of knowledge. For example, empirical research is, in general, defined by the systematic or logical investigation of, or inquisition for, knowledge (Katzenellenbogen, Joubert & Abdool Karim 1997:3; Huysamen 1993:35-36).[9] A more specific definition for research, from an empirical framework for example, would be: “a systematic process of gathering and synthesising empirical data so as to generate knowledge about a given population for a selected topic” (Bailey 1997:1). At least in this description, the terms “data” and “population” seem to point to the characteristic attitude of the researcher.

Another approach is that in its broadest sense, research may be defined as a way in which to find an answer to a problem; a way to seek the best answer by obtaining the best possible solution (Hammersley 1995:102; McKenzie 1997:8). In order to provide the most appropriate solution to a certain question, the process of finding such an answer should be pursued by the methodology as already discussed.

Research is further divided into two main streams: basic or fundamental research, and applied research. While applied research uses already existing knowledge in order to expose general laws of connection and/or causal factors that apply to a certain group at a certain time, basic research concerns itself with

[9]Again, this definition of research is not wholly satisfactory from an ideology-critical point of view. Obviously, ‘system’ and ‘logic’ are not *defining* for scientific research only. They also occur in everyday life, when someone goes about some or other task *logically* and *systematically*.

generating fundamentally new knowledge (Katzenellenbogen *et. al*. 1997:3; Huysamen 1993:35-36).

In terms of the basic or applied type of research, the present study would clearly belong to the former type, but this is as far as OT is concerned. As far as the philosophical tool I am using is concerned, my investigation would count as the application of a given theory.

Once again, I have to emphasise that the importance of the *purpose* of the research, as well as the *nature* of the research question, determines the appropriate methodology. Finlay (2006:325) states in this regard: "If a piece of research is to be evaluated, it *needs to be evaluated on its own terms".* In accordance with the design of this study, which is a philosophical analysis, the study seeks not to find 'empirical' answers, but rather answers about the *meaning* of the role of ideology in OT.[10] My own view, derived from philosophical discussions, is that research is geared toward *aspects* and from their *coherence* with other aspects of reality, which is *abstracted* from everyday contexts.[11]

To further elucidate, the 'type of research' question as it applies to the present study, I refer to Mouton (2001:57). He refines the differentiations of research by describing two main types of study, namely, empirical studies and non-empirical studies. Under the former reside traditional qualitative and quantitative studies. The latter is described as conceptual analysis, theory or model-studies, literature reviews and philosophical analysis. The following table provides a clear overview:

[10] The study design will further be discussed under 1.4.

[11] To illustrate the concept of looking at the realm of research through different spectacles, Dooyeweerd's analysis of the fifteen aspects of reality may be referred to. These aspects in order, are: number, space, kinematic, physical, biotic, psychic (psychological), logical, historical/formative, lingual, social, economic, aesthetic, juridical, ethical and belief/spiritual. Dooyeweerd's aspect theory will receive further attention in Chapter 4 and in the epilogue. For further attention refer to L. Kalsbeek (1975).

<table>
<tr><th colspan="3">TYPES OF STUDY</th></tr>
<tr><th colspan="2">A. Empirical Studies</th><th>B. Non- Empirical Studies</th></tr>
<tr><th>a) Using primary data</th><th colspan="2">b) Analysing existing data</th><td rowspan="3">Examples of study designs include:
Philosophical analysis, Conceptual analysis, Theory building, Literature reviews</td></tr>
<tr><td rowspan="2">Examples of study designs include:
Surveys, Case studies, Programme evaluation, Ethnographic studies</td><td>i) Textual data</td><td>ii) Numeric data</td></tr>
<tr><td>Examples of study designs include:
Discourse analysis, Textual criticism, Historical studies</td><td>Examples of study designs include:
Secondary data analysis, Statistical modelling</td></tr>
</table>

Table 1.1 Types of study (Mouton 2001:57).

It should be clear that the nature of this study entails a non-empirical type of research since it will not be making use of any ‘data’ (in a positivist sense), but will rather be generating some sort of new information by analysing what kind of ideologies have been and are influencing the stance of the OT profession.

1.3 Theoretical Frameworks

Most individuals in the Health Sciences will recognise that empirical studies are known to use either quantitative, qualitative or a combination of the two study designs. These study designs are usually classified as falling under the

"positivist" and/or "interpretive" frameworks. The study design of this particular study will be further explained as falling under the "critical theoretical framework", although Henning (2004:23) does not acknowledge philosophical analysis as an example of this framework.

Henning (2004:15) states that the *purpose* of any study not only determines the chosen methodology of executing the study, but also needs to be grounded in an epistemological "home", which she later refers to as a theoretical framework. Cognisance of the appropriate framework is of the utmost importance to avoid confusion when concerning oneself with research. Whether it is about deciding what the problem to be researched is, how to execute the research and - just as important - the reading of research, the end result is to deliver valid critique (even if it is within a tainted search for truth). Failing to know what the theoretical framework/context of the research is, may be compared to looking at the realm of research through a particular colour of spectacles and presuming that every researcher sees it in that particular way.

Henning (2004:17-27) distinguishes between three frameworks in "epistemology", namely: positivist, interpretivist and the critical theoretical framework, respectively.[12]

1.3.1 The positivist theoretical framework

> *Typical examples of this type include survey studies, verification of hypotheses, measurement and scaling, statistical analysis and also in the post-positivistic paradigm, qualitative and quantitative*

[12] The critical examination of each of these theoretical frameworks in research is virtually a study on its own and will not be explored in this chapter. The purpose of this chapter is to *define* and *explain* the methodology that has been chosen for the purposes of ideology critique and analyses in OT and its environment. Therefore, the ideological manifestations of theoretical paradigms in research will receive attention in ensuing chapters and within the context of the present study.

> *descriptive studies that usually capture meaning at the level of description only* (Henning 2004:18).

The positivist framework, which I will later treat in a technical sense as an *ideology*, is intimately and explicitly related to ‘science' and empiricism of which the latter, in short, postulates that which is perceived through the physical senses of observation only, may be accepted to be true. Positivism in particular holds the philosophy that the only 'truth' is measurable (in so far as being observable, aside from logical and mathematical truths) and should be accurately described through data that are stripped from any ‘subjectivity’ (Popper 1972: 36n). Thus, the concept of *verification* is very important. Although some researchers within the positivist paradigm accept both quantitative and (most) qualitative data as ‘objective’, quantitative types of study generally remain higher on the hierarchy of repute and funding (Capra 1983; Finlay 2006:320; Gadamer 1996:2; Hammersley 1995:1; Usher 1997:1-7; Whiteford 2005:34-48;).

While the positivist type of study provides invaluable information especially for the Health Sciences and has increased the standard of health care practice (referring here to the Flexner Report in 1910 (HomeoWatch 2006; MedicineNet.com 2006)), the current day use of positivist research methods to me appears often to fall short of relevant, meaningful and substantial contributions to the *theory* (discourse) of OT. The use of the positivist framework will receive further critical attention in subsequent chapters.

1.3.2 The interpretivist theoretical framework

> *Whereas the positivist believes that the goal of science is to uncover the truth, the interpretivist believes the goal of science is to hold steadfastly to the goal of getting it right about reality or multiple realities even if we can never achieve that goal* (Henning 2004:20).

The interpretivist framework defined from the ideological perspective, which I will be introducing later on, could be viewed as a deeply philosophical reaction to the obsession of positivism with graphs and numbers; an obsession which actually excludes the research participant's own view. This reaction, as so often happens, tends, in the end to (ideologically) overemphasise the 'understanding' of ultimate subjectivity, over and against positivism's focus on 'scientific' objectivity (Popper 1972:162-165, 305-307).

1.3.3 The critical theoretical framework

> *Critical theory examines the processes of gaining, maintaining and circulating existing power relationships (and) aims at promoting critical consciousness and breaking down the institutional structures and arrangements that reproduce oppressive ideologies....*(Henning 2004:23).

The critical framework may be elucidated by Harvey's (1990:1) definition of what he calls "critical social research". He claims that in opposition to traditional positivistic

> *concerns to discover the factors that cause observed phenomena,…critical social research is underpinned by a critical-dialectical perspective which attempts to dig beneath the surface of historically specific, oppressive, social structures*.

Based on these definitions, it is thus clear that the epistemological "home" (Henning 2004:15) of this study is grounded in a critical theoretical framework. Nevertheless, I should point out that 'interpretive' approaches may themselves be contextualised within 'critical theory' approaches.

1.4 Study Design

This study has been identified as making use of philosophical analysis, which is defined as the following:

> *Studies that are aimed at analysing arguments in favour of or against a particular position, sometimes of a normative or value-laden kind. Studies that develop substantive points of view about the meaning of life (metaphysics), morally acceptable behaviour (ethics) and coherent and consistent forms of reasoning (logic)* (Mouton 2001:178).

It is said that a core difference between applied (empirical) and basic (non-empirical) research, is the point of departure in the study design and methodology. While applied research requires a given study design prior to the collection of data, basic research usually entails a so-called “emergent” design, which implies the prerogative of the researcher to adapt the procedures of ‘data-collection’ in order to gain benefit from data that emerge as the study progresses (Huysamen 1993:173). Here I must point out that if philosophical analysis (ideology critique) is accepted as a legitimate study design for non-empirical research, Huysamen’s pre-occupation with ‘data-collection’ (in the sense which is usually understood), is not relevant. Such ‘collection’ is not how philosophers and/or critical theorists go about their work.

Thus, I can only agree with Mouton (2001:146) when he argues that categories such as data collection, sampling, data analysis and the degree of control dimensions, are not appropriate and in fact, irrelevant to use when referring to these types of studies.

On the positive side, it is important to point out that one of the strengths of the design of the present study, lies in the fact that “both at a formal and substantive

level, philosophical analysis is an indispensable tool for making sense of our world" (Mouton 2001:178).

1.5 Method of Analysis

The method of philosophical analysis that I will use may now be specified as ideology-critique (Mouton 2001:178).

In accordance with Thompson (1990: 277-291), a well known sociologist and ideology theorist at Cambridge University, this study resonates with the three levels of analysis in his own model of ideology critique:

- the socio-historical analysis of concrete contexts of domination (Chapters 2 & 3 and 5),
- the formal-structural analysis of the theory (model) of ideology critique that is used (Chapter 4) and finally,
- a creative interpretation of these analyses (Epilogue). The application of these levels of analyses in the respective chapters of this study has been outlined in the previous chapter.

Let me now make a few summary points about the precise kind of ideology theory I will use (adapted from Visagie 2004:62-63). (Refer also to Diagram 1.1 as illustrative of the following points):

i) The term ideology will be used in its critical and not in its neutral sense. (That is; 'ideology' refers to domination relations, rather than mere 'worldviews').

ii) Two spheres of domination may be distinguished. Firstly, a discursive sphere where certain values may become dominated by others.

Secondly, a social sphere where social groups stand in relations of domination to one another.

iii) In the case of the first sphere, the pathological domination of certain values, goals or norms by a super-ordinated ‘hypernorm’ will be designated as ‘hypernormative’ domination.

iv) Hypernormative domination in the first sphere (for example, conceptualising and portraying a given culture as an overriding goal), is linked to social domination in the second sphere. (In the given example, the hypernormative discourse around Afrikaner culture has led to the social repression of apartheid.)

v) In the first sphere, a ‘landscape’ of many different ideological (hypernormative) structures is evident and they are interrelated in various ways. In the second sphere, it is imperative to distinguish between different types of domination related to class, race, gender, age, etc.

vi) Aside from hypernormative constructions (ideologies) within everyday life, there are those that occur in the worlds of theory and art. For example, in the first, positivism sets certain norms that are subject to various other norms and values (as I have pointed out above). In the world of art, movements from romanticism to surrealism and beyond have revolved around hypernormative understandings of what constitutes a ‘true’ work of art.

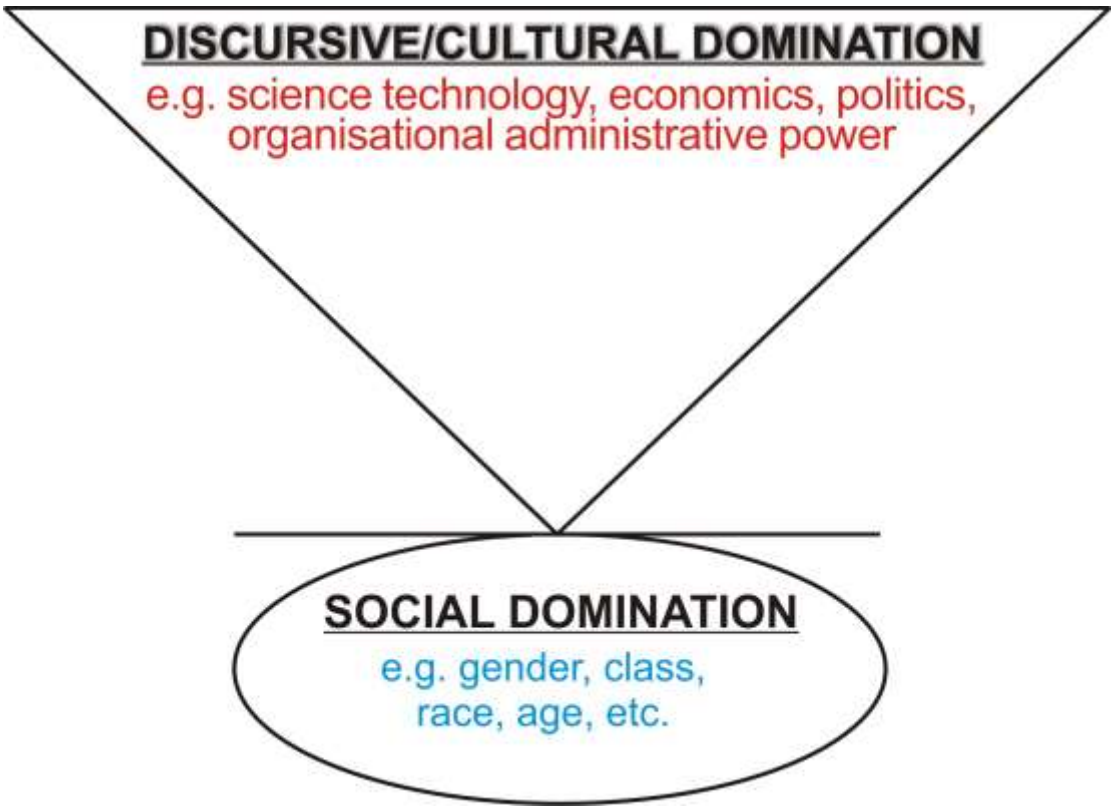

Diagram 1.1 A Model of Ideology Theory: Two Spheres of Hypernormative Domination: 'Discursive' and 'Social' *(Compounded from Visagie n.d. unpublished manuscript: 2-15).*

These few points give an idea of the kind of ideology critique that will be applied to OT further on in the study. Thus, in the later parts of this study, I will be investigating ways in which OT has been subjected to the described domination (discursive and social), and/or possibly have created such form of domination.

Returning now to the wider 'critical theory' framework of analysis, Harvey (1990:5) describes the process of analysis as follows:

> *For critical methodologists, knowledge is a process of moving toward an understanding of the world. Critical social research thus aims at an analysis of social processes, delving beneath ostensive*

> *and dominant conceptual frames, in order to reveal the underlying practices, their historical specificity and structural manifestations*.

For my study, this means ‘unearthing’ ideological constructs beneath normal and acceptable (or widely legitimised) discourses and practices in OT.

Although this study will be mainly employing philosophical analysis by means of ideology critique, it will also be using components of the theory/model-building method, since the researcher will be applying ideology theory to the development and current stance of occupational therapy (Mouton 2001:177). As far as critical analysis may *transform* OT theory or at least part of it, I will therefore be attempting to contribute to OT theory as such.

Concerning the socio-historical part of the ideology critical analysis: this will consist of an ideology critical analysis of the history of the OT profession as well (based on the emergent nature of the study design) the socio-historical experiences of four experts from various fields in the OT profession. (This part of the analysis is further explained in chapter (5).)

The application of the above described analytical tool is delimitated and guided by the following practical factors:

a) The defined boundaries of the occupational therapy profession as such.

b) The thematic boundaries of the chapter index.

c) Frequent contacts with the study leaders and both fields of OT and philosophy.

d) The mentioned source literature.

1.5.1 Trustworthiness

I will now address some other issues that are often traditionally raised in the introduction to OT type of research, as I have come to know it.

As already mentioned, this type of study does not lean toward the traditional tendencies of deductive reasoning that require a certain sequence of steps with the aim of verifying a preconceived premise, and can therefore neither be classified as a quantitative nor a qualitative study design.

Based on the fact that the research is typified as basic or 'non-empirical' research with an emergent study design and with the ('data') sources (that is literature, observation and informal, semi-structured interviews) being meaningful only in terms of their context, the implication is that not all data have to be submitted to customary reliability and validity checks as is the case of other types of research (Mouton 2001:146, Harvey 1990:8).

However, Mouton (2001:175) does point out that as with any study design, the present design type is subject to possible limitations and sources of error. These may entail the following:

- a tendency to hyper-abstraction that is far removed from everyday problems,

- a tendency towards dogmatism and intolerance of other philosophies, and

- the fact that the interpretation of the data will be partially subjective in terms of the researcher's theoretical framework.

Consequently, the following steps will be taken to meet four criteria for trustworthiness (Krefting 1991: 214-222), in order to decrease considerably, if not infallibly counteract these possible limitations:

1.5.1.1 Credibility is traditionally defined by the accuracy of the scientific findings or, as in this case, the extent to which the results of the critical analysis are "recognisable to people outside the research setting" (Taylor 2002: 105). The following measures reside under the criterion of 'credibility':

- A variation of triangulation by means of corroborating a specific theme in ideology critique such as the existence of Western techno-scientism for example, by using different sources of information, such as the self-understanding of occupational therapy as well as relevant philosophical and sociological literature, combined with observation and possible informal, semi-structured interviews. This may be coupled with a reflective approach of intellectual rigour in which the researcher returns repeatedly to the 'data' to confirm these categories, patterns, themes and linkages (Bailey 1997:147-150).

- 'Member checking' will ensure that the researcher also corroborates the findings with her co-study leader who is a senior lecturer in the academic department of Occupational Therapy, UFS.

1.5.1.2 Transferability may be considered as the second aspect of trustworthiness and is defined as "whether the research can be seen transferable to other settings…[or]…contexts" (Taylor 2002: 106). In the present case, this criterion is met by the following factors:

- Ideology critique as such, is a well-known field of study and is widely used for analysing power relations in various settings. The specific tool of ideology critique that I will be using, has been successfully applied in fields such as art and music, aside from academic discourse itself.

- The fact that the tool itself has sought to incorporate inputs from some of the most recognised power theorists in the world, such as Foucault (1965; 1980) and Habermas (1971; 1984; 1987; 1990), for example.

1.5.1.3 Dependability, the third aspect of trustworthiness "relates to how consistent the data findings are" (Taylor 2002: 107) or in more traditional terms, how replicable the research is:

- By using a systematically and analytically well-developed model of ideology analysis that also integrates several types of ideology analyses (as indicated above).

- By consulting an expert as a study leader on the use of ideology theory as a tool of philosophical analysis, care will be taken to ensure that the tool itself is applied correctly.

- Peer examination and member checking of the analyses and member checking of the interviews will be utilised, in an attempt to corroborate the illustrations with the experience of other occupational therapists (Bailey 1997:148-150). Chapter 4 & 5, which will entail the application of ideology theory to the occupational therapy profession in broad and in the lives of OTs, will be – once completed – handed over to a peer for non-recurrent peer review. This chapter will be reviewed by a peer in the local OT

department who is considered by others as having a strong background in the theory of occupational therapy. The objective of this review will be to ensure that the method of analysis, i.e. ideology critique, remains relevant to the profession (practice and discipline) of occupational therapy.

1.5.1.4 Confirmability is the final aspect of trustworthiness and refers to the strategies that the researcher uses to limit bias within the research (Taylor 2002: 108). In the present case, this again relies on the following three factors:

- By consulting an expert as a study leader on the use of ideology theory as a tool of philosophical analysis, possible misinterpretations of the theory, which is the other side of confirmation, will be counteracted.

- Peer examination of the analysis itself will either confirm or seriously question the many aspects of the analysis.

- The variation of triangulation as already described under 'Credibility' (5.1.1.1).

As can be seen from my attempt to take these criteria seriously, there is a significant overlap between them and the attempt in itself might appear to be somewhat contradictory to the emergent design character of the present study, as discussed previously. Perhaps again, this is the result of formalising criteria separate from actual research projects within unique environments.[13]

[13] For a more comprehensive argument on matching appropriate evaluative criteria with different types of research methodology, Gail Finlay's (2006:319-326) article on this subject may be consulted.

1.6 Ethical Aspects

The standard ethics of research of this type will apply. The overall concern is for (an approximation of) truth. In case of: theoretical conflict, factors of power and influence, loyalty to persons and/or institutions, personal prestige, etc. – my own view is that such considerations should all bow before the force of the best argument (Habermas 1971). This stance I consider to be a truly *academic* ethic, applicable to all fields of research.

The above notwithstanding, colleagues and other persons related to occupational therapy and its institutional environment, as well as other disciplines, will be treated with the necessary fairness and respect. The research proposal has met the approval of the ethical committee of the Faculty of Health Sciences, UFS.

Where expert representatives are approached for their input as part of the socio-historical analysis of this study, informed consent has been obtained for their participation and the use of the information they provide, during the interviews (Appendix A). Other considerations pertaining to the execution of this part of the study are fully outlined in the relevant chapter (5).

1.7 Conclusion

The process of composing the ‘traditional research proposal’ was indeed an interesting one. In reflection, my attempt here probably testifies to the ‘artistic’ aspect of OT. It is an authentic attempt to connect the “unbridgeable chasm” (Usher 1997:5) between the two paradigms of so-called empirical and non-empirical research.

For similar future endeavours, one might reconsider the relevance of some of the steps in the process, such as considerations and endorsement by Biostatistics

and the Ethical Committee, for example. Another consideration that might be worthwhile is to re-assess appropriate terminology; for example, replacing the traditional ‘protocol’ with ‘proto-theory’ for this type of research. Perhaps, this study could be a ‘proto-example’ for a new kind of methodology in OT, which some (Yerxa 1992: 81) argue the profession is in need of.

CHAPTER 2
Identity and Ideology (Part I): A Brief Contextual History of Occupational Therapy in the Western World

2.1 Introduction

The purpose of the next two chapters is to investigate the formative developments that might have had an influence on the ontology of the occupational therapy profession.[1] For that reason, the history of OT will be discussed only briefly and simply for the purpose of sketching a background for the ideological-critical discussions that are interwoven as part of the chapter. Ann Wilcock's (2001 & 2002) invaluable and detailed historical study on the use of occupation for health purposes has been implemented as the primary resource for chapters 2 & 3 due to the extensive nature and high standard of this work.[2] Another reason for limiting myself to this resource, (for the purpose of OT history) is that the approach of chapters 2 & 3 is less professionally historical than it is more an analysis of the ideological profile of the history of OT and therefore, more attuned to the openings for ideology that mark the history of the field.

Before embarking on the analysis of the present chapter, it is important to note that there is not a singularly definitive history of occupational therapy, but indeed many occurrences that contributed to the establishment and development of OT in many different places in the Western world. Some of these occurrences came

[1] Blair & Robertson (2005:270) uses the definition of ontology as "a philosophical standpoint that looks at how we came to be". According to this definition it seems similar to ideology in its neutral sense, something akin to 'worldview'. In this case, understanding the 'worldview' of OT for example, "provides a language that enables knowledge about it to be shared and lays the foundations for the way knowledge is generated". Ontology is more usually defined as the philosophy of what basically exists, of "being". In relation to OT then, *its* ontology would be 'the world of basic things' as it exists for OT (Honderich 1995:634).

[2] For a comprehensive view on the history of occupation for health purposes, from primitive times right up to the establishment and contemporary development of the OT profession until the end of the 20th century, particularly in the United Kingdom, Wilcock (2001 & 2002) may be consulted.

about at approximately the same time and others not, but what together, constitute what may be termed as the 'history' of the occupational therapy profession.

The pre-formative (Reed 2005:570) events that culminated in the establishment of OT as a profession, probably originated fairly simultaneously in North America and Britain. One needs to bear in mind though, that there is a history of OT in these countries as well as in the rest of the world, including South Africa. The roots of the profession however, were established in the Western world before taking specific forms in the East and in Africa (Black 2002:141; Iwama 2005:251-252).

The story of the OT profession is very young, considering that the profession was established only in the 20th century. Having said this, it should however be noted that what is regarded as the core concept of OT, namely occupation, is inextricably linked to the very origin and existence of humankind: a species which *per se*, is associated with purposeful and meaningful occupation that is performed by choice.

Wilcock (2001:12) points out that OT's understanding of occupation might be closely connected with the philosophical concept of *praxis*, which in essence means 'action' and from which the term 'practical' derives. The concept of 'praxiology' is also referred to as the "science of efficient action", which concerns itself with "methods of doing anything in any way…from the point of view of effectiveness" (Wilcock 2001:12). This view of occupation, in my opinion, does not seem wholly satisfactory, especially if we choose to *define* occupation as having to be 'meaningful' and 'purposeful' in order for occupation to be 'therapeutic' (Breines 1989; Kielhofner 1992; Trombly 1995).[3]

[3] The sidebar (l) will henceforth (during Chapters 2 & 3) designate all ideology analyses done by the researcher. Unless indicated by references included in such portions, the arguments are those of the researcher's performed according to the methodology described in Chapter 1. These references serve the

The definitions and practices of what is constituted as being 'meaningful' and 'purposeful' occupations were and still are formed, by the particular 'spirit of the time', by different worldviews and by specific social boundaries (Hocking & Whiteford 1995:173; Wilcock 2001:559).[4] In any case, the concept of meaningfulness transcends that of efficiency and effectiveness. Action may be highly effective and efficient yet lacks meaningfulness for the agent; for example, work which may be experienced as routine and boring, even demeaning.

Karl Marx used the term *praxis* in the sense of human beings being creative, autonomous and self-regulating beings (Wilcock 2001:363). Lobkowicz says in the same context that the term "refers to almost any kind of activity which a free man is likely to perform; in particular, all kinds of business and political activity" (quoted in Wilcock 2001:12). Compared to the view of Petrovic (an occupational scientist) who stated that if a definition for *praxis* is chosen that entails "freedom…then it is evident that there always has been more unfreedom and uncreativity in human history that the converse" (quoted in Wilcock 2001: 556). (This is, for example, a direct connection to the pernicious role of ideology in human history.)

To my mind, the notions of occupation, action and practice all relate to a more fundamental concept: that of creativity. Without doubt, the latter is essential to human being-in-the-world. It describes both what all of us *do,* (also in the most trivial contexts) and what should be part of an *ideal* situation for us. Implied in the concept of *creativity,* is that of *freedom.*[5] But these are systematic-philosophical

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purpose of pointing towards either factual information (as is in the case of Wilcock), or affirmation of ideology analyses (e.g. Capra) as in single cases.

[4] I note in passing that what we will encounter later as the social sphere of ideology domination, is of direct relevance here. Social boundaries lend themselves to various forms of domination such as, for example the phenomenon of class division. And a field like OT may either *accept* such boundaries (if only by its silence) or *critique* them.

[5] From an ideological point of view, one could remark that Lobkowicz's reference to business and politics is an indication of an ideological selectiveness. Why single out these two domains? One answer would be that they are suggestive of power. Besides, there are also patriarchal overtones here; note the reference to "free man". Creativity is such a wide concept that it would be quite impossible to reduce it to a singular

issues to which I will return in a later context. For now, my focus is historical-critical.

This chapter will be divided into two sections. The first deals with occupation for therapeutic purposes prior to the Age of Enlightenment. Since Moral Treatment is generally considered as the predecessor of OT, this theme, as well as the pre-formative years of the profession, will be discussed in the second section (Reed 2005:570). (The next chapter will entail the main focus of OT, which is the establishment of the OT profession in the early 20th century and onwards.)

2.2 Therapeutic Occupation Prior to the Age of Enlightenment

Before Medieval times (up to the pre-industrial era), people lived off the earth, mostly in agricultural communities (Capra 1983:37) and the main purpose of occupation was the very survival of humans. Being meaningfully and purposefully occupied was not only a normal human activity for which the family and the individual took responsibility, it served a therapeutic purpose in the most general sense of the word, as it also counteracted the suffering that was (and still is) equally part of being human. Certain individuals in society who were seen as spiritual leaders (e.g. shamans) and/or in possession of mystical powers or superior wisdom, at times also played the role of a "proto-therapist" and prescribed certain occupations for health purposes, for example dance rituals and the wearing of certain amulets combined with the use of herbs and baths (Wilcock 2001:30, 558).[6] It seems that during these times, occupation/work could scarcely be ideologised (absolutised). (That is to say, the way in which work may relate to narcissism and the cult of personal achievement – one of the ideological characteristics of modern, highly industrialised societies).

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specificity. Virtually *everything* has a creative aspect. Lobkowicz's attenuation seems to deny the meaning of creativity that is not professionally career-driven (for example, empathy and authentic care) and 'macho' as business and politics are often viewed.

[6] Wilcock (2001:555) refers to many kinds of "proto-occupational therapists" who prescribed some kind of occupation for health purposes prior to the birth of the profession, as we know it.

During the Greek-Roman period (600 BCE – 400 CE) the state, along with philosophers and physicians, took the role of prescribing occupations for health purposes with the focus on the balanced wellness of the physical body and mind. This is well illustrated when looking at Plato's view of a balanced educational curriculum that ranged from physical exercises to mathematics and music (Stumpf 1977:51). One of the central themes that was addressed during this time in view of human occupation, was that of *praxis* - a term of Greek origin, meaning 'action'. Aristotle uses it to speak of good practice (*eupraxia)* and bad practice (*dyspraxis)*. He also distinguished between ethical, political and, at times, economic *praxis*. The notion of *praxis*, as established by Aristotle, remained as part of the philosophies of later modern thinkers such as Kant (Wilcock 2001:29-30, 72-73).

The Medieval period (400 – 1400) was characterised by the victories of the Roman Catholic Church and its subsequent domination of all spheres of society.[7] Naturally, the emphasis changed from health promotion of the body and mind to the absolute value of the spirit and the afterlife. The father of the foundations of medieval philosophy is often referred to as being St. Augustine (Delius, Gatzemeier, Sertcan, & Wünscher 2000:20).

On the other hand, there are indications that some monks and nuns acted as "proto-occupational therapists" who prescribed certain occupations for spiritual and physical health purposes (Wilcock 2001: 554, 558). During this period, all practices that were not approved by the church were severely criticised. Under the watchful eye of the church, some scientific advances did take place, although "its main goal was to understand the meaning and significance of things, rather than prediction and control" (Capra 1983:38).

[7] The Medieval period is also known and referred to by some as the 'Dark Ages', based on the strict control of the Roman Catholic Church in the generation of new knowledge. However, the latter term will not be used here in order to recognise many finer developments that did occur during this time in areas such as music, art and literature, for example.

In this context, it may be noted that what we have here are, in fact, the trappings of a kind of ideology, where ecclesiastical power not only created various forms of social domination (the most extreme being the domination of the state by the church), but also a 'discursive' domination (a concept that was mentioned in Chapter 1 and will be returned to in Chapter 4). By the latter I mean a mindset wherein certain church-promulgated 'spiritual' values come to dominate other values in an unjustified way. This occurs, for example, when people view certain 'earthly' occupations as less spiritual and less meaningful than others – namely, those specifically associated with the church. This seems to be a mindset that has been carried over to a certain extent even to the present day.[8]

The end of the Medieval period was apparent when the theological doctrine of the Church was progressively challenged and with that, the re-birth of the values as upheld during the Classical period (Greek-Roman). Thus, the Renaissance was born, where the power for initiating therapeutic practices gradually returned to familial values. Early medical physicians (Wilcock 2001:559), along with humanist principles: the autonomy of reason and the drive to more freedom in culture and society, began to exert their influence. Wilcock (2001:137) specifically points to the congruence between humanist values and OT, as occupational therapists fully appreciate and embrace human potential and dignity in their fundamental approach to the people with whom they work. The post-Renaissance beginnings of Modernity were specifically marked by René Descartes' (1596-1650) theory of the thinking mind in the material body, which, until present times, made a tremendous impact on the development of science (Capra 1983:40-62). During this period, another kind of 'freedom' was offered to humankind: one in which the domination of knowledge and truth as proclaimed by the church could rightfully be questioned.

[8] This mindset has however been repudiated (by some) within the subsequent history of the Christian Church itself. Compare the stance that an early Reformation figure such as Martin Luther took on this matter during the development of the Reformation, when it was decided to move away from a nature-grace dualism, in order to relate all of ordinary life to God and not just certain elevated areas. In this sense work *as such* (and not just Church work) came to be seen as vocatio Dei: a calling from God.

2.3 Moral Treatment

2.3.1 The first steps to Moral Treatment: The Age of Reason

The Age of Enlightenment, also referred to as the Age of Reason, was an extension of civilisation's shift from the organic-agricultural view prior to 1500 when the authority of Aristotle's teachings and those of the Church dominated, to a pre-industrial mindset. René Descartes' theory of analysis, as well as the contributions of other scientific theorists such as Galileo Galilei, (Capra 1983:37-39) coupled with the Renaissance values of the autonomy of reason and freedom of the individual, culminated in the Age of Enlightenment, eventually showing the way to modern science. Immanuel Kant is regarded by many as significant to this period with his well-known *Critique of Pure Reason (1781)* in which he argues that human logic and reason is also subjected to the *structure* of the mind, which shapes the interpretation of knowledge (Delius *et al* 2000:70; Magee 1998:132-136).

One of the other many advantages of the Enlightenment was the increase in literacy (after the introduction of printing had commenced during the Renaissance (Delius *et al* 2000:27)), which made information and communication about health and health promotion much more accessible. Due to the later benefits of industrialisation, substantial evolution occurred on the levels of affluence and prosperity, goods and services, e.g. libraries, child education and eating out. Things that were previously reserved only for the rich became affordable for the more average person. The birth of modern science – the generation of knowledge with the aim of benefitting humankind - sparked a new age of optimism in terms of human 'self-regulation' as the "pursuit of and right to happiness…personal fulfilment…[to] maximize pleasures and avoid pain as they sought to achieve their own ends" was the order of the day (Wilcock 2001:223-224, 265).

Without doubt, these social advances are generally considered as beneficial and advantageous to human social development. However, we must recognise that these advances are rarely without a darker side that usually accompanies progress. In view of ideology critique, one such shadow is, for example, the fact that we realise today that the very preoccupation with happiness and pleasure as absolutised goals in and of themselves, might be contributing to all kinds of illusions about human existence. In accordance with Hollis (2001:101-102), I would agree that human existence is about the experience of meaning and not about 'happiness' as such. Authentic happiness is experienced within the context of a meaningful life (and not the other way around). In terms of the ideology model, this is an illustration of a fatal 'hypernormative reification' (refer to Chapter 1 where the term 'hypernorm' is clarified) of happiness that began to play a significant role in Western society from the beginning of modernity. In its current depiction, the happiness ideal appears to be mostly, among others, our conception of the pursuit of 'fun'. The crucial existential question in a consumerist society has become: are you having fun? In countless mass media productions, we hear parents asking this of their children, romantically involved couples asking this of each other, etc. And all of this is, of course, inevitably linked to how we qualify and experience occupation and creativity (and how we 'ought to' experience it).

A capitalist economy in England, united with materialism and economic power, soon led to class differences, between the affluent and the very poor. A paucity of money became synonymous with poor physical and mental health and higher mortality rates. Wilcock (2001:224, 225) also mentions many accounts of very young children being forced into child labour, leading to deteriorating health and social circumstances.

Here we see how a (discursive) fixation on happiness, tied to economic hypernorms, links up in the social sphere of ideology in terms of class domination. At the same time, we see another characteristic of ideology emerge,

namely, discourses that act as a ‘filter’ between different social groups, justifying or ‘softening’ the domination of one by the other. In this instance, the church continued to play a role in making it possible to endure suffering without questioning the whole social context in which it took place.

The increasing plight of the poor masses became the target of many philanthropic activities, of which ‘workhouses’ were an example. The workhouses were part of social industrial relations, as it was thought that “early intervention might reduce or negate ongoing or more expensive ones later on” (Wilcock 2001:227-335). Although the intention of these workhouses was to offer employment to the poor, many of them later evolved into punitive institutions (due to profligates) for those who were poor and unable to contribute to economic upliftment (Foucault 1965:51).

While these workhouses could be viewed as an important proto-concept for future vocational re-training, their practices were far removed from being therapeutic, because here occupation was seen as punitive, as opposed to restorative (Wilcock 2001:342). It is also here that something of crucial importance in the history of occupation happened. What might be considered as a crucial point is that a sharp differentiation appeared to have been made between labour and work, as labour was intended as punishment to those who were poor.

One can speculate as to the question that arises here, namely, whether many people today do not experience their work as ‘labour’ in the sense of it being deprived of inherent meaning (for them), especially for those involved with mechanical and menial tasks. Forms of factory labour are usually cited as examples in this regard. The consequence of this is that the whole concept of work has become for many, either mere labour-for-money, or, for the privileged, a means to personal enrichment, power and prestige. One can see how pursuit of the latter, on a vast social scale, may result in the creation and maintenance of

the former. In both cases, we are confronted by hypernormative distortions of the concept of work and in both cases, interestingly, the hypernormative goal has to do with money. In one case it is about 'survival'; in the other about power and prestige. In both cases the idea of work, as a meaningful activity in terms of creativity, which brings its *own* reward as a goal in itself, does not come into its own. Furthermore, we continue to live in a society that is not very critical of these deformations of work.

The institutional treatment (for example 'madhouses') of those who suffered from psychiatric diagnoses, was also taken advantage of in an economic sense by entrepreneurs, of which some were self-proclaimed and/or trained medical care-takers, although it would probably be quite difficult to establish a correlation between the level of training of the proprietors and the type of treatment that was induced by them. Approaches for remedial purposes in madhouses during the 18th century for the treatment of psychiatric illnesses, as we know them today, varied between punitive (e.g. chaining, whipping etc), physic/organic (e.g. bleeding, opiates, electricity) and moral management (e.g. behavioural, environmental or occupational). There is evidence though, that treatment in madhouses was not all, as we would refer to it in today's terms, torturous and that some proprietors used varied occupations for remedial purposes. Prayer, walks in the fresh air, the handling of pets and reading are a few examples (Wilcock 2001:306-312, 331).

From an ideological perspective, it is important to note that although the Age of Enlightenment was characterised by newfound knowledge, it was also the dawn of the dialectic of the Enlightenment (Horkheimer & Adorno 1972). This is because of the fact that the newly discovered path of technological-scientific knowledge led to social consequences that were in direct opposition to the promise of emancipation through science and technology. The Dutch philosopher, Herman Dooyeweerd (1953) also made much of this dialectic, pointing out that even before the Enlightenment, two separate ideals had arisen

in ‘humanistic’ society; science, on the one hand, and freedom on the other. Either one was perceived to be potentially at odds with the other. In terms of the ideology model I am using, we may speak here of the developing ideologies of science and freedom, where both may act as distorting hypernorms. For example, one can see how science may act as a hypernorm for freedom and vice versa. In the first instance, freedom, for example, may be delimited in the interests of a ‘scientifically’ managed society; in the second instance, science may be regarded as meaningful only in so far as it contributes to our freedom. As far is OT is concerned, the point I am making here is that human occupation or creativity should not fall prey to either a scientific (positivistic) OT or to a anti-scientific OT that supports itself on romanticised ideas about limitless human potential (freedom). I will return to these issues later on.

2.3.2 The high times of Moral Treatment

The Enlightenment period which brought fortune, education and knowledge, coupled with ‘moral awareness’ in the form of religion (“the brotherhood of man” (Wilcock 2001:294)), eventually led to an increased recognition of those less fortunate. In the late 18th century, this notion further evolved into what is of particular significance to the history of OT, known as Moral Treatment (although often being understood in the same sense as “psychological” treatment (Wilcock 2002:38)). This phenomenon is considered by many to be the predecessor of occupational therapy (Wilcock 2001:293) because up to this point, the mentally disabled were institutionalised under inhumane conditions, since they were thought of as having lost their reason and therefore did not deserve to be treated as humans, but rather as animals.

Due to the importance of Moral Treatment for OT, it would be appropriate to refer to two particular individuals, Tuke and Pinel whose exceptional decisions and conduct steered the treatment of the ‘insane’ into a definite direction that marked

the use of occupation for therapeutic purposes in an official fashion (Wilcock 2001:313-330).

William Tuke (1732-1822) (as accounted by his grandson Samuel Tuke), was approached by The Society of Friends for advice when one of their members died under dubious circumstances after being admitted to an institution for the 'insane' near what is known today as New York. He compiled an initial proposal in 1792 for an "institution" for the mentally ill (The Retreat) that entailed, among other things, the use of occupation and the immediate environment for therapeutic purposes. In the proposal, he described open areas where farm animals could be kept, a garden and "grounds" where the patients could "exercise" and family could visit.[9] The financing and building of the Retreat obviously took some years until its opening on 11 May 1796. The intentions for therapeutic occupation were realised, as can be gathered from the following:

> *The garden is on the north side of the house, and contains about one acre…affords an agreeable place for recreation and employment, to many of the patients…superintendent also endeavoured to furnish a source of amusement…by supplying each of the courts with a number of animals…it is believed they are not only means of innocent pleasure; but...sometimes tends to awaken the social and benevolent feelings.* (Samuel Tuke quoted in Wilcock 2001:317; Ibid 313-17, 457).

Having read this, it is quite noticeable that in this setting, the work/occupation that the patients 'exercised' seems free of the 'survival-prestige' motives that have been previously mentioned. In fact, it appears that this small 'therapeutic community' represents a piece of ideology critique on the broader society of that time. It also appears that many of the occupations that were performed at the

[9] During these times the term 'exercise' included the meaning of what we understand as occupation (Wilcock 2001:315).

Retreat, were very similar to what we would refer to today as relaxation or leisure and in fact, might be a confirmation of what was an attempt to find a way creatively, to regain occupational balance in view of the pre-industrial time. However, this might also serve as an example of why as an OT, one must ask what the *purpose* and *meaning* of a chosen activity would be. (Compare my previous remarks on the concept of meaningfulness).

Philippe Pinel (1745-1826) is referred to by many as literally unchaining the insane in Europe. He did so when permission was granted to him by the National Assembly in 1798, after being appointed as a physician in Paris to the 'lunatic infirmary' of Bicêtre, which was a hospital in Paris where he saw how patients were chained and treated as animals.[10] Without having knowledge about research methodology, he saw fit carefully and empirically to document (among other conclusions), the difference in outcome of mentally ill patients when treated without "corporal indignity" (Wilcock 2001:319):

> *I then discovered, that insanity was curable in many instances, by mildness of treatment and attention to the state of mind exclusively, and when coercion was indispensable, that it might be very effectually applied without corporal indignity* (quoted in Wilcock 2001:320).

Here one might ask whether the term "corporal indignity" does not indicate the danger of a moral goal 'high-jacking' (in the hypernormative sense) the experience of creativity. If creativity is accepted as a core approach in OT, it might be asked whether creativity right up to the present day, is not required to bow before some kind of morality, for example in the sense of 'uplifting' members from different (lower) socio-economic settings. In other words; we have to answer the question: does creativity in our profession stand in the service of a 'higher moral purpose'? My own view is that if my question is answered in the

[10] Also see Foucault's (1965:241-278) *Madness and Civilization: a history of insanity in the Age of Reason*.

affirmative, it is indicative of a form of moralism, however well intended. One might argue that the very term “Moral Treatment” shows a subordination of creativeness-for-recovery to moral goals. Obviously, I am not denying that there is a moral aspect to everything an OT does, but this does not mean that creativity needs something outside itself to justify it.

Pinel’s moral approach entailed two main characteristics, namely “a degree of liberty” or freedom and “the use of occupation”. Other terms that he used included “laborious employment” and “active occupation”, which are all clear reflections of his understanding of the therapeutic value of occupation. Much credit can be given to the fact that Pinel saw the fundamental worth of ‘work’ for the purposes of human well-being. His investigations culminated in the well-known text: *A treatise on Insanity*, which was published at the end of the Age of Enlightenment, first in France in 1801 and later being translated in England in 1806. His scientific dissertation was considered as the point of departure for subsequent medical practitioners for their view and study of mental illness (Wilcock 2001:320, 321, 330).

Pinel’s conclusions about the value of occupation for recovery, might prompt one to consider the possibility of the historical commencement of a symbiosis between occupational (therapy) and medical discourses, the latter being linked to the development of biological science. This leaves much room for contemplating what influence these two connections had on the historical development of OT. Inevitably such connections, however advantageous they might seem, also open the door to ideological domination and distortion.

Moral Treatment expanded into Scotland and the rest of Europe, as well as America.[11] State treatment facilities were established with far-reaching

[11] Note Foucault’s (1965) critique on Moral Treatment in the sense that it, in fact, gave birth to the rationalised and acceptable idea of the psychiatrically ill to be confined and institutionalised in a socially acceptable fashion.

occupational treatment programmes, seemingly more effective than any other prior treatment approach, including medicine (Wilcock 2001:519).

The Moral Treatment Era peaked between 1817 and 1847 in America, chiefly through the influence of Samuel Tuke in New York at the Retreat who had furthered the work of his grandfather William Tuke, late in the previous century. In the aftermath of the Civil War in the USA, the shift from agriculture to industrialisation created an awareness of the value of human activity and that humans may be seen be self-regulating, meaning that they can create their own fortune and wealth, through an occupation.[12] The treatment of persons labelled as insane, changed dramatically from being physically restrained (among other means such as frequent abuse) to that of occupying their time with activities and work (labour). The Worcester State Hospital in Massachusetts, offered popular evidence that recovery from illness is very possible and even quite likely, by employing activities that varied between the creative, the physical and the educational (Wilcock 1998: 168,169; Wilcock 2001:517, 518).[13]

Up to this point it seems that the aspect of creativity was partially a kind of ideology-critique of, on the one hand previous inhumane practices concerning the mentally ill, and on the other, a mechanistic worldview. Creativity manifested itself quite coincidentally as part of an attempt to re-establish occupational balance in a sense. With the actual birth of OT, creativity reclaimed a major role in this profession (once again coincidentally), until the sixties, when a significant split between the 'creative' and 'functional' schools in OT (in the UK) occurred (Wilcock 2002:283). Until this day, the fundamental aspect of creativity in OT is structurally limited to a particular type of activity that can be offered to the patient for the purpose of treatment in a certain context.

[12] This could be used as another example of creativity/occupation standing in service of hypernormative power and prestige, as previously mentioned. If this should be true, self-regulation does not seem to be the innocent issue it might seem.

[13] On a fundamental level, 'creative activity' seems to be different in character from 'occupational' and 'educational' activity, because creativity is interwoven in all of these types of activities, and could be considered as an inherent property to any 'occupational' or 'educational' activity/action.

2.3.3 The decline of Moral Treatment: Moral Treatment making way for the 'science of Industrialisation'.

Ironically, the very success of Moral Treatment led to its collapse, both in Britain and America, although the establishment of institutions to treat the ill was a later consequence during the 19th century. Moral treatment initially occurred, in most cases, in smaller private institutions and with their wealthy patients. Because of its success, social reformers advocated for its application in state-owned facilities as well. Consequently, these institutions soon became flooded, also by immigrants of different languages. Due to a lack of already decreased resources on account of the Civil War in America, institutions were unable to accommodate all the patients and the quality of care declined (Wilcock 1998:169-170). Other reasons for the failure of Moral Treatment in the United States included racial and religious prejudice, a lack of facilities and personnel, and a continued belief that insanity was ultimately incurable (Wonser 2000:2).

Peloquin (1989:537-544) offers another reason for the downfall of moral treatment in the line of ideological critique. She points to the domination of 'scientific' medicine over the 'natural' prescription of occupation:

> *Moral treatment's decline relates closely to a lack of inspired and committed leadership willing to articulate and redefine the efficacy of occupation in the face of medical and societal changes. The desire to embrace the most current trend of scientific thought led to the abandonment of moral treatment in spite of its established efficacy. The failure to identify and address the social and institutional changes that had gradually made the practice and success of moral treatment virtually impossible led to the erroneous conclusion that occupation was not an effective intervention.*

I would agree with Peloquin in terms of pointing out the growing control of 'science' as a hypernorm for evaluating creativity, a distortion that not only dominated the continued structural and formal application of occupation for therapeutic purposes, but which, in fact, removed it from the entire arena of treatment of the mentally ill. Nevertheless, I also have a question for Peloquin's interpretation; and that is whether she is sufficiently aware of the danger of not only scientism but also moralism. (Incidentally, note how we have here two ideologies that are, in fact, opposed to each other). Thus, the danger in ideology critique is always that to fight the one ideology, one will be lured into the camp of its opposition without realising that one is (often) a mirror-image imitation of the other.

It is important to note that another reason for the decline of moral treatment may also be related to the fact that it was mainly executed by people without formal medical training.[14] Moral treatment dominated the world of medicine, especially in the psychiatric field, and

> *…doctors had to accept a consultant role in the use of occupation as therapy…Perhaps because of that, the majority of physicians did not give up their search for a treatment more fitted to their practice base, and so the dominance of moral, occupational regimes was relatively short-lived, in a way similar to the rehabilitation medicine in the 20th century* (Wilcock 2001:454).

Before the end of the Moral Treatment era, industrialisation came into being around 1780. During the 19th century the workhouses that were initially an effort for the relief of the poor, evolved into punitive facilities for this part of the

[14] The original term that Wilcock (2001: 454) refers to here is "physician's" which may be seen as an example of how the 'moralism' in Moral Treatment came to be hyperdominated by medical discourse – besides the way in which the former infiltrated the concept of occupation.

population. It is here, as has been mentioned, where the meaning of labour became separated from work and subsequently occupational deprivation, alienation and injustice appeared to have become prevalent. Although work for those who were employed was not meant to be punitive, it indeed created occupational distortions because industrialisation as such, reinforced with even greater strength, the concept that the purpose of occupation is mostly economic (as previously noted); a value that has persisted until today. This is coupled with another value: that of wealth, which in many respects, is more highly regarded than health (Wilcock 2001:227-335, 534, 542, 544).

In attempts to counteract the possible pernicious effects of capitalism which took on a hypernormative function during the age of industrialisation, the notion of 'occupational utopias' emerged. One such was Jacques Rousseau's plea for naturalism. This is a naturalism that Rousseau, linked not to a scientistic ideology of nature, but to its opposite: a nature that reflects a hypernormative freedom. (Compare my previous remarks on the clash between science ideology and freedom ideology. Compare also Dooyeweerd's critique of Rousseau (Dooyeweerd 1953:317-324)) Other ideas in this context included liberal capitalism, agrarian communalism, individualism and utilitarianism. Several occupational theories were also devised and implemented with apparently successful results, such as those of Karl Marx, John Ruskin (who is regarded as the father of the Arts and Crafts Movement) and William Morris. The latter delivered a critique on the lack of creativity of the industrial system and the occupational imbalance that occurred due to "disconnection between labour and leisure which he believed caused social neurosis" (Wilcock 2001:373).

Social activism was also undertaken by women and although few women of affluent descent were regarded as having made ground-breaking contributions, one acceptable role was that of caring for the ill. Coupled with the moral duties of Christianity, it was also commendable to deliver services to the poor and less fortunate (Wilcock 2001:378-379). Although not all women who made a mark in

social activism were necessarily affluent, the tacit rules of moral social conduct were the foundation for most.[15] Examples of such women who were pioneers in the use of occupation to address the occupational imbalances that had resulted from the industrial revolution in Britain, included Elizabeth Fry, who advocated humane conditions in prisons for women, and Octavia Hill, who managed 2 000 boarding houses and flats (at the time of her death) for decent living circumstances, promoting meaningful occupation of time and the importance of play for children. Among these pioneers were also the well-known Florence Nightingale and American-born Jane Addams who is generally known for her role in the establishment of Hull House. After visiting similar facilities in London, she was one of the women who advocated Feminism, with a view to women's suffrage (Wilcock 1998:174; Wilcock 2001:346-390).

In spite of the collapse of Moral Treatment, some of its principles allowed for therapeutic occupational programmes to continue to expand across Britain, Europe and America. These programmes were evidently marked by their efficacy in the treatment of the mentally ill, exceeding the results of any other treatment before the arrival of modern medication (Wilcock 2001:519).

In the last years of the 19th century, industrialisation was viewed as the solution to poverty and the age referred to as the 'Progressive Era' in American history (Reitz 1992:50).

[15] Here might be anther example of morality taking on some hypernormative functions; this time in the context of social activism.

2.4 The Birth of Occupational Therapy: A Formative Period [16]

The Industrial Revolution brought about a great leap in human evolution, but was also coupled to a reductionist and mechanistic approach to problem-solving. In medical science the viewpoint was that everything could be understood by breaking the object into its constituent components; thus, disease and illness were viewed as the result of a "mechanical defect" (Ackoff quoted in Wilcock 1998:171; Capra 1983:37-62).

Apparently, opposed to the idea of Cartesian dualism, was one Adolf Meyer, a Swiss born neuro-pathologist and psychiatrist (he later referred to himself as a mental hygienist), who advocated that a mind-body connection was important and that a holistic approach was necessary.[17] In this context he stressed the role of purposive occupation in individual life experiences, claiming that it played an important part in the aetiology of mental diseases (Wilcock 1998:172-173; Wilcock 2002:46). In his well-known paper titled *The Philosophy of Occupation Therapy* (published for the first time in 1922), Meyer (1977:639), in a visionary fashion, promoted (among other ideas about health):

> *the value of work…in the problems of adaptation,…a development of the valuation of time and work [and] ...attain[ing] balance…[by]…actual doing, actual practice, a program of wholesome living as the basis of wholesome feeling and thinking….*

Meyer's contribution may be seen, in part, as a criticism of the ideology of Cartesian dualism. The latter was inspired by a hypernormative (ideological) understanding of the 'scientific method' according to a mechanistic model (Capra

[16] This view of a "formative period" is found in Reed (2005:570) and is defined as being from 1900-1929.
[17] The philosophy of René Descartes (in approximately 1637) proposed that humans are constituted by a thinking immaterial soul within a machine-like body. Descartes had problems in explaining how the two parts are related to each other.

1983:93-192; Dooyeweerd 1953:555-559). This Cartesian view of a wholly material body and its parts later came to influence the scientific self-understanding of medical discourse and the so-called bio-medical model.

During his participation in the Mental Hygiene Movement, Meyer established a connection with Jane Addams who worked at Hull House in 1889 in Chicago. Hull House was a 'settlement' house which was established to meet some of the economic, social and health needs of immigrants and assisted them in adjusting to industrialised society at the turn of the century. It was established mainly by Jane Addams who championed rights for women, such as education, employment and other social advantages only then enjoyed by men. Ironically, the occupational deprivation that she herself felt was probably due not only to these factors in a more indirect way, but more to her affluent descent and lifestyle while growing up. She took a prominent standpoint on feminism and employed only women to work at Hull House, for example (Wilcock 1998:174; Wilcock 2001:389).

Addams's view on meaningful occupation led to her involvement in the establishment of an Arts and Crafts Society in 1897. She viewed this type of activity as a means of comfort and of giving meaning to the lives of the working class after hours; a view appreciated by socialists Ruskin and Morris in Britain, as mentioned previously (Wilcock 2001:389). The views of the Arts and Crafts Society in America on "mental and moral growth" coupled with the American ideas of capitalism and individualism of the 19th century (Wilcock 1998:176), led to the transition from socialist to individualist values; a transition that became part of the future of the OT profession.

This is of basic importance for the ideological profile of the OT profession. The founding of Hull House was much more than a mere club. Once again, one may look at it as representing a kind of ideology critique on industrialised society of the time. Hull House offered an opportunity of 'creative leisure' after hours for

employees subjected to an ‘institutionalised’, mechanical mode of employed labour. This, once again, is not very different from contemporary times, as previously mentioned, where many people labour for money or prestige, living for after hours when leisure can begin. In other words, for many, the concept of ‘creativity’ is far removed from everyday life at work.

In America there was another significant person in the formative years of OT by the name of Eleanor Clark Slagle, who initially studied Jane Addams’s curative course at Hull House and developed her own thinking on the basis of William James’s philosophy of pragmatism. She coined the term “habit training” (loosely what contemporary occupational therapists would refer to as Activities of Daily Living) as an important way to reinstate health. She also worked closely for some time with Adolf Meyer and is considered by many as making a substantial and invaluable contribution to the OT profession (Wilcock 1998:178-179).

From an ideological point of view, William James’s philosophy is a hypernormative interpretation of the ‘practical’. The criterion comes to be: that which ‘works’ over (abstract) ‘theory’. Pragmatism is essentially opposed to ‘principled thinking’, where the latter goes from principle to practice and not the other way around. This might offer an explanation as to why the initial theoretical base of OT, lacked principles (Wilcock 1998:180).

Furthermore, it may be argued that the term ‘habit training’ was in essence a resultant view of Moral Treatment, with special reference to the potential shadow of ‘moralism’. Nevertheless if being practised as part of a balanced occupational regime, it holds much therapeutic value and habit training. If hypernormatively implemented, it may very well be used as a kind of ‘moralising treatment’. This may dominate the individual preference of a person as to how and when activities of daily living should be performed, for example. The whole notion of habit training may also be driven by a kind of behaviourist ideology, which views human nature as totally malleable, ignoring the possibility of humans possessing

rich innate capabilities, which need to be *freed* more that *formed*. (In recent times, it has been especially Noam Chomsky, the linguist and philosopher/activist, who has battled against behaviourist ideology (Smith 1999:96-97, 105)).

The advent of the 20th century was marked by a relived social consciousness, as well as by a time in which advancements in the field of medicine were taking place, heralding many possibilities. Feminism was also at a high point with the issue of “women’s suffrage” as this “was considered as the pinnacle of justice at the time” (Wilcock 2002:27-28).

In Britain, special needs for the disabled enjoyed priority and several institutions and facilities such as hospitals, schools and workshops were established. In America, in Massachusetts, a particular physician, Herbert J. Hall, began to prescribe occupation in 1908 as a medical treatment; what he referred to as “work cure”. In the same state, a nurse by the name of Susan Tracey noticed the positive effect of occupation (mainly crafts) on the recovery of orthopaedic patients. Both of these individuals’ initiatives led to training programmes for nurses in the use of occupation with patients. In Britain, Europe and America, occupation was still seen as a significant treatment tool in institutions for psychiatric patients (Wilcock 2002:31-37, 39-44).

During this decade, women played an important role both in the growth of the structured use of occupation for therapeutic purposes and in an increased awareness in social health by governments in the Western World. These factors, coupled with the support of particular men in the medical profession, established the foundation for the commencement of the OT profession (Wilcock 2002:48).

2.4.1 1910's - World War I

This decade is well known for the First World War, but it was also the decade in which "scientific management" as a discipline materialised as a result of social- and healthcare workers' combined efforts to address problems arising from the war. It is from this discipline that "work study" derived, and is considered to have laid some significant fundamental practices for the later OT profession. It is within this discipline of "scientific management" that terminology, such as "activity analysis", "curative" and "remedial" became prominent, as well as relevant principles, such as "Instead of adapting the man to the work…adapt[ing] the work to the man" and that servicemen who suffered war-imposed injuries "…be kept busy…[and]…re-educated…" as soon as possible. Another very important concept that arose as a result of the war is 'rehabilitation'. (Wilcock 2002:53-54, 58-59).

There is a potential tension here between the discipline of 'scientific management' (from which OT seemingly benefited in a field, such as work rehabilitation) and the discipline of OT as such. If scientific management is conceptualised within a framework orientated to the natural sciences, it could be highly problematic when pertaining to the 'object' of human beings. This is because natural science *per se* does not take normative (cultural, social, moral) human behaviour into account but only the 'scientific laws' of nature. (In other words the physical, biotic and involuntary psychological aspects of human beings). On the other hand, if occupation is viewed only from an economic-scientific perspective, then 'survival' or 'power and prestige' (as economic factors, noted earlier) threaten to become hypernormative determinants. Note should also be taken of the danger of 'scientific management' exerting a kind of organisational *control* over occupational activity that leaves too little space to the *free* creativity of the people concerned. The critical question is: Has any of these problematic issues succeeded in infiltrating OT discourse at some point? It seems foolish to dismiss the possibility out of hand.

It was during the war that the value of occupation was seemingly recognised as being equally important for curative and economic purposes in the employment of soldiers in a post-war society. This fact notwithstanding, the view of occupation for curative purposes ceased with the end of World War I and such programmes were subsequently discontinued by most governments, which gives the impression that the ultimate value of these programmes was perhaps due more to an economic agenda than to the well-being of war victims (Wilcock 2002:54, 77, 82).

It is noteworthy that the 'economic purposes' of these occupational programmes for rehabilitation seem to have initially held elements of both the following potentially ideological agendas: 1) the mere economic survival of the individual soldiers who returned after war, and 2) the economic well-being of the (governmental) system. The question here arises: to what extent does the maintenance of the political-economic 'system' co-determine the innate purpose and philosophy of OT? It is telling in this regard, that during both World War I and II, soldiers who returned home were often employed in jobs for which they were not best suited; in other words, for the sake of maintaining the system without questioning possible shortcomings (pertaining to occupation, work, labour, creativity) of society at that time. Another illustration of the economic goal being confused with the goal of human health, was that most curative occupational programmes were closed down in Britain after World War I; that is after they had served their 'economic purposes' (Wilcock 2002:77, 181-196).

In Clifton Springs in New York, on 15 March 1917, The National Society for the Promotion of Occupational Therapy was founded by, among others, Eleanor Clark Slagle. Another co-founder, George Edward Barton, an architect who had personal experience of the healing properties of meaningful occupation, persuaded the rest of the founders "to accept 'occupational therapy' as the name of the new profession" because, as he later stated, the term "reconstruction

aides" had no indication of involving therapeutic input (Wilcock 2002:80-81). It was during the founding meeting that a document was drawn up stating that the OT profession is based on the following threefold objectives:

- …*the advancement of occupation as a therapeutic measure;*
- *the study of the effect of occupation upon the human being;*[18]
- *and the scientific dispensation of this knowledge*
  (Wilcock 2002:83).

Looking at these objectives from an ideology-critical point of view, they appear to be reasonably innocent, provided that the term 'scientific' in the latter objective is interpreted within the context of scholarly education and not as indicative of a positivistic mind-set. This seems to be an issue that the OT profession is still struggling with today. The apparent ongoing difficulty in the profession of consolidating the 'science' and 'art' parts of the definition of OT is obvious (Blair & Robinson 2005:269-276).

Wilcock (1998:179-181) remarks that despite this document, it seems that from a historical point of view, OT soon became increasingly practically orientated, especially in its education of students, and less concerned with research and the distribution of such information (referring to the latter two objectives). Another problem was apparently the lack of a "formalised philosophical base" as was illustrated, for example, in the absence of principles for the content of those education programmes for OT students that were adopted by an American council in 1935. Some reasons that are attributed to this predicament are the "complexity of ideas that culminated in[to] occupational therapy", geographic considerations and the obviousness of the benefits of occupation for health purposes. The effect of a poorly "formalised philosophical base" for future OTs,

[18] This objective seems to leave much room for the study of the creativity aspect as part of human nature.

has however, been a point of discussion ever since Wilcock (1998:179-181). Perhaps a factor to keep in mind here is the pragmatic paradigm referred to above; a paradigm which in itself seems to be at odds with aspirations to be 'scientific'.

It was in March 1918 that a stunning incident occurred, globally highlighting the immense value of occupation for therapeutic purposes. Four women designated as civilian aides (or 'proto-therapists' as Wilcock refers to them) sailed from New York to France to arrive at a hospital that specialised in "shell shock". With no formal training and limited resources, they apparently succeeded in 'occupational therapy' to an extent that within weeks, a "thousand such aides were requested". These (167 dispatched) aides were initially not required to have any medical background, but were recruited for proficiency in "social work, library, arts and crafts teaching, or commercial skills" and worked with both physically and mentally war-traumatised patients (Wilcock 2002:67).

Much later in the 20th century it was argued that the very fact that these aides accepted the conditions of working under "strict medical supervision" was part of the developing "willing acceptance of the medical model by occupational therapists" (Wilcock 2002:67). In my view, these early relationships between the reconstruction aides and the medical specialists, determined the patriarchal and paternalistic relations between OT and the medical profession that still exist today. We see the aides readily submitting in the roles of "technical assistants" to the supervision and prescription by medical doctors (Wilcock 2002:67-68). It should be noted that here I am using both the terms patriarchal and paternalistic in a technical sense; the former in the sense of a gender hypernorm (maleness) intruding into various values, goals and relationships; the latter in the sense of a domination relationship between two academic discourses and their practices.[19]

[19] This point is in agreement with Capra's (1983:121-122) argument that the Scientific Revolution coincided with the "establishment of an almost exclusive male medical elite [and] the intrusion of medicine into domains…which had traditionally been the province of women."

These concepts of domination may manifest themselves concretely as a relation between two professional groups, such as medicine and OT.

This chapter briefly surveyed the history that formed part of the pre-formative years of the OT profession. The formal beginnings of the profession, from its infancy until the end of the 20th century will now be discussed in the following chapter.

CHAPTER 3

Identity and Ideology (Part II): A Brief Contextual History of Occupational Therapy in the Western World

In this chapter the focus is on the period of the 1920s up the end of the 20th century. Again, my aim is to analyse how history and ideology intersect in the professional discourse of OT. I end the chapter with a brief look at the immediate context of the study itself, namely, the development of OT in South Africa.

3.1 1920s - The Beginning

While the American Association of Occupational Therapy was established in 1923, the third decade of the 20th century was marked by OT also being seen as a separate health profession in Britain. OT departments were established in various kinds of "curative" facilities, including hospitals and towards the late 1920s, the first training school was established (Wilcock 2002:89).

OT aligned itself closely with the medical profession, especially with some remarkable individuals in the medical field (such as Adolf Meyer) who viewed their patients holistically and wanted to treat them as such. According to Wilcock (2002:91), this was a strategic move:

> *Alliance with medicine, fast developing a strong voice in many matters that would concern occupational therapists, could only be of benefit to the fledgling profession which consisted, in the main, of women.*

During this time, however, it seems that the subordinated role of OT to medicine continued. For example, although occupation was seen by some as an

indispensable therapeutic medium for tuberculosis patients, doctors in America opposed this by suggesting that surgical intervention in the treatment of tuberculosis was becoming the necessary norm at that time. This reductionist sentiment was later regarded as having social and economic agendas rather than the intrinsic merits of surgical treatment. Despite the opposition however, other treatment approaches to this particular disease continued, one of which, was the active involvement in occupational therapy programmes (Wilcock 2002:96). Additonally, in the field of psychiatry, it has to be acknowledged that some medical specialists (such as Sir David Henderson, for example) embraced occupational therapy as a reputable and "the most enduring" medium of therapy and they did much to promote the occupational renaissance in mental health (Wilcock 2002:95-105).

Margaret Barr Fulton was the first qualified British OT who also recognised that OT in some cases had more success "than the more technically rigid approach of the doctors, good as they are" (Wilcock 2002:112). Strikingly similar to many health professionals' frustration in contemporary practices today, there was also Fulton's frustration with administrative bureaucracy. With the commencement of the National Health Service, she addressed the delegates at the national OT congress in Scotland in 1957 regarding this issue:

> *These new schemes - carried out in glorious triplicate and at fabulous expense - have already encroached to an alarming extent on the time essential for adequate patient treatment* (Margaret Fulton quoted in Wilcock 2002: 113).

Fulton's judgement indeed points to yet another ideological mechanism entering into the life of OT: the hypernormative functions of administrative logic over and against other non-negotiable goals and values (especially the very well-being of the patient).

3.2 1930s - A Female Profession Requiring Supervision

During this decade, political and economic difficulties, such as unemployment, were prevalent world-wide, and had a direct influence on the standing of a young profession such as OT. Another challenge for the profession was to explain how scarce equipment and material needed for activities for therapeutic use were without an obligatory economic result (Wilcock 2002:138).

This is a good example of how the hypernormative goals of the "system" (to which I have referred previously), specifically in this case, the economic goal, were implicitly overriding the goals and values of health and patient care. Coupled with this was the unfortunate disposition of the OT profession having to 'qualify' its position in the medical paradigm. Nonetheless, despite everyday adversities, the profession continued to grow as more training schools for OTs were established (Wilcock 2002:138-139).

In 1933 a formal document titled *Memorandum on Occupational Therapy for Mental Patients* was issued by the Board of Control in Britain. One of the central themes was the issue of medical supervision over OT, which was even included in the very definition of OT (as quoted according to the document in Wilcock 2002:143-144):

> *…the treatment under medical direction, of physical or mental disorders by the application of occupation and recreation with the object of promoting recovery, of creating new habits, and of preventing deterioration*.

Although a necessary distinction was made between mere occupation and therapeutic occupation it was stated that:

> *… it is recognised that any form of occupation may have a therapeutic value if applied under the direction of the physician and in the hands of the staff who are specially trained in this branch of medical therapy* (quoted according to the document in Wilcock 2002:145).

The position of an OT as a "new class of officer" was described as someone who "has the education and mentality to interpret the doctor's instructions in the widest therapeutic sense". The memorandum also stated that "[t]he economic value of occupation need not be stressed" (Wilcock 2002:144, 147).

The latter statement is a remarkable anti-ideological sentiment. Clearly an attempt was made to keep a distance from 'economism'. Unfortunately, this caution was not equally apparent with regard to 'medicalism'. In spite of the subordination of OT to the medical profession however, there was also the positive side of many influential medical doctors advocating OT as a very important therapeutic means (Wilcock 2002:149-159, 165-174).

In 1934 the first public exhibition in London was held to increase public awareness about this profession. Another event that marked this decade was the first journal publication in the (British) Association's Journal named *Occupational Therapy* (founded in 1938) which consisted of articles and letters, including one by the medical director of a well-known clinic in London who regarded OT as a most important "ancillary medical service". Another paper by a young medical officer was published in 1936 as a thesis in fulfilment of his MD degree and in which he argued that OT was not taken up with the same degree of enthusiasm in Britain as in North America and to some extent attributed this fact to the limited attention OT received in medical journals. This observation continues to be valid in current times (Wilcock 2002:133,149), which leaves some questions as to the balance of the 'symbiosis' between OT and the medical profession; a balance that OT seemed to had hoped for when it decided to align itself with the latter.

3.3 1940s - World War II: A Profession's Growing Spurt

The 1940s was marked by World War II. A serious shortage of OTs developed as governments recalled the value of occupation for restorative purposes as was practised during World War I, especially in physical settings. This challenge was met by offering short courses in OT and at different levels of qualification and due to a partial success, many textbooks on OT were published during this period (Wilcock 2002:217-219). Furthermore, OT also enjoyed more media focus, during which the novel term 'rehabilitation' received attention and discussion. On account of the shortage of work, people were often employed in jobs for which they were not suited, the results of which became clear only after the war and one of the difficulties that rehabilitation had to address at this time (Wilcock 2002:181-196, 217-219).[1]

One indirect consequence of the war for the OT profession was the distributive development of OT in other parts of the world. For example, one Dorothy Bramwell was evacuated to Egypt from Malta after attending a family wedding. There she established OT services to cater for the victims of war (Wilcock 2002:202-205). It was also during this time that two British OTs sailed to South Africa to establish an OT school at the University of Witwatersrand in Johannesburg. The ship was stranded and these OTs lost all their belongings, except for one of them being able to hold on to a fur coat and her notes on how to run an OT training school (Wilcock 2002:202-205).[2]

Along with the war and subsequent staff shortages, patients in mental hospitals were confined behind locked doors, leaving them with less freedom for balanced occupational activities. Thus OT in mental hospitals had to stand back for

[1] The issue of the system's goals for economic "survival" and "prestige" hypernormatively overriding what is truly best patient care, has been previously noted in this chapter.
[2] According to a South African OT historian however, they did lose all of their possessions including their notes (Davy 2003:1).

physical cases that took priority. Materials were scarcer than ever and OTs were forced to consider more “realistic occupations” than craftwork, for example (Wilcock 2002:211-212).

Although one can understand that the War imposed many limitations on the availability of material goods for example, one should remain suspicious of a term such as ‘more realistic’. The crucial question is: More realistic according to which (hyper)norm?

The Second World War allowed a tremendous expansion of numbers in the OT profession, and Wilcock (2002:221) refers to this occurrence as having “had precipitated the profession into adulthood almost too suddenly”. Academic interest continued to grow and there is evidence that OT was also increasingly challenged to prove itself as a scientific discipline. However, at that time, the young profession still had to establish a solid research base and was yet again confronted with another set of demands with the arrival of social care soon after the war. Instead of reverting to the former foundational questions “it tended to develop a pragmatic common sense approach because its benefits appeared so obvious at the time” (Wilcock 2002:221). This was resisted by some visionary thinkers who realised the importance of a research base and who called for putting research on the (British) Council’s agenda (Wilcock 2002:213, 221-223).

3.4 1950s - Founding an International Voice

After World War II, the National Health Service in Britain was established. Contrary to the times after the previous world war, the state attempted to continue rehabilitation after the war and greater emphasis was placed on patients returning to the work force as soon as possible (Wilcock 2002:234). This is another example of how systemic economic imperatives may become intertwined with the internal goals of a discipline such as OT.

In 1952 the World Federation of Occupational Therapists (WFOT) was founded (with South African, Vona du Toit being chosen as the first vice-president of the WFOT) and the first international OT conference was held in 1954 (Davy 2006:5). Interestingly, OT as profession appeared to be regarded with less enthusiasm by the medical profession and even at some point was referred to as "an unjustifiable expenditure" (Wilcock 2002:234). One of the possible reasons for this was that it was argued that mere supervision of OT by doctors was not enough without the medical practitioner being familiar with the theory and practice of OT. This seemed a tall order in the uncertain post-war period and in view of the establishment of National Health Service, when the medical profession had to consolidate its own role. Fortunately, the establishment of a government health service enabled the extension of OT programmes, by means of passing bills that endorsed the welfare rights of disabled persons in the job market, for example (Wilcock 2002:22, 234-235, 237).[3]

The advent of a national social health care system was coupled with much official effort by the OT profession to live up to a 'professional' standard. This was partially attained by national conferences at which the medical profession was also accommodated and OT was subsequently able to publish papers on its profession in medical journals (Wilcock 2002:234-240).

Concepts such as rehabilitation, remediation (with the development of many kinds of 'equipment' for remedial purposes), reablement (a client-centred approach being a central component), independence, resettlement and paediatric and geriatric care featured within the OT profession. More than ever during this decade, research became a prominent topic of concern for the OT profession and the first major controlled study (4 115 patients) on the value of occupational therapy was conducted, which marked the beginnings of a research

[3] Perhaps here is an example of 'job' opportunities really needing to be secured through links between the OT discipline and the economic system, when both the nature of 'jobs' and the relation between the discipline and the system remains open to critical questioning.

ethic for the OT profession in Britain (Wilcock 2002:245-251; Lock in Wilcock 2002:251-275; Ilott in Wilcock 2002:275-276).

3.5 1960s - Making a Paradigm Shift to a Reductionist Approach

Wilcock describes the sixties as a "watershed era" during which a division occurred between those who viewed the creative aspect as central to the profession, as opposed to those who viewed functional activities and independence as the way to go (Wilcock 2002:283). According to Duncan (2006:28, 30), the OT profession underwent its first "rare and traumatic" paradigm shift from an occupational paradigm to a mechanistic paradigm. This was due to the crisis the profession had encountered during the previous two decades in which it had had to prove itself as a (natural) science.

In the light of the "new ethos concerned with social health, social justice and the rights of people with disability" (Wilcock 2002:283), this was probably a partial result, due in some measure to a newly awakened social consciousness, and to a reductionist approach in treatment due to major scientific advances. Additionally, there was the failure to hold on to the "apparent preoccupation of the pioneers with the creative aspects of occupation as therapy" (Wilcock 2002:283). Subsequently, the question of proper assessment enjoyed much attention along with ideas that training should be upgraded from a diploma level to a degree level, with "calls for postgraduate education opportunities" (Wilcock 2002:283, 314-319). It seems to me that this development again marks the continuing dialectic between the 'art' and 'science' components of OT.

The issue of assessment probably coincided with the dawn of the reductionist era (Reed 2005:570). During this time, medicine became "increasingly scientific" and for a while, the quest of the OT profession to meet these scientific standards

through valid and reliable assessment, enjoyed precedence over the OT treatment of a patient. On the other hand, appeals were also made to observation and clinical judgement as being part of acceptable and worthy OT practice in the field of psychiatry. Furthermore, at this time, along with continued research to validate and sustain OT's philosophy of treatment (Ilott in Wilcock 2002:321), previous concepts such as activity analysis became more prominent in view of an increased focus on assessment in OT (Wilcock 2002:284, 298-299).

Here it is apparent that the criteria for 'clear/accurate assessment' were hypernormatively steering away from a full focus on creativity. It is also clear that a misguided formalisation of such criteria may have come to override a creative application of clinical judgement and intuition. Obviously, the latter cannot be reduced to natural scientific laws only.[4]

From the re-emphasis of activity analysis, the term that is still in contemporary use, namely 'activities of daily living', flowed from this, resulting in the term 'occupation' being replaced with 'activity'. One of the outcomes of this was another identity crisis in OT: calls for the change of name of the profession and to rethink its essential definition (Wilcock 2002:284).

In a government report that was published in 1963 pertaining to Health and Welfare Development of Community Care, four groups of people (mothers and young children, the elderly and the mentally and physically disabled), were identified by the British government as requiring community care. While OT was not mentioned in this report, it was of specific significance for OTs. Thus, although industrial and remedial rehabilitation continued from the previous decade, much attention was given to community and group therapeutic settings,

[4] This may be compared with a hypothetical situation at a university that is dependent on government subsidies. In compliance with a government programme to 'standardise education', we can envision how *administrative* criteria of how material should be assessed, may override inherently *educational* criteria of what should be taught (Johnson 2006:393-394).

which were not only conducted by OTs, but also by the emergence of non-governmental organisations (Wilcock 2002:285).

A critical summary of a report (*The Seebohm Committee Report)* by Education, Housing and Health Ministries in 1965 was issued on changes and steps that should be taken for more optimal family circumstances and was published in the *Occupational Therapy Journal* in 1968. In this summary, issues surfaced about investigating the government committee's vagueness about the "true nature and range of occupational therapy" (quoted according to the document in Wilcock 2002:286) and whether OT belonged to the "para-medical or social welfare" profession.[5] Probably, as one of the consequences, a subcommittee on remedial professions was formed. Wilcock (2002:286) states that:

> *[t]his process included a review of career pathways, lack of research opportunities and low salary levels of therapists, and the limited experience of many doctors to provide appropriate prescription and supervision [as well as the] overlap between occupational therapy, physiotherapy and remedial gymnastics.*

Many of these issues are currently still relevant, although the report was published in 1972. This report, even back then, also acknowledged that

> *[t]he degree of involvement required places a good deal of pressure on the occupational therapist's personality, her own view of life, individual attitudes and opinions, if there is to be more than a superficial exchange between patients and herself* (quoted according to the document in Wilcock 2002:304).

[5] The question of OT belonging to the medical or social disciplines has again recently been raised by Blair and Robinson (2005:272) where they argue that OT probably falls "on a fault line between medical and social margins".

As an attempt to control the standard of practice due the changing roles of OTs, the national body for the OT profession in Britain (Association of Occupational Therapy), piloted a committee of investigation in 1963. This report titled *OT, Present and Future* acknowledged the changing roles of the OT profession, along with suggestions for training to be adapted accordingly. In this report, the issue of the importance of OTs working under medical supervision was re-emphasised, implying the vital importance of doctors to comprehend the purpose and roles of occupational therapy. In 1966 the fourth WFOT conference was held during which the relevance of OT across the age spectrum was debated (Wilcock 2002: 289-290, 292).

3.6 1970s - [6] OT Proving Itself Scientifically

The 1970s is referred to by some as the “Age of Doubt” after the “Age of Confidence” in OT in the 1960s (Margaret Smith quoted in Wilcock 2002:346), although it was also marked by much progress and enthusiasm in fields such as education and organisational restructuring within the OT profession in Britain. Philosophical questions were also raised about the definition of a healthy person. In the same vein, “chronic progressive diseases,” depression and alcoholism, as well as the effects of “boredom and loneliness” raised new concerns for “earlier preventative paradigms of care”. The focus of assessments from the previous decade evolved slightly in the direction of “functional assessment” and the standardisation of such tests (Wilcock 2002:331-334, 354-355).

A statement by the Tunbridge Committee (an affiliation of the Standing Medical Advisory Committee on Rehabilitation) was published in February 1972 by HMSO (Her Majesty’s Stationery Office) for review and discourse by OT,

[6] This decade, according to Reed (2005:570), indicates the commencement of the Era of Synthesis until current times.

physiotherapy and remedial gymnastics. In this statement four problematic issues were identified:

- The poor salaries paid to the remedial professions in comparison with other professions with similar "responsibilities and educational background", recommendations being made for better remuneration "to encourage more men into the profession";

- lack of senior posts as part of a problematic career structure;

- controversial indications that OT should be allowed more range for autonomy in the application of treatment;

- once again, the deficiency of research pertaining to various forms of remedial and rehabilitation treatment was raised (Wilcock 2002:335-336).

In 1969, the British Association of Occupational Therapists (BAOT) was founded between the two OT organisations in Scotland and the United Kingdom. In this setting many issues enjoyed attention, one of which was the responsibility of OTs for ensuring social justice for their clients.[7] During the first European Congress (1977) for OTs, with the theme *To exist - or to live*, attention was focused on the ongoing difficulty OTs have "in defining their role, and indeed the profession itself" and whether OT was living up to the its extensive role as outlined in the definition of OT formally compiled by the WFOT the previous year (Wilcock 2002: 339-347):[8]

[7] This is interestingly, an issue that recently surfaced again in some OT circles with the publication of Kronenberg, Simó-Algado & Pollard's (eds.) *Occupational Therapy without Borders* in which the subject of occupational justice is widely explored. It is also only recently that the term 'occupational justice' (among other terms) has been incorporated in a position paper of the WFOT (World Federation of Occupational Therapists) (2004:1).

[8] This theme could indeed, as such, also be seen as a piece of ideology critique which questions the role of creativity in society.

> *Occupational Therapy is assessment and treatment through the specific use of selected activity. This is designed by the Occupational Therapist and undertaken by those who are temporarily or permanently disabled by physical or mental illness, by social or developmental problems. The purpose is to prevent disability and fulfil the person's needs by achieving optimum function and independence in work, social and domestic environments* (quoted in Wilcock 2002:346).

In line with coming closer to what is referred to, in current times, as 'occupational justice', a medical doctor delivered a paper during the (British) OT Annual Conference in 1975 in which the definition between disability and handicap was referred to – the latter being defined as when "patients …are unable to do what they want" after being disabled. He continued by saying that "handicap is a disease" and "the physically disabled have five main diseases – poverty, bad housing, being cold, independence in the home, isolation" (Dr JA Muir Gray quoted in Wilcock 2002:353; Ibid).

Additionally, a difference appeared to be present between OT in physical rehabilitation and the rehabilitation of the mentally ill, in the sense that while it seems that increasing pressure was put on 'physical' OTs to work reductionistically, the greatest tool in mental rehabilitation was regarded by many as the 'self of the therapist'.

Wilcock (2002:362) also mentions that projective techniques became trendy, and one cannot but wonder about the tension in principle between these views and what was/is generally regarded as 'objective science' in the world of biological medicine. A downside of therapy expanding into the community was a reduction of OT services in institutional facilities, and once again, OTs found it difficult to explain their services as being of vital importance (Wilcock 2002:361-364).

Here it seems that a number of issues are relevant, such as the concept of community – in the context of occupational justice – which has the potential to undermine the focus on creativity as such (in both the therapeutic and theoretical sense). If we are concerned with creative occupation in the first place, then the struggle for occupational justice must *build* on this, not *displace* it. Furthermore, to help people express their creative impulses is already a service to society, to which other services may of course, be added.

On the research front, disappointingly few research studies were published, although a high standard and an imposing "range of methodology" were evident. The lack of research was attributed more to a lack of facilities, time and students, as well as tutors and (so it seems to me) less to the practical thinking of the "practically trained therapists" (Ilott in Wilcock 2002:373-374).

While this decade was marked by great advancements by the OT profession (in Britain) in the fields of organisational re-structuring, community and group therapy and education, doubt surfaced about the profession as it became aware once more that it was not being fully understood by the medical profession and the public. Wilcock (2002:374-375) contemplates possible reasons for the self-doubt, among these, being a "too rapid transition" from creative and curative activities in hospital settings to the functional approaches in community settings, a "total rejection of former practices, which left the majority of the profession without a historical foundation", or a blend of these factors "in combination with a loss of a philosophical base."

3.7 1980s - A Profession Self-Reflecting

This decade was marked globally, by spectacular technical advances and an extension of OT having to verify itself on the scientific front. As a result of this research, the OT profession expanded, with a growing increase in specialisation. Duncan states that OT underwent a second paradigm shift at this time when it realised that the previously embraced mechanistic paradigm was too reductionist and insufficient for the profession. OT adopted a “contemporary” paradigm in which it re-acknowledged occupation as central to human health. The issue of self-doubt that prevailed from the previous decade was tackled in a similar fashion and two major investigations of the profession were initiated during this decade by the College of Occupational Therapists in Britain (Wilcock 2002:385-428).

One of these two investigations into the professional status of OT in Britain, is of particular interest: The Blom-Cooper Inquiry under the chairmanship of Louis Blom-Cooper, QC. Among the findings they reached, the conclusion that the definition that was used by The College of Occupational Therapy was “too broad and unfocussed to be useful in the description of the role” and suggested the following (document quoted in Wilcock 2002:402):

> *Occupational therapy is the assessment and treatment, in conjunction and collaboration with other professional workers in the health and social services, of people of all ages with physical and mental health problems, through specifically selected and graded activities, in order to help them reach their maximum level of functioning and independence in all aspects of life, including their personal independence, employment, social, recreational and leisure pursuits and their inter-personal relationships*.

Other critical conclusions of the Commission (based on questions asked), were the following:

- "occupational therapy is needed as an integral part of health and social service provision";

- "there will be a continuing and expanding need for fully professional occupational therapists";

- "further consideration should be given, in the long-term if not in the immediate future, to the creation of a united profession of rehabilitation therapists, permitting post qualification specialisation" and

- "the next decade and increasingly into the twenty-first century occupational therapy should be largely relocated in community care services" (quoted in Wilcock 2002:403).

In view of the persistent experience of "being misunderstood", the Commission ascertained that OT was "something of a submerged profession", further having the difficulty of ridding itself of an "outdated image" and consequently recommended a change of name. They gave the following reasons for OT's "long and continuous struggle to establish and maintain an autonomous practice":

- *The dominant position held by the medical profession in the division of labour in the health service, and the similar domination of the social work profession in the local authority domiciliary services…*

- *The dependence of occupational therapists on doctors and social workers for access to their clients…*

- *A…false and damaging stereotype of their function, derived unmodified from the very earliest pre-occupations of do-gooding volunteers…*

- *The pronounced female composition of the profession*

- *Given the difficulty of measuring the outcome of occupational therapy procedures, and the competition for resources from users of high technology, the professional activities of occupational therapists are likely to be seen peripheral to the main medical and surgical objectives of care. They may even be judged as luxuries* (quoted in Wilcock 2002:403-404).

These findings in fact, may be viewed as a remarkable piece of ideology critique. Note the actual terms 'dominant' and 'domination' that are used: the key terms that are also used in the model of ideology analysis featured in this study. Another remark pertains to the word "do-gooding" (Wilcock 2002:403), which may be seen as strongly indicative of the issue about 'moralism' in the OT profession, as was previously discussed.

The recommendations made by the committee were not seen as drastic or novel, since many of them have been taken "under active consideration" already (Wilcock 2002:404). Interestingly though, these findings to my knowledge (and as far as could be established), were not offered as general points of discussion among members of the OT profession in South Africa, as being perpetual issues about the existence of the OT profession as such.

With regard to education, it appears that syllabi became more streamlined and continuous attention was given to the development of theoretical models (Wilcock 2002:410-413). Although research expanded it was stated by a member of the Research and Development Committee that it was still a case of "there are too few occupational therapists involved in research and unfortunately, unlike many other professions, research is not considered to be an integral part of our

career development". A further remark pointed to the question of researchers taking leave from the profession, as an "elitist activity" because of the often inaccessible linguistics it involves for both basic and applied research (Ilott in Wilcock 2002:410-413, 425-426).

At the Federal Conference of the Australian Association of Occupational Therapists in 1980, the keynote speaker, Hester Monteath concluded that a golden thread of "what it is that is exclusive to occupational therapy" is absent. She therefore recommended five core responsibilities waiting (of some included): determining the boundaries of our profession, being clear about the latter in our communication to others and research as a "keynote to our credibility" (Monteath quoted in Wilcock 2002:428; Ibid 2002:428).[9]

The above mentioned issue as well as the comments made about research being viewed as separate from the way in which many OTs viewed their roles, can probably be related to a certain 'practicalism'. Perhaps, due to the fact that OT has not been coupled directly to the study of some or other fundamental aspect of reality, such as the basic disciplines of biology, linguistics, physics, psychology, law, etc., as has been mentioned before, there are also OT ties to the philosophy of pragmatism, which in principle, is directly opposed to 'principled' thinking.

3.8 1990s - Comprehending Human Rights

In the last years of the 20th century, travelling and communication on a global scale became commonplace. Information technology enabled OTs to "become aware of, respond to, challenge or influence ideas and theories as soon as they became available" (Wilcock 2002:438). Multi-culturalism also became a reality for

[9] The other two recommendations that Hester Monteath made regarding the mentioned issue is "stocktaking…look at what we are doing" and the "evaluation of every technique that we apply", which resorts under research (Monteath quoted in Wilcock 2002:428)

many OTs. The client-centred approach became not only a concept used by the therapist, but also something their clients began to comprehend. The Committee of Occupational Therapists for the European Communities (COTEC) stated that the philosophy of OT is based on problem-solving. During this time also, the Code of Ethics was reviewed and a client-centred approach was re-constituted (Ilott in Wilcock 2002:437-444, 438).

Looking at the latter part of the definition of OT as stated by COTEC, the question may once again be asked: from which fundamental aspect of reality does OT 'solve problems'? There is no singular aspect that OT focuses on with regard to a person with a disability. This is clearly reflected in the many issues that we attempt to juggle with in our definition. Sometimes we look at a person from the physical point of view to solve a problem, or the psychological, or the kinematic, for example, but there is no singular aspect that offers OT the theoretical grounding (such as creativity, for example) from which all the other aspects may be viewed.

A review by Greg Kelly in 1997 (which was published in the British Journal of Occupational Therapy), comprised early correspondence of OTs and he found that themes such as standardised tests, pleas for research and scientific validation, spirituality/religion, other therapies, change of name and gender issues have remained central through the history of OT up until current times (Ilott in Wilcock 2002:447).

National and international conferences continued and issues such as OT had to become more politically involved in order to fight the systems that allowed occupational injustice and the relentless stereotyping of persons with disabilities, were some of the subjects that received continuous attention (Ilott in Wilcock 2002:449-450, 452). These issues were later also reiterated and extensively explored in the OT text book titled *Occupational Therapy Beyond Borders* by Kronenberg, Simó Algado and Pollard, published in 2005.

In 1994, at the WFOT Congress, one of the delegates Martin Boey, suggested that OT move away from the medical model and closer to occupational science. He also argued that holism, client-centredness and problem-solving should become central matters in the education of OTs and that a paradigm shift would be necessary. Amongst other subjects that received attention was a call for the use of qualitative research (Ilott in Wilcock 2002:455).

In practice, the term ‘occupation’, once more began to replace the term ‘activity’, although it was argued by some that both the terms ‘occupation and purposeful activity’ should enjoy equal merit. Rosemary Hagedorn, a well-known OT in the conceptualisation of OT models, argued that four components are central to the profession, namely, the person, the occupation, the therapist and the environment. She continued that the “base of personal paradigms…were dependent on three R’s: reasoning, reflection and research” (Ilott in Wilcock 2002:458).

On the research front, evidence-based practice was and still is, identified as either feasible to the practising therapist when conducting research or an “inappropriate tool to assess the effectiveness of occupational therapy interventions” (Ilott in Wilcock 2002:459). Other issues that enjoyed prominence were the importance of community care, primary care and the various fields of specialisation, such as palliative care and private practice (Ilott in Wilcock 2002:458-462. Many topics centred on occupation, although a review of the content of publications “between 1989 and 1996 revealed that most papers were related to clinical and descriptive work, in that they illustrated, rather than evaluated, current practice” (Ilott in Wilcock 2002: 476).

In conclusion, with reference to this decade, it is argued by Ilott (in Wilcock 2002:479) that beside achievements in education, the most striking achievement was the “more holistic understanding of people’s rights and responsibilities” and

the importance of occupation as a vehicle for people's return to well-being in their respective communities.

3.9 Summary of Identified Ideologies in the History-profile of OT

Time Frame	Ideology	Result
Medieval times.	Church ideology.	'Spiritual' occupations valued over 'earthly' occupations.
Enlightenment (Age of Reason).	Science ideology, freedom ideology. Pre-occupation with happiness over meaning, materialism.	Fixation on natural science and on freedom as against science: future influence on OT.
18th Century.	Labour-for-money, possessive individualism, beginnings of power and prestige ideology.	Meaning and creativity suppressed. Religion acted as filter to view those who are poor.
Late 18th century: Moral treatment.	Moralism	Occupation serves moral purposes.
	Medicalism	Medical discourse becomes powerful in occupational discourse.
Late 18th century and 19th century: industrialisation.	Economism, Capitalism	Economic needs of state or private sector increasingly hypernormalising labour over creativity.
Late 19th century and 20th century: Pre-formative years of the OT profession	Pragmatism	Need for OT "theory" undermined.
	Moralism	See above
20th Century: World War I	Threat of scientific managerialism.	Attempts external control of occupational activity

		from supposed scientific principles.
20th Century: Post-war	Economism	Imperatives of the economic system overriding the philosophy of OT.
20th Century: 1917 Founding of OT	Scientism, Pragmatism	OT torn between a science ideal and a need to be pragmatic.
20th Century: 1918 'reconstructive aides' sailed to France	Medical paternalism, Patriarchy.	OT dominated by the medical profession with the latter itself, representing male power.
1930s – 1950s:	Economism, Scientism, Pragmatism.	See above.
Establishment of British National Health Service (1945-1951)	Administrative bureaucracy.	Organisational imperatives shape patient care.
1960s – 1970s Reductionist Era	Scientism, Positivism, Capitalism, Politicism.	See above. OT profession undergoes a paradigm shift from the "paradigm of occupation" to the "mechanistic" paradigm (Duncan (ed.) 2006:30). Scientific imperatives threaten values of patient care.
1980s - currently	Techno-scientism, Moralism identified, As above.	See above. OT acknowledges insufficiency of

		mechanistic paradigm and moves to the "contemporary" paradigm (Duncan (ed.) 2006:30).

Table 3.1 Summary of Identified Ideologies

3.10 A Very Brief Account of the History of OT in South Africa

The introduction to Chapter 2 above stated why Wilcock's resources have been used to perform an ideology analysis of the *historical profile* of the OT profession. However, in view of the fact that the researcher is a South African, it seems only fitting to add a short account of the history of the profession in this country. It needs to be emphasised though, that the reason once again, of such account is *not* a historical study *per se*, but more an account of ideological-historical purposes and affirming, to a certain extent, the ideologies that were identified by using Wilcock's resources.

As far as could be established, there is currently no formally structured and detailed compilation of the OT profession's history as a whole (such as those compiled by Ann A. Wilcock for Britain), in South Africa. Resources that are available entail, for example, SAAOT (South African Association of Occupational Therapists) working documents, a summary of their minutes and meetings from 1945 until 1975 (compiled by Joan Davy), and other anecdotal accounts of the early beginnings of the profession and educational programmes in South Africa. The researcher also conducted interviews with experts in the South African OT profession regarding the course and development of the profession in this country. However, it soon became clear that a proper and deep investigation of the history of the OT profession in South Africa is a study all on its own that requires an empirical and appropriate methodology for historical research and will consequently fall outside the scope of this study (Mouton 2001:144, 170-171).

The development of OT in South Africa has not occurred in isolation, but is very closely linked to developments in the rest of the world. Therefore, one could assume that many of the ideological phenomena in the analysis previously discussed, are also relevant for OT in South Africa. Nevertheless, a hampering fact in this regard is that large parts of the scarce documentation are in the form of administrative reports (such as the minutes of the SAAOT meetings, for example), which are not sufficiently *discursive* to serve as proper objects for ideology analyses.

The history of the OT profession in South Africa started in the midst of World War II when the profession expanded worldwide and is therefore considered as a very important time in the history of the profession as a whole (Wilcock 2002:181-182). In 1943, two women from the United Kingdom – Miss M Crouzas and Miss L McArthur sailed to South Africa to implement an OT education programme at the University of the Witwatersrand in Johannesburg. The ship was torpedoed, during which they lost everything (including personal belongings) that they had brought along to establish the infrastructure of an OT department (such as equipment, textbooks and samples). These materials were all irreplaceable, given the economic scarcity due to the War and the founders had to get along without them, although they apparently received much assistance from the University and hospital workshops. Nonetheless, a three and a half-year diploma course were offered at the University of the Witwatersrand (Wits) in 1943, after which courses were changed in 1970, to a four-year degree course (Davy 2003:1; Franzen (ed.) 1993: iii).

Beside lectures in abnormal psychiatry, lectures in sociology and a yearly visit to the archaeological site at the Sterkfontein caves formed part of the course. Many hours of training were spent in activities such as weaving, basketry, sewing, macramé, pottery and lapidary (polishing semi-precious stones) and later in the 1980s these were varied with printing, wire-work and stool-seating. Clinical

training initially occurred in Cape Town due to a lack of clinical OT departments. A central theme with most of the alumni students at the University of the Witwatersrand was the recollection of natural science subjects such as anatomy, physiology, biology, zoology, and physics and chemistry, all which formed a significant part of the OT curriculum at the time and most recalled the rather unpleasant associations with particular subjects such as chemistry and physics (Franzen (ed.) 1993:1-31).

The strong representation in the curriculum of the natural sciences seems to concur with the increasing pressure that was put on OT to validate itself as a natural science. In fact, this occurs at the same time as the profession's gradual paradigm shift from an occupation paradigm to a mechanistic one (Duncan 2006: 30; Wilcock 2002:213). This, of course, concurs with the notion of a dichotomy in OT between a reductionist and a holistic philosophical view or of OT lying on a "professional fault line between social and health care" (Blair & Robinson 2005:272; Hagedorn 1993:3-4).

In 1945, an OT department at the Grootte Schuur Hospital in Cape Town was started by Elizabeth (Betty) Turner, one of three qualified OTs in the country at that time. In the same year, the South African Association of Occupational Therapists (SAAOT) was founded by no less that five OTs. Interestingly, the presidency/chairmanship of this body was held by various male representatives from the medical profession until 1966, when Prof. G du Toit suggested a change of SAAOT's constitution to allow for an OT practitioner to be elected for this position. In 1949 the first SAAOT newsletter appeared. During these times, the association was concerned about issues such as the need to promote OT in hospitals, the poor salary scales that needed to be addressed and the "protection of the term Occupational Therapy being used by unqualified persons" (Davy 1975:1, 6, 19; Davy 2006:4).

The 1950s was marked by, as already mentioned previously, the founding of the World Federation of Occupational Therapists (WFOT) in 1952. Vona du Toit, a South African OT, is considered one of the co-founders and first vice-president of this federation. While research became a prominent point of pursuit for OTs in Britain, South Africa followed suit by publishing its first OT journal in 1953. Unfortunately, due to a lack of articles and financial support, the journal had to be temporarily discontinued in 1958. However, on the education front much progress was apparently made and the first memorandum for minimum standards regarding student practices was drawn up in 1958 and has remained very much the same since then (Davy 1975:7, 8, 12; Wilcock 2002:275-276).

The OT training centre that was opened in Pretoria in 1955 was followed by one in Stellenbosch in 1961. During the 1960s, issues such as poor salary scales for OTs (an issue in Britain as well (Wilcock 2002:286)), the acute shortage of OTs, persons without qualifications practising as OTs (compulsory registration at a national body was not yet required) and the issue of international conferences and meetings, enjoyed attention. South African OTs indeed featured internationally, as three expert advisors in South Africa were appointed by the WFOT during this time. An interesting point documented was that in 1965 SAAOT requested from the Minister of the Interior to hold WFOT meetings in SA, but this request was refused. The details were not given, but considering the political context of SA during this time, this refusal may perhaps have been related to governmental security agendas (‘statism’ intertwined with apartheid’s ethno-nationalism) hypernormalising the internal aims and values of a profession such as OT. During this decade, evidence was also found in the minutes of SAAOT of several attempts at negotiation for the training of non-whites as OT staff, but these efforts were not realised until many decades later – for reasons that were not mentioned, but that may only be assumed (Davy 1975:13-23; Davy 2006:4).

In the following decades, the OT profession continued to expand, particularly in terms of private practices, parallel to the further development of speciality areas. Training centres at the University of Cape Town (1972), the University of the Free State (1976), MEDUNSA (1976) and the University of Durban-Westville commenced and the need for the training of auxiliary staff and for establishing clinical areas was advocated. In 1972 the Bill in Parliament, which made registration of para-medical professions compulsory, was finally passed. Although permission was also finally and conditionally granted to SAAOT for a WFOT council meeting to be held in South Africa in 1980, notions for the training of Black OT staff were referred to the Professional Board for further attention. Membership in 1975 stood at two hundred, as opposed to ten members with 9 associates in 1946.

The profession took the standpoint of no racial discrimination, remaining true to the general global ethos of OT. One example would be at Grootte Schuur Hospital, where all races were treated together in the same OT area (Davy 1975:23-32; Davy 2006:4-5). This is an example of a disciplinary discourse and practice serving not to justify and sustain relations of domination, but to counteract them. However, it may also be argued that the OT profession in SA at that time chose to be the unwitting slaves in its apathy of the conceptual and social ideology of apartheid as “very little time has been spent on developing population reasoning and practice and on expanding ethical and moral reasoning to include a social justice and equity perspective” (Duncan 1999:4; 5).

In 1990 the OT profession, along with other health professions, raised significant objections to declining health services. In 1993 it was recognised that the SAAOT had to be restructured toward transformation and an official Transformation Committee was appointed to assist in this task. In 1994, a new constitution was drafted and the name was changed from SAAOT to OTASA (Occupational Therapy Association of South Africa) which indicated the inclusiveness of auxiliary staff. OTASA broadened its functional structure as well, and currently

various committees perform specific functions. The association currently champions organisational efficiency, the marketing of the profession and the recruitment of new members (Davy 2006:5).

3.11 Conclusion

The story of the history of OT appears to be quite a sad one, like those of many other disciplines, when considering it from an ideology-critical point of view. In my view, 'moralism' – the need to do good and to uplift those who are 'less fortunate' or 'less healthy' – remains a deep underlying characteristic of the OT profession; one of which the advantages and disadvantages will be addressed in a later chapter. It seems, however, that since the decline of Moral Treatment, OT has been consistently challenged to remain true to the 'art' part of its definition. Its relationship with the medical profession, which was initially one of symbiosis, later proved to be one of submission as a secondary and non-essential 'para-medical' profession, when OT decided to align itself with the medical model and profession. This led to a continuous 'dialectic' between the art and science qualities of OT and in my view, also a tension between the physical and psychiatric spectra of OT in theory and practice, ultimately losing the philosophical foundation of OT in viewing its clients and patients in a truly holistic perspective. This tension and dialectic will apparently continue as long as OT sees itself as an extension of the bio-medical model *practice*, despite that fact that it has moved away from it in theory.

This chapter has related a brief account of the history of the OT profession up until the end of the 20th century. The main ideologies that have contributed to the shaping of this profession were identified and briefly discussed. These formations may be pictured as contributing to a full-scale map of the total ideology environment of OT. It is this latter environment that forms the theme of the following chapter.

CHAPTER 4
Ideology and Occupational Therapy: A Systematic Perspective

4.1 Introduction

In the previous chapter, an ideology analysis was conducted, in terms of the hypernormative tendencies, of the historical profile of the OT profession, especially as it is known in the Western world. The purpose of this chapter is to explore more systematically the tool of ideology analysis that was used in this historical profile.

One might ask why an OT such as myself ventures into the disciplines of philosophy and sociology to answer questions about OT. This query, to some extent, has already been addressed in the Introduction and Overview as well as in Chapter 1. There it was argued that the questions asked in this study about the problems in OT are essentially philosophical and in this sense, congruent with the 'art' component of the definition of OT (Blair & Robertson 2005:274). Another part of OT's philosophical base is the holistic view of the human being as an occupational being (Wilcock 1993:17-23; Yerxa 1993:3-10). The very quality of the term 'holistic' implies that OT as an (applied) science should (and has) draw(n) from various disciplines that reflect the many dimensions of a human being in her/his totality, including her/his social and philosophical aspects. It has been pointed out that although we would like to say that the OT profession works holistically, in terms of everyday practice, we still need to venture 'beyond occupational therapy's limited grasp of holism' (Kronenberg, Simo Algado & Pollard 2005:3).

In the same vein, we can say that OT as a discipline originated, developed and still exists among other dimensions (aspects/contexts), also in the social realm.

This means that OT has unquestionably been shaped and influenced by social and of course, cultural dynamics. Thus, it is not only appropriate, but in fact necessary, to visit disciplines such as philosophy and sociology in search for some answers to the questions in OT as already formulated earlier.

4.2 A Model for Ideology Critique

The term ‘ideology’ was first coined in 1796 by Destutt de Tracy, a French thinker. This was part of an intellectual attempt to salvage the ideas of the Enlightenment after the Jacobin Terror, during which the (intellectual) supporters of the Enlightenment movement were viciously persecuted by Robespierre at the time of the French Revolution. De Tracy intended the term ‘ideology’ to be about the “science of ideas”, meaning “a combination of philosophy and education based on the systematic analysis of ideas” (Thompson 1990:29). Before this ideal could be fully established, it was interrupted by other historical events such as the Napoleonic wars. The notion of ‘ideology’ subsequently became influential in the political arena and evolved from the “science of ideas” into the “ideas themselves” (Thompson 1990:32). More importantly, the concept of ideology later took on a negative connotation (by Karl Marx), and served to designate “ideas” in serving the interests of domination. (Karl Marx’s social critique demonstrated the differentiation between the ruling (powerful) and working (powerless) classes, the latter being forced to sustain the former’s position of power and comfort (Visagie n.d.: 5)). This negative meaning of the term still co-exists today with a more neutral usage (ideology as a kind of worldview (Thompson 1990:48)).

There are many models of ideology critique, of which I will be introducing one in this chapter. This particular model has been developed by Johann Visagie who made a deliberate effort to unify several different ideology analyses within one

comprehensive model.[1] This model is formally labelled 'Ideological Typography in Modernity' and I will henceforth refer to it as ITM. ITM incorporates the critical notion of ideology because of its "fruitful and defensible" purposes: "to study the ways in which meaning serves to establish and sustain relations of domination" (Thompson 1990:55-56).

The present study employs this concept of ideology in order to investigate absolutisations, distortions, selective rationality, and the privileging of some norms above others, and other similar systematic asymmetries (Thompson 1990:59; Visagie 1994:7). It is this concept of ideology which is related to the environment pertaining to OT.[2]

The following statement summarises the characteristic use of the term 'ideology' in the ITM model:

> *We do not understand ideology in a neutral sense, referring to any system of beliefs, values or a worldview. Ideology is intrinsically a negative phenomenon, one which creates decidedly distorted [and autonomised] values and perspectives across a broad range of human behaviour* (Visagie & Pretorius 1993:53).

A second issue to be noted, is that the use of the term 'ideology' in ITM, is understood in a much wider sense than in only the political. The critical potential of ITM, extends beyond the political to the presence of ideologies in everyday life, into relationships at work and at home, right through to the manner in which

[1] Professor Johann Visagie is the Head of the Philosophy Department at the University of the Free State in South Africa.

[2] It is important to distinguish between the meaning of 'critical' and 'negative', which was an issue that was raised by some of my colleagues. The purpose of the present study is by no means to deliver a senseless 'analysis' of 'negative' value on 'all the wrongs' and 'wrong-doings' of the OT profession. This is not the meaning of 'critical thinking'. A critical analysis refers to looking at and evaluating all sides of a coin. Epstein (2002:5) defines critical thinking as "evaluating whether we should be convinced that some claim is true or some argument is good, as well as formulating good arguments."

we view and treat our bodies (Foucault 1980:55-62). It is precisely the *critical* perspective of ITM over the whole landscape of human functioning that makes it suitable for a philosophical investigation of theory and practice in OT.

Another feature of ITM is the link it establishes between ideology as relations of domination between social *groups* (e.g. race, class, gender etc.) and ideology as dominant *discourses* in culture and society. These latter discourses (for example the cultural force of science or technology or the media) have the power of exerting their influence on cultures as a whole, even on the whole of Western modernity as such. The implication for OT is that ITM enables one to analyse OT critically on two levels: (1) the level of discursive issues, (or 'value' domination), and (2) the level of social group dynamics (or 'people' domination) (Visagie n.d.: 5). Clearly OT can be studied on both these levels. (See diagram 4.1.)

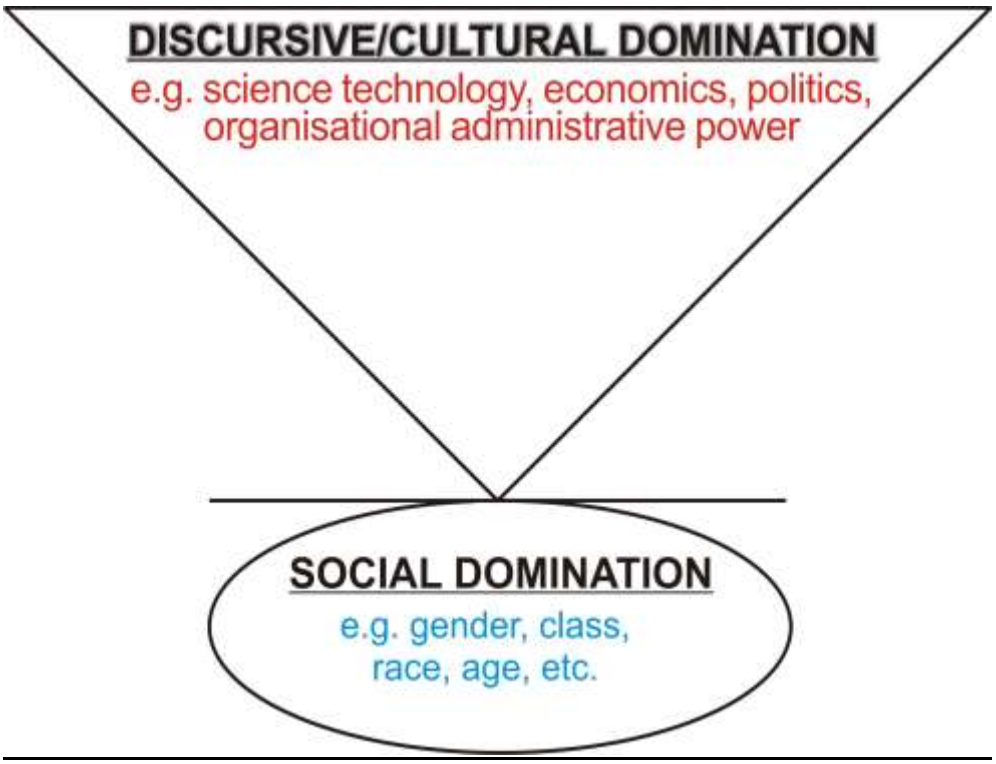

Diagram 4.1 A Model of Ideology Theory *(Compounded from Visagie n.d. unpublished manuscript: 2-15)*[3]*.*

[3] All diagrams of the ITM model in its depictions with different levels of ideology are compounded from the mentioned resources.

These levels do not stand in a dualistic relation towards each other, since discursive domination and social domination are intimately intertwined, as will be demonstrated shortly. It is this quality, which enables the ITM model to overcome imbalances of disparity where ideology models previously tended to restrict themselves to one of these two dimensions. Nevertheless, ITM claims to have appropriated certain inputs from these rather one-sided models. Such inputs come, for example, from sources like neo-Calvinist philosophy, neo-Marxist theory, post-structuralist Cultural Critique, and so on (Horkheimer & Adorno 1972; Dooyeweerd 1953; Ellul 1975; Giddens 1979, 1984; Habermas 1971, 1984, 1987, 1990; Marcuse 1966). As my interest in this study lies with the application of ITM and not the complicated origins of the latter, I leave these issues aside and turn directly to my immediate concerns.

To illustrate the above intimate intertwinement of the social and the discursive realms, one can compare the case of Afrikaner ethno-nationalist ideology during the years of the South African apartheid regime. This ideology caused its supporters to commit to the dominating (discursive) values/goals/norms of ethno-nationalist ‘volks-ideology’ that ruled and dominated over social aspects such as art, education or the church, etc. Essentially this meant that the hypernorm (the technical term used to embrace the values/goals/norms referred to) of the survival of the Afrikaner people came to ‘interpret’ issues such as what art should be (i.e. not alien to the people), what education about ‘one’s own’ entails and in what relation the Church should stand to the people. Even more essentially, what happened was that the goal of cultural survival came to dominate the other norms *internal* to art, education, the Church and other matters. Crucially, the said hypernorm came to dominate the interpretation of legal principles; for example, not allowing blacks to vote.

Of course, all of this also affected the field of O.T. For example, if a black prospective student wanted to study at a specific university that offered a

reputable standard in education and training in the health professions, and that university happened to be Afrikaans, she/he would be unable to do so, because the dominating discursive norm of ethno-nationalism proclaimed a 'civilized responsibility' and therefore a right to gradually and slowly educate black people in order to bring them to a kind of 'cultural maturity'. Due to this political slant of education, it may have taken years or even generations before one could, for example, become a black OT. This dominance of a specific enthroned absolutisation in the *minds* of people was, however, immediately and obviously linked to social practices and tensions between social groups (thus the intertwinement between the two realms of ideology).

Following this type of analysis, I shall endeavour to investigate the hypernorms which occur broadly in Western culture of modernity and in its social components, specifically in South Africa. More specifically, the focus will be on what the effects thereof are and have been on the profession of OT, with the hope that the results will offer some explanation for certain problems in the professional stance of OT. I shall however not attempt (here) to address the application possibilities of ITM in terms of the wider context of Africa. The reason for this is that sources on ITM have not progressed very far in this direction. Nevertheless, it seems quite likely that a similar intertwinement of discursive value and social value domination will also feature within the African setting. It should be kept in mind that progressively more people of African indigenous descent, are becoming 'Westernised' to various degrees. This implies that much of the ITM will be applicable in terms of this mixed cultural setting. A final remark in this context: ITM may be said to reject both 'Afrocentrism' and 'Eurocentrism' and thus rejects the notion that OT should be aligned with one or the other. At issue here is the essentially hypernormative/ideological character of both '–isms' (Visagie 2004:57-96).

It is important to remember that virtually all ideologies are born of an 'intention for the good', for example, for progress, or in the name of social consciousness. And

'good' power as such, is necessary. 'Good' power is, for instance, the power that a government wields in so far as this power is qualified by, for example, a constitution and a human rights declaration or simple rules and regulations about traffic and taxes that need to be followed in everyday life. 'Bad' power, however, occurs when such allocated power is abused at the cost of other values and aims, resulting in various kinds of ideology domination (Van der Merwe 2005). In a sense one can say that ideologies, especially at the discursive/cultural level, are born out of desire but within the context of a certain belief system or worldview; but this 'worldview' must then be understood as essentially ideological. Thus, it has the effect of 'steering' on social aspects or in terms of "people domination" in everyday life situations (Visagie n.d.: 2-15).

Finally, I wish to end this section with a remark about the 'ethics' of ideology analysis. It is the contention of ITM that despite using an objective system or model of analysis, the analyst is inevitably, also part of the ideological environment. Visagie (1994:61) refers to this as the *principle of total enmeshment*. Thus, besides the intertwinement of the discursive and social spheres of ITM with each other, enmeshment of the analyst with what is analysed, is also inevitable. He furthers the argument by saying that the relationship of the analyst with the analysed is however not one of "conflict" but rather, one of "contamination" and that the concern of the analyst therefore should be one of "epistemological guilt" rather than one of "epistemological justification". Therefore, when drawing an ideological interpretation, one should practise circumspection and a suspicious awareness (Visagie 1994:61-64).[4] What it basically means, is that the ideology analyst should always show a necessary humility; she is aware that, somewhere along the line, and even though she cannot pinpoint it at all times, she herself and also her analyses, are

[4] This resonates with the "essential intellectual traits" of a critical thinker as described by Paul & Elder (2006:13-14), which include intellectual humility, intellectual courage, intellectual empathy, intellectual integrity and fair-mindedness. Other essential traits of a critical thinker that they describe are intellectual autonomy, intellectual perseverance and confidence in reason.

infected with what we call ‘ideology’. One cannot live in the real world without this being the case.

Nevertheless, linked to “total enmeshment” is the understanding that elucidation and insight in dominations and distortions may still be of liberating value. Visagie (1994:64-66) refers to this as the *principle of emancipatory reflection as a co-operative venture.* This means that however vulnerable our ‘objective’ methodologies are to ideology, we can still hope to make some progress in knowledge and understanding, without ever being able to ‘arrive’ at the ‘full truth’. What is also important here is that ideology analysis, as previously stated, a co-operative venture. This means that the present study is actually dependent on other people from the profession of OT to *contribute* to the larger project: the Critical Self-reflection of OT.

4.3 Occupational Therapy and the Ideological Environment

4.3.1 The realm of Discursive Domination

Let us return to the discursive realm of ITM where the great steering powers are situated. (see Diagram 4.2.).

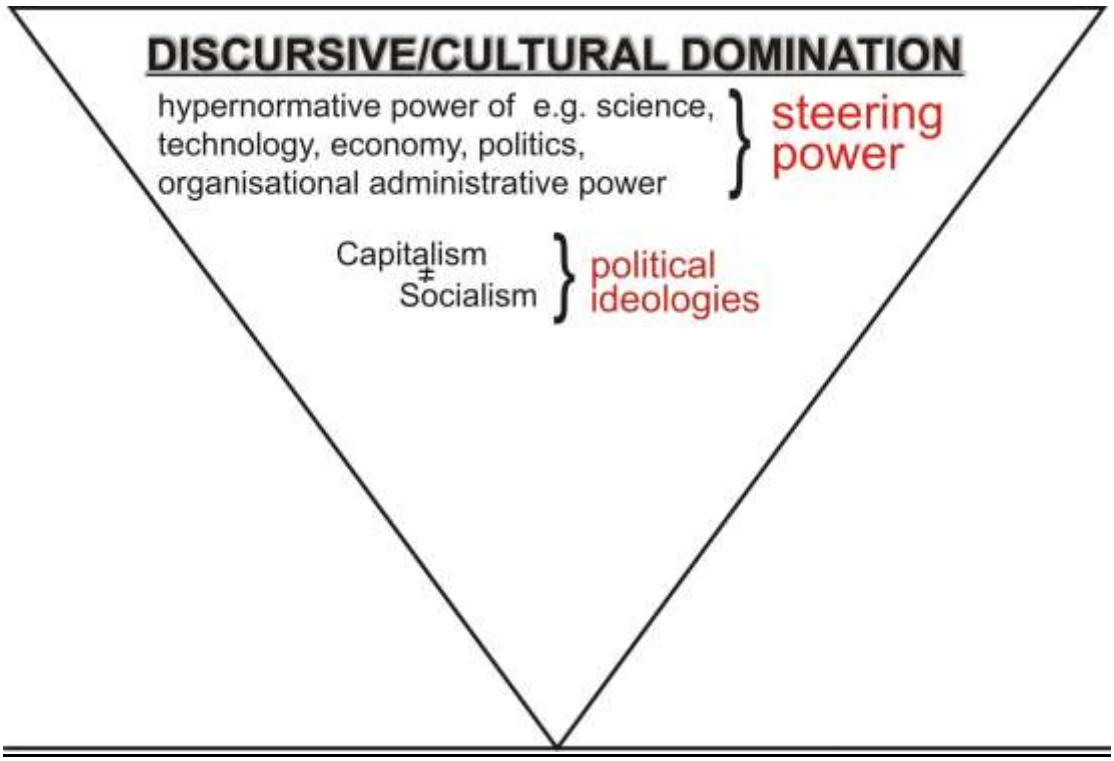

Diagram 4.2. Diagram of Discursive / Cultural Realm of Domination

4.3.1.1 The ITM steering powers

The ITM model expresses a view that is affirmed by many theorists of culture and society. Science and Technology are, if not *the* main forces of Western culture today. It has to be remembered though, that within the ITM framework, these entities are not regarded as being malevolent *per se*. It is in the hypernormative effects that are imprinted in culture: in other words, the way in which the pursuit of 'techno-science' and belief in these entities, sabotage the ideal of a 'balanced' culture. Let me illustrate this concretely, with reference to the broad environment of OT. Consider, in the context of a hospital, how the value of technology (for example a fixation on the best and newest machinery available to staff) may come to override other legitimate norms, such as *empathetic human care*, come even to displace the latter. Looking at the history of OT, and turning to the science ideal, an example may be taken from the 1960s when OT made a concerted effort to prove itself as a science and subsequently allowed, for some

period of the time, that the *assessment* of a patient overrode the aspect of *treatment* (Ilott in Wilcock 2002:321). Looking again at technology as such, and also at organisational-administrative power, I want to point out a norm that is inherent in these two logics, and that is *efficiency*. Of course efficiency is not something we want to eradicate, but in its hypernormative distortion, efficiency becomes an absolutised goal in itself. We (begin to) forget to ask: *Who* or *what* is it that has to be efficient? Merely asking this question shows that efficiency cannot be a goal in itself: it has to be meaningfully contextualised.

In terms of OT, it is clear that a fascination with efficiency may come to stand *between* the OT and her client, or the OT and her field of knowledge. Then issues about, for example, meaning or creativity in terms of either therapy or the theory of OT, may become more or less concealed beneath something that may in fact, never be of primary importance.

Margaret Fulton Barr addressed the issue of administrational efficiency in 1957 when a national health system was implemented in Britain and she remarked on how bureaucracy intruded on the time that should be spent on patient care (Wilcock 2002:113). Administrative power does not only exist in the frame of the state as such, but also for example, currently at our (and other) universities, where it connects with requirements by the government to ‘standardise’ higher education:

> *Those of us in higher education are struggling to think about what we do in the classroom in a way amenable to the social-scientific methods of “learning outcomes” and assessment rubrics that are being urged upon us by the ever-more asserting accrediting agencies. But it is hard to describe the marvelous and mysterious growth of a young mind, over the course of a semester no less than that over the full four years of college experience, in rigorous and mathematically quantifiable terms* (Johnson 2006:393-394).

The command for an Institutional Audit and the introduction of a Performance Management System are factors that involve the administrative goal of writing *everything* up, keeping track of virtually every action of the lecturer inside and outside the classroom, all which need to be updated. I am not arguing against excellence in education, which is certainly a necessary aim, but crucial questions need to be asked here: How do all the administrative goals influence *teaching* in OT? Has the teaching as such, become subservient to administrative goals? If the latter is to be answered in the affirmative, then we are certainly dealing with a distorted picture of the excellence which is striven for in higher education. In reaching this very *aim* of excellence, it is, after all, administration that must serve teaching and research and not the other way around.

With reference to the ideological manifestation of economic power, there are various issues that come to mind. Something that is of immediate concern to us in South Africa, is the current position of universities in which, in many cases, the freedom to do research where one's authentic interest lies, is hypernormalised by socio-economic agendas, the major one being that of monetary support. Duncan and Nicol (2004:454) point out that research within even the post-positivistic paradigm, for example critical theory, is regarded as being

> …*unhelpful in a health economic era, where resources are limited and monies are allocated to interventions that can demonstrate their worth.*

Another example would be how the philosophy of OT was hypernormalised by the economic determinants of the use of specific materials during and after World Wars I and II. These determinants prescribed the treatment approaches that OTs had to apply at that time, and ultimately the level of creativity in the treatment process and selection of activities for treatment during those times. In a similar vein one may refer to the socio-economic goals inherent in the 'community

service' programmes that have recently been emphasised by the government, especially pertaining to the health professions.[5]

In the most general sense, economic power relates, in the ITM landscape, specifically to the capitalist economic system and then also to the socialist alternative. In terms of hypernorms, the first system is marked by, amongst other things, consumerism, possessive materialism and competitiveness. The second system is discernible by collective structures that threaten individual and personal freedom. The political-economic environments in which OT finds itself are always a mix of these systems and their hypernorms, if it is not a case of exclusive capitalism.[6] These parameters and their effects, real and potential, on the teaching and practice of OT, should really be the subject of an ideology analysis on its own; here, I can merely point to the connections. We need to be aware of that the work and creativity in which OT is interested (especially within the view of doing, being and becoming for the well-being and healing of a person (Wilcock 1999:1-11)), are severely threatened by the vicious competitions of the capitalist cult of 'market-forces' and their sovereign rule over the work place.[7] Two remarks are appropriate in the present context. The first is that even if a hypernormalised situation is something that urgent need has forced upon us; for example, a situation where pure academic concerns *have* to come second to socio-economic concerns, for humanistic reasons; then, while conforming to this need, we still have to *recognise* the ab-*norm*-ality of the situation and that means rectifying the situation as soon as possible. A second observation of what is often overlooked, is that merely offering education at a university to those who eventually return to the community to deliver a service, already qualifies as

[5] What follows is my interpretation of personal communications with Johann Visagie during the latter part of July 2006.

[6] Capitalism is involved with hyper-excessive tendencies of prosperity (continued growth), possessive individualism and accumulation of goods (materialism) and power in a consumerist society. That is a society where everything is for sale, including labour; the strong line of reasoning that Marx used when he pointed to the segregation of classes between the bourgeoisie and the proletariat, the latter maintaining the capitalist wealth of the former (Honderich 1995:120; Visagie n.d.:5).

[7] Ingleby (1981:44-45) refers to interesting and deep interactions between capitalist societies, their politics, what is viewed as health and the subsequent maintenance of psychiatric 'disability,' for example. For a critique of capitalism from the perspective of "libertarian" socialism, see Chomsky (2003).

delivering (primary) community service. This necessarily implies that if a new type of community service should be added to the primary community service of the university, it in actual fact, qualifies as an *additional* service to the community. During this process, it is of utmost importance that the unique character of a university is kept in mind in order to be aware of hypernormative threats to the essence of a university. Hypernormative threats to a university, it is important to remember, are also in principle, threats to the well-being of OT.

Capitalism however, may also be viewed as having an exceptional influence on the whole of Western modernity and of course OT. In some ways it may be said that it was indeed, one of the factors that indirectly *contributed* to the establishment of the profession. Hull House in Chicago offered Arts and Crafts programmes after hours and was a concrete ideological critique against an industrial capitalist society that robbed its employees of inherent meaning and creativity in their daily lives in the factories (also refer to Chapter 2, section 2.4). On the contrary, it was scientism (in the form of 'medicalism'), combined with capitalism that to some extent contributed to OT's decision for survival to align itself strategically with the medical profession in the 1920s (Wilcock 2002:91), probably partially due the medical profession's view of the imperative significance of science as part of its "intellectual orthodoxy" (Ingleby 1981:42). Of course, in current times, all professions, including OT, remain a part of a capitalist society in the Western world, and there is continued debate about the relation between the goals of the helping professions and the ideals of business (De Witt 2002:6).

Some vital questions for OT now arise:

- Has OT become a naïve minion of Capitalism?

- In which ways has OT been keeping hypernormative structures in place?

- Is there any room for OT to be critical about these relations?

Kronenberg and Pollard (205:69) argue that OTs work with people in their social contexts. These social contexts are frequently the very reason for their disability, and because of this, OTs should recognise one of our roles as being that of a "social agent". Blair and Robertson (2005:272, 275) point out that the allied health profession of OT could be regarded as being on a "professional fault line between health and social care", confirming that the OT profession should consequently at least consider what other relevant disciplines have to say about different views and methods in research, for example.

In asserting the view that OT cannot ignore the political-economic arena, Kronenberg and Pollard point out that one could make a differentiation of the term politics in its "aspect approach" and in its "domain approach" (Van de Eijk quoted in Kronenberg et al.2005:70). While politics in its "domain approach" refers to the governmental context, politics in its "aspect approach" indicates its integration in the phenomenon of human occupation, the latter of which OT is directly and most other professions, are indirectly part of. They also point to the connection of the political nature of an OT, as well as being *critically aware* of its implications in his/her daily practice (Kronenberg & Pollard 2005:70, 72).[8]

Ann Wilcock (2000:85) emphasises the importance of a personal, professional and educational occupational philosophy when she states:

> *We need to understand that the way in which governments and communities support or constrain engagement in occupation can lead to encouragement or restriction of individual talents, interests, well-being and health.*

[8] Kronenberg et al. (2005: 69-71) refer to the term of politics in the domain or governmental approach with a capital 'P' and politics in the sense of everyday living with a small 'p' or pADL (political Activities of Daily Living).

4.3.1.2 The supporting ideals for the steering powers

The strength of any steering power is often maintained or even 'fired' by supporting ideals such as reason, nature, progress in the form of happiness, and so on. (See Diagram 5.3). With the dawn of the era of industrialisation, as is still the case today, the steering power of capitalism is maintained by, among other things, the 'ideal of happiness'. Happiness couples with capitalism, individualism and materialism and in a consumerist society become a hypervalue for Western modernity (refer to previous remarks about the happiness ideal in Chapter 2, section 2.3.1). This of course, also continues to shape the activities that OTs choose as a therapeutic medium for their patients and clients.

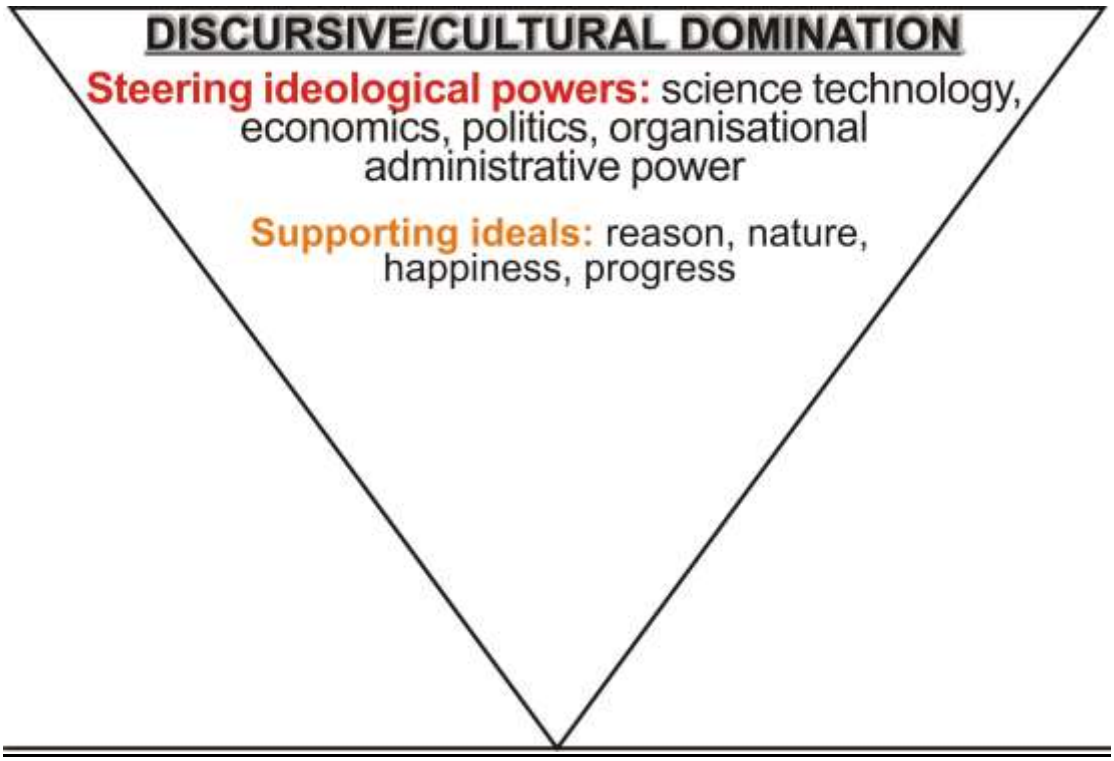

Diagram 4.3. Diagram of Discursive / Cultural Realm of Domination: Steering Powers and Supporting Ideals (Rationalisations)

The ripple effect of capitalism may be much deeper than has just been described. Ingleby (1981:42-45) supports Foucault's (1965) argument about the profound interrelations between politics, capitalism, and scientific positivism.

At the beginning of the industrial era, it was up to the medical establishment to deal with those who were unable to contribute to a prosperous, capitalist society; those who were 'malfunctioning' in the 'big machine of prosperity'. These people (patients) were cut off from society and subsequently institutionalised by means of a process of rationalisation and labelled as 'insane' or 'abnormal'. Subsequently, another process gradually occurred, that of the "psychiatrization" of society:

> *..whereby mental illness is not seen as confined to a particular segment of humanity, but as potentially occupying the segments of everybody's mind* (Ingleby 1981:44).

Pathology was rendered as inimical to the happiness/meaningfulness ideal, because, according to this ideal, meaningfulness may only be experienced by means of happiness. In the language of ideology analysis, this points to the hypernormalising of meaning, through the goal of happiness. This entire process is being sustained by positivistic research that keeps producing 'new' explanations for pathology with 'new' techniques for treatment, reducing human experience to the simplicity of the laws of natural science and redeeming patients from personal and social responsibility, as well as redeeming social institutions from their accountability.

This account offers an explanation of why the positivistic paradigm in the medical professions remains pervasive, in spite of the philosophy of science delivering overwhelming arguments and 'evidence' against its relevance, and also highlights its contribution to *creating* and *sustaining* a culture of pathology or potential pathology (Ingleby 1981:44-45).[9]

4.3.1.3 Integrating discourses

We now come to an ideological entity situated 'below' the steering powers and their supporting ideals. It is located on a separate 'layer' of ideological discourse, because it is culturally more concrete, more specific than the more generalised discourses on the 'upper' layers. This is the *achievement* ideology; the whole concept of 'success' as a hypervalue, with the subsequent philosophy that there are merely 'Winners' or 'Losers' in life.[10] This ideology acts as an integrating discourse: it integrates, even more than the previous ideologies, the members of a society on a level that cuts through the actual self-awareness of individuality.

This achievement ideology has one tentacle in the sociological area and the other in the psychological area. Sociologically speaking, it refers to the logic of capitalism in the sense of the economic system perpetuating the labour-for-money culture (in Western modernity), for one of the following reasons (or a combination of both): either for prestige and personal enrichment, or for mere economic 'survival'. It concerns the (hyper)norm of a culture that encourages families or individuals to accumulate, or at least strive to acquire, goods or services that are 'top of the range' such as luxury motor vehicles, technological gadgets, the 'best' schools etc.

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[9] In terms of ITM analysis we have here the complicated interaction between three ideological entities: capitalism, politics and the happiness ideal. The first two have been indicated in terms of the realm of discursive ideology. The ITM 'location' of the latter entity is something that I shall return to below.

[10] There are other integrative discourses such as 'selfism' but will not be explored in this study in order to remain close to the purposes of this study.

The other tentacle of this ideology reaches into the psychological areas of everyday life. We are familiar with the whole idea of having to ‘perform’ (a clear metaphor), or even to own nothing less than ‘the best’: anything less is merely ‘not good enough’ - hence not meaningful enough.

All of this leaves OT with more questions. How does the achievement ideology feature in the education of OTs for example? Do the academic institutions of OT apply the same ‘moral kindness’ toward students who experience difficulty in coping than the profession does toward clients? Or do academics merely expect them to cope with a highly demanding curriculum and if not, dismiss them with ‘Maybe you’re not cut out for this profession’?

Could this be a case where professionalism might be hypernormalised? Baptiste (2005:179) remarks that “without question the environment around us has broader and grander expectations of us as practitioners than in the past”. In a research project that was undertaken by Courtney (2005:211-216), the meaning of the concept of excellence among private practitioners was investigated. Although the findings indicated that the definition of excellence in OT practice is quite complex and the reasons for wanting to achieve this are all well motivated, it was pointed out that excellence is not the same as mere competence. Traces of the achievement ideology in defining this concept were however also evident:

- One of the research participants described professional excellence as being a “perfectionist…(who possesses) a want to be the best” (quoted in Courtney 2005:215).

- Courtney states that participants generally referred to “superior standards of ‘communication’, ‘presentation’, ’timeliness’, and ‘responsiveness’ to clients” (2005:215).

- She also notes that :

> *Achieving public recognition was seen by some participants as being significant to professional excellence, which concurs with the view of authors in the occupational therapy literature and is of relevance to OT AUSTRALIA's proposal to recognise specialists* (Courtney 2005:215).

Of course, these examples in the literature do not imply that wanting to deliver excellent services to the people we work with is ideological; indeed, OTs as with other health professions, have an ethical responsibility to do nothing less than that. The question is, however: are there *other* equally important values in the OT profession that are repressed or dominated because of the value of striving for excellence? How does that impact on OT practitioners who do not qualify as rendering 'excellent' practice, but who still deliver a competent and meaningful service to their clients?

Ultimately, the question about the achievement ideology is an important one when it comes to what the influence of this could be on the very people to whom we deliver a service, or what effect it could have on the occupations that people have. One could argue that 'underachieving' possibly has detrimental effects on the psyche of many people or that the secondary effects of wanting to achieve or live up to the achievement ideology lead to people choosing occupations and jobs that some might find are deprived of personal meaning or creativity, eventually contributing to one of the reasons they need medical treatment in the first place. Diverging to the multi-disciplinary field of being an OT, some questions may also be asked about the influence of the achievement ideology on the relationships of doctors and other health professionals.

4.3.1.4 Protective power

Descending as it were to the next level of the discursive realm of ITM, with still more concrete and individualised formations, and a level that connects with the imperative of 'recognition', is that of 'protective power' or "pastoral power" as Foucault refers to it (Dreyfus & Rabinow 1982: 213-215) (see diagram 4.4).

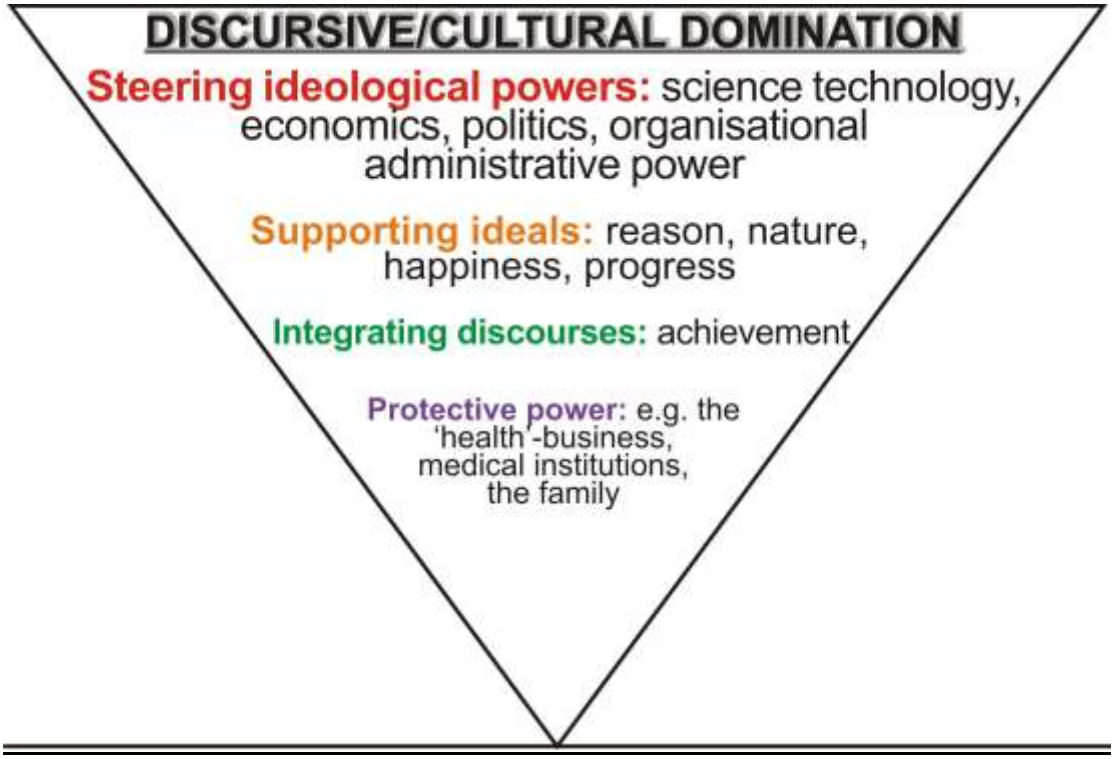

Diagram 4.4. Diagram of Discursive/Cultural Realm of Domination: Steering Powers, Supporting Ideals, Level of Protective Power.

This level refers to the need in our culture and society to experience the protection of one's existence. Again, this is normal, but the need for the protection of our bodies against disease and death, may assume hypernormative proportions. It can assume the characteristics of a cultural neurosis.

Prior to the Age of Enlightenment, when the spirit and afterlife were valued as absolute, the Church was the institution which dispensed protective power. In a secularised society however, the earlier protective power of the Church has been transferred to all those institutions that play a role in protecting people in some way or another. Thus, in this context, the protection of our *bodily* existence displaces the earlier centrality of the care for the soul. Especially in societies that are in the process of becoming secularised, people are much more concerned with the here and now and not so much with the hereafter. Health, fitness and youthful appearance all have become hypergoals in society and in the lives of individuals.[11] This is a result that the health industry wants to live up to. Fulfilling such expectations, the industry comes to dispense 'hypernormal' health, the most important commodity in life.[12] How might all of this relate to OT? Might this be one of the reasons for the problems concerning the identity of OT? That we attempt to offer answers to our clients for eternal and instant health instead of also exploring creativity and meaningfulness in everyday life experiences, including being ill or unwell? One does not have to be an adherent of some religion to take the message to heart that physical and mental health should not be idolised. Again, a critical OT may want to take note of issues such as these.

4.3.1.5 Pastoral havens

The following ideological level that I wish to explore is another level just 'below' the level of protective power. Here we reach the ultimate 'micro' dimensions of ideology, where increasing concreteness and specificity come down to the level of the individual, within her/his own unique life/context. There is still the link to the upper levels; in fact, this micro level enables the latter to penetrate to the

[11] An interesting exercise is to browse around in a bookshop at the shelves of the top 100 best sellers and at the popular magazine section. Try to establish the common themes of the titles of these books and magazines and then place it in the bigger picture of ITM. Furthermore, note how many of these books and magazines carry the theme of physical and psychological health and longevity. (This, in fact, indicates another steering power in the discursive realm that will not be addressed in this study: the power of the media.)

[12] Here we see immediately the link between economic (capitalist) and protective power.

individual's daily existence. The ideologies on this level are what ITM refers to as "pastoral havens" (Visagie 1994:87). (See Diagram 4.5.) Examples of these could be love and sexuality, art, consumerism, working for a cause, etc.

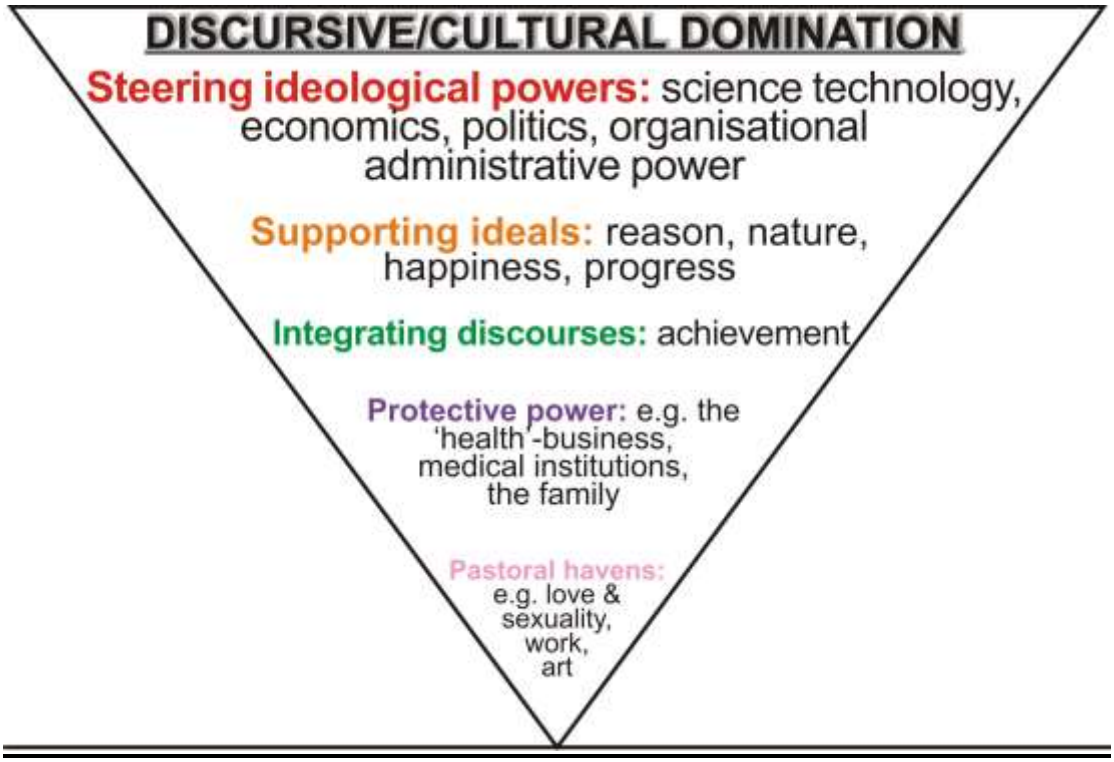

Diagram 4.5. Diagram of Discursive/Cultural Realm of Domination: Steering Powers, Supporting Ideals, Level of Protective Power and Level of Pastoral Havens.

Of interest to us is a pastoral haven that may be designated as 'work,' whatever the degree of creativity involved. It is well-known that Freud referred to the two basic imperatives of a good life as love and work. Once again, this pastoral haven as such is neither negative nor necessarily detrimental to the individual; it is about the *hypernormative function* that this pastoral haven fulfils. A well-known example would be the case of the 'workaholic' – let us call him Jack.

Jack works between 12 and 16 hours a day. He is highly successful, but has been running into increasing problems with his wife because of neglected

relationships at home. Although Jack is experiencing increasing stress, it is not due to the fact that he feels he is working too hard (in his view), but rather the effect that the extended hours at work have on his family. This could serve as an example of someone to whom an OT often cannot provide a satisfactory answer to the problem of how to achieve a well-balanced daily life. (Compare the well-known analogy of a preferred and general balance between 'energy-output' and 'energy-input' and a balanced activity profile in everyday life). Jack works as much as he can because of the energy he draws from the level of creativity that he reaches at work (Csikszentmihalyi 1993:38-42). This is an example of how *work* (a pastoral haven) that is an outlet for *creativity* in Jack's life, hypernormatively interferes with the norms of a love relationship and parental roles. In practice, this may mean that Jack begins to view his family as a 'base' where he can touch down for rest and refreshment before launching out, every morning, on his 'real' and all-important 'journey'. While a continuously increasing number of people worldwide, including in South Africa, seek to be rendered disabled to continue with their own occupation (Ellen 2002:1; SASOP 2006:2), loss of work for Jack will have extremely destructive effects on his existence (or doing, being and becoming (Wilcock 1999:1-11)). This dynamic may be related to any pastoral haven.

But in the above example, the work at issue was indeed *creative* work. We know in our society that this is by far not the norm but the exception, as most people in the South African context work to survive (Fourie, Galvaan & Beeton 2004:69-84; Watson & Fourie 2004:33-50; Wezempilo 2005:1). The issues here, in my opinion, are whether OT should distinguish between work and, if it is up to OT, to help patients in identifying and practising *creative* outlets when they feel dehumanised in their jobs because of the lack of meaningfulness or praxis they experience in this sphere of their daily life.[13]

[13] While Wilcock (2001:12) refers to 'praxis' as *effective* activity, Ingleby (1995:43) refers to it as *meaningful* activity.

4.3.1.6 The spheres of the Discursive Realm

Where the different levels of ideologies in ITM may be differentiated on a transverse level as has been illustrated above, delineation may also be made on the longitudinal dimension: what may be referred to as the 'spheres' of the discursive realm (see Diagram 4.6.).

The first sphere has to do with those ideologies that occur in the socio-cultural realm and it is the latter that has been at issue up to this point. The second sphere, that will shortly receive attention, is what ITM refers to as "highly theoretical paradigms" (Visagie 1994:88).[14] Examples that reside in this sphere include the whole field of philosophical ideologies such as existentialism, neo-Marxism, structuralism, post-modernism, and so on. Here we find a philosophy that is very relevant to the profession of OT: positivism.

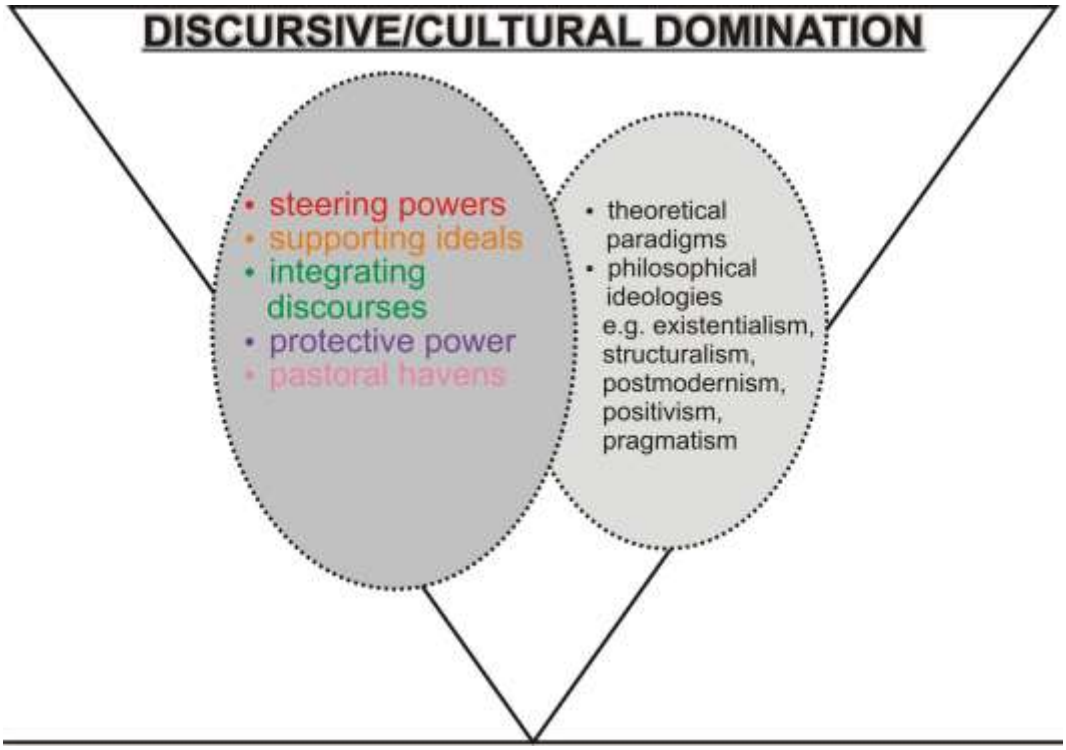

Diagram 4.6. Model of Ideology Theory: Spheres of Discursive Realm

[14] The third sphere pertains to the ideology in art and aesthetics and will not be explored in this study.

Positivism is still often seen in science as the only gateway to the truth. The 'golden key' that positivism offers is that sound knowledge is something that can be proved by observation through the senses and which is therefore seen as being 'objective'. Positivism initially developed in the middle of the 19th century and became established in the earlier decades of the 20th century as "logical positivism" (or "logical empiricism"). It strove to increase the validity of the 'scientific' approach and to unify all such 'sciences' with physics, which is regarded as the heart of science (Delius, Gatzemeier, Sertcan & Wünscher 2000:103-107). The downside of this approach turned out to be that often *all* aspects of being human were reduced to the standards of the laws of natural science (Honderich 1995:705-706). This reductionism amounted to a denial of the normative features of being human. Natural 'laws' differ from socio-cultural 'norms' in that the former have an automatic validity.

This process of 'standardisation' as we know it, often involves the fixation on and obsession with, what is called empirical foundations: absolutely neutral observations and verification 'standards' which themselves cannot be empirically verified (Ingleby 1981:28-34, 40-42). This model is often associated with the ideal authority of the natural sciences; sometimes it is claimed that other disciplines in fact have to imitate the natural sciences if they wish to be respected and regarded as in any way 'scientific'. Apart from the fact that the post-positivistic philosophy of science has shown that the ideals of positivism in terms of the natural sciences themselves were misguided, these ideals have had, and still have, a devastatingly hypernormative effect on our views of culture, society, and humanity that cannot be ignored (Kuhn 1970; Popper 1965).

What I will call administrative 'positivism' has to be distinguished from the original philosophical paradigm, although there are definitely certain analogies between the two. An obsession with data, tables and graphs, quantification, etc. is more often than not the case. The similarity here between this kind of managerial

positivism that is, for example, rampant in higher education circles and the ideology of the administrative power referred to above should be noted.

Without a doubt though, positivism has heavily influenced medical training and practice and, as has been illustrated throughout the history of OT, also played a major role (via the medical model) in the establishment, development and probably the very survival of the OT profession.

In the circles of the philosophy of science, this approach has been discarded for some time now (increasingly since the late 1950s), mainly because of the indefensible assumptions of objectivity, the naïve interpretations of the history of science and reductionistic approaches (Ingleby 1981:23-71; Hacking (ed.) 1981; Kuhn 1970; Popper 1965). In fact, the positivistic approach has also been discredited in its previous irrefutable reputation by many contemporary discoveries and developments at the very heart of science; i.e. physics. As has already been noted, the foundation of positivism, has been shown to be wrong. Popper (1965) demonstrated how theory in fact *precedes* observation (not the other way around), and how verification itself is *never* conclusive. Kuhn (1970) showed how paradigms determine 'facts'. Lakatos (1965) showed how one may judge only a whole research *programme* (not single experiments), and then only in terms of its general fruitfulness. Chomskyan linguistics (Chomsky 2002) is an example of Lakatosian heuristics (the art of finding data, a theory), where research programmes are *not* rejected in the face of seemingly irrefutable counter-evidence.

Unfortunately, the 'death of positivism' has not yet been felt in many university departments either (Blair & Robinson 2005:272; Visagie 1980:31-38; Popper 1972: 321-322). One of the reasons may lie in the very intertwinement, interdependency and filtering effects that positivism, capitalism and administrative bureaucracy have on one another (Ingleby 1981:42-45). Blair and

Robertson (2005:270) argue that the epistemological problems that positivist approaches in the OT profession create are that:

> *[t]he pursuit of 'objective evidence' raises epistemological concerns for professional groups who work in situations of complexity and discontinuity, such as chronic enduring health, deteriorating conditions or multi-causal situations where humanistic values underpin practice. Equally, it perpetuates a dominant discourse concerning methods of inquiry and the nature of knowledge, which serves to separate rather than unite theory and practice.*

Cusick (2001:102, 110) points to the threat to "occupational therapy concepts and processes if deterministic elements of evidence-based practice predominate", as well as the risk of "losing our professional soul".

Sometimes positivism is fought from other philosophical vantage points such as neo-Marxism or (currently in vogue), postmodernism. Nevertheless, in terms of ITM, both these philosophies will also 'register' in the 'second sphere' of ideologies. This is because both, whatever insights they may have provided, in fact, take their points of departure in 'key-formulas' that are the equivalent in theory of what hypernormative constructions are in socio-culture. For example, both Adorno (neo-Marxist) and Derrida (father of deconstructionism), espouse an anti-rational emphasis on individuality and contingency (Visagie 2005). This is the very opposite of positivism, but simply goes to the other extreme. All of this is important when discoursing about the philosophical foundations of OT.[15]

[15] Ingleby (1981), from whose work I have quoted, has drawn much of his inspiration from these anti-philosophies, and therefore his critical work should be read with a critical eye.

To conclude this particular section of the study, mention should also be made of pragmatism. This is a philosophical worldview that also has links to the 'natural attitude'. Its appeals lies exactly in its seeming 'naturalness' and 'practicalness'. (The name 'pragmatic' derives from the Greek word for 'action'). As a philosophy, pragmatism is once more enjoying a prominence that it experienced at the end of the 19th and the beginning of the 20th century, as invented by Charles Sanders Peirce, and subsequently altered by William James as well as by James Dewey (Honderich 1995: 710-712; Magee 1998: 186-191). Currently, it has been revived in the writings of the neo-pragmatist philosopher, Richard Rorty (e.g. 1989).

Pragmatism basically sets out to cut through *theory* that is not linked to some kind of demonstrable *usefulness*. This is the 'golden key' that it presents to its adherents to unlock 'ultimate reality'. Again, these key constructions operate in philosophy just like hypernormative constructions in the socio-cultural sphere. The problem here is that a fixation on practicality, usefulness, concreteness, the 'cash value' of ideas, etc. acts as a criterion of what is regarded as *worthwhile*. However, even in a love relationship for instance, or in religion or art (occupations (in the 'occupational therapy' sense of the word) of utmost importance for humans), we know that need and desire and truth and meaning, are not covered by the notion of 'usefulness'.

Returning to the theme of the OT profession, Ikiugu and Schultz (2006:86-97) argue for pragmatism as a foundational philosophy for OT. They (uncritically) explain pragmatism as serving a foundational point of departure for OT by studying 'action' and 'experience'.[16]

[16] A very basic objection to their espousal of pragmatism as a base for OT, would be that their proposal does not seem to entail any kind of socio-cultural criticism. In this sense, their pragmatic approach and an ideological-critical approach seem to be poles apart. (I am not claiming that pragmatism, as such must necessarily be socio-culturally adaptive to the ideological world. Rorty's type of neo-pragmatism *wants* to be critical, but still *without* theory (e.g. Rorty 1982)).

However, from a philosophy of science point of view, 'action' and 'experience' *per se* cannot be studied on their own, nor can they ever be. That means one cannot have a discipline for example that only studies 'action' or 'experience' as these concepts are related to the different perspectives of different *aspectual* approaches. Many disciplines, in fact, study human 'action' and 'experience'. In order to study these concepts, they should be linked with different aspects of reality.[17] For example, the discipline of psychology studies 'action' and 'experience' from the point of view of the psychological aspect, economists from an economic aspect, sociologists from a social aspect, the medical profession (mainly) from a biotic aspect, and so on. In order for the OT profession to remain true to a(n) (applied) science, it has to be clear in its understanding from which *aspect/s*, it studies 'action' and 'experience'. If one returns to another central concept of OT, namely, 'occupation', the same logic may apply that has just been argued in terms of the concepts of 'action' and 'experience'. However, if we consider the peripheral values surrounding occupation, namely the notions such as 'purpose', but also 'meaning' (among others) (Trombly 1995:960-972), one might consider the aspect of *creativity* as being a possible aspectual point of departure for the OT profession.

On the positive side, Ikiugu and Schultz's (2006:86-97) project is commendable for facilitating and perpetuating the debate on investigating "tools" and a "philosophical framework" for the OT profession and its "identity problems". (I return to some of these issues in the final chapter of this study). [18]

[17] For a short and uncomplicated explanation of Dooyeweerd's analysis of the fifteen aspects of reality one can refer to L. Kalsbeek (1975). These aspects in order are: number, space, kinematic, physical, biotic, psychic (psychological), logical, historical/formative, lingual, social, economic, aesthetical, juridical, ethical and belief/spiritual. Dooyeweerd's aspect theory will receive further attention in the Epilogue.

[18] Although Ikiugu and Schultz's (2006) reference to a certain action and experience, as being key notions of pragmatism, makes sense if one understands that this philosophy basically wants to move *away* from theory 'for itself' to *practice*. From this point of view 'usefulness', 'action', and 'experience' all fit together. But all of this comes at the cost of theoretical depth and even theory itself.

4.3.2 The Realm of Social Domination

Let us now move to the 'lower' realm of the ITM: that of ideological social domination. (see Diagram 4.7.)

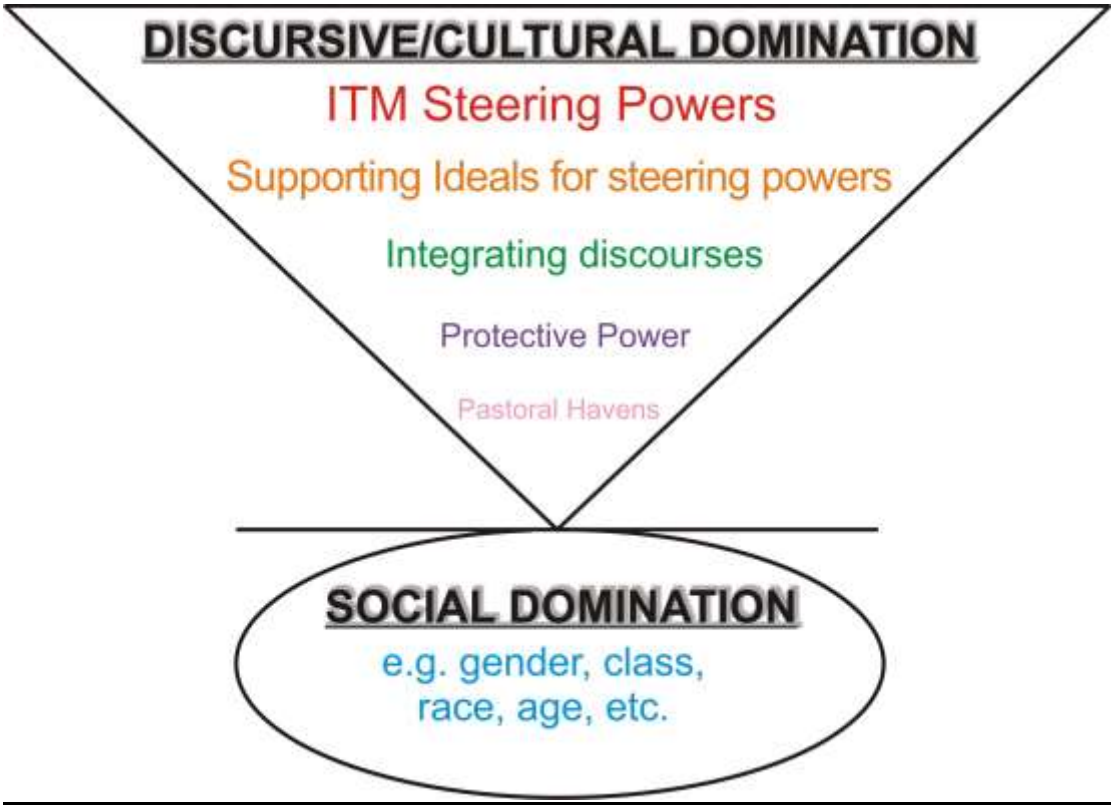

Diagram 4.7. Model of Ideology Theory: Realm of Social Domination

The realm of social domination not only concerns itself with dominations that occur on the levels of roles or class (the famous and sole-denominator of Marx), but also of race, gender, age, etc. When these natural differentiations take on hypernormative values, they evolve into ideologies that may be analysed in the discursive realm of ITM. Contrarily in the social realm we look at the actual socio-historical relations of domination between different groups, and also at the kind of discourse that *facilitates* this domination. All such relations of domination come into conflict with the central norm that is each time, collectively disobeyed: that of

mutual recognition. In contemporary times, what we find is that social groups do not want mere removal of discriminatory barriers; they want *active recognition* for their contributions (Taylor 1992:25-73).

In the history (as well as the current stance) of the development of OT, we have seen various forms of these types of domination in the social realm. An example of this is the role of capitalism during the period of industrialisation when the hypernorms of prestige and income allowed discrimination against a part of the population (class) who was poor and not entitled to better health and meaningful employment and was in fact, forced into punitive labour through workhouses for not 'contributing' to a growing economy (Foucault 1965:51; Wilcock 2001:227-335).[19]

Another example is the strong and continuous dynamics of patriarchy and paternalism from those in the medical profession toward 'para-medical' professions of which the latter mainly (at least in the Western world) consist of females. The fact that OT has been viewed as subordinated and subservient to the medical profession, combined with values in the social realm, might in fact, contribute to the unremitting issues around OT circumscribing and defending its identity (Capra 1983:121-122; Blair & Robinson 2005:272; Wilcock 2002:67-68, 91, 143-144, 234, 286, 289-290, 403-404; Christiansen 1999:547-558, Joubert 2003:3). Aside from patriarchal domination, it should be noted that elitism *as such,* is a way in which one group may withold recognition from another, even if there is no immediate domination visible**.**

The role that age plays in the Western world in general, and the way that this logic dictates that skilled and experienced OTs in the academic and practical fields retire according to the pension policies of their employers, should also be

[19] There are various connections between these forms of dominations and the dominating hypernorms of the discursive realm, as has been referred to above. Here we see the link between economic hypernorms and class domination. But these connections will henceforth not be the focus of a separate analysis, as this will take us too far from the particular purposes of the study.

taken into account for its detrimental effects on the profession. On the other hand, younger colleagues in similar institutions could automatically be viewed as being less valuable in their opinions and ideas, due to assumptions of ‘lack of experience’.

In a country such as South Africa, even with a young democracy, issues such as the language in which tertiary education is conducted, and prevailing ideas about the manner and content of the curriculum presented in certain disciplines, are also of importance to OT. In such matters, we are confronted by a denominator of domination that has not yet been listed, and that is *culture*.

Finally, it is important to note that no attempt has been made here to give an exhaustive list of the denominators of social domination. This is an open issue, and a critical awareness within the OT profession might, in future, very well add new denominators that have escaped previous analyses.

4.4 Conclusion

Critical thinking and reasoning are often mentioned as one of the essential traits of being a competent OT (Professional Board for Occupational Therapy, Medical Orthotics/Prosthetics & Art Therapy 2006: 5; AOTA 2005:661). The question is, however, what unified and self-consistent theoretical *tool* do we, as OTs, use to think and reason critically about the impact of the environment as a whole, on the people with whom we work? Especially considering that we inevitably also form part of that environment. It seems that OT has one of two choices (as has been mentioned before): we can either be critical of these contexts and ourselves within them, or we can remain the unwitting slaves of the forces and powers in our surroundings and within ourselves.

CHAPTER 5
Occupational Therapy and Ideology Theory: The Practical Issues

5.1 Introduction

In the previous chapter, some light was shed on the deep and complex systematic work of ideology theory (Ideological Typography of Modernity), regarding the environment in its broadest sense and the OT profession specifically. In view of extending the continuity of this study, the current chapter will entail an attempt to illustrate the dynamics of ideology as manifested in the practical, everyday experiences of working OTs.

In terms of the methodological aspect of my analysis, I should point out that the interviews that follow stand in the same relation to the formal-structural analysis of the previous chapter; for example, the interviews that Janice Radway (Thompson 1990: 307-313) conducted to supplement her formal-structural analysis of narrative patterns that govern a certain type of love story. In other words, Radway wants to corroborate, in a specific socio-historical environment, her formal analysis of the ideology inherent in romance novels. In this way then, socio-historical analysis is the complement to formal-structural analysis and both form part of a more general 'hermeneutic' methodology for ideology analysis.[1]

For the socio-historical aspect of the present study, four OTs were selected to be interviewed individually. The participants were chosen based on their expertise in four areas of the OT profession:

[1] For a discussion of Radway's work, as well as the 'hermeneutic' methodology in general, see John B. Thompson's (1990: 307-313) *Ideology and Modern Culture.*

- Academia
- Government service management
- Medico-legal
- Private practice

These categories were selected because of the variety of OT roles that they require in practice and because of the widely different forms of expertise that are needed in each of these fields within different environmental contexts.[2]

Twelve questions were formulated to be addressed to the participants. Except for the questions on the short background of each participant, the indicators for these questions were found in the theory and systematic aspects of ITM, as well as the results of the ideology analysis of the OT profession's history (Chapters 3 & 4). Permission for participation was obtained from each interviewee after they were informed about the purpose of the semi-structured interview, namely, to investigate the ideologies that OTs generally have to deal with in their everyday lives (see Appendix A). Since the researcher had to question experts in the profession, it was also seen as being appropriate to provide other explanatory background, namely, the title of the study, as well as a short orientation regarding the content, in order to obtain *informed* consent for the interviews (Appendix A). However, the ideologies that have been identified as a result of the prior analyses, were not discussed with the interviewees, so as to encourage authenticity and a less guarded honesty. The candidates were assured that participation was voluntary and that each person was free to refuse to answer

[2] Although the *purpose* of these interviews within the context of the methodology of this study is shortly clearly explained (p. 128) the researcher is fully aware that another selection of participants according to different fields of speciality, age, cultural groups, race, and so forth, may very well result in the interpretation of other and/or more ideologies. However, another selection of participants will not deduct from the purpose of this chapter, namely to *illustrate how* (and not '*corroborate if*') ideologies are experienced in the daily lives of practising OTs.

any of the questions. Two of the interviews were conducted in person and the other two telephonically, because of geographic considerations. The researcher wrote the replies and comments down as given by each participant, and returned the transcriptions of the interviews to each participant for member checking.

The following questions were asked:

1. Please state your current OT job and give a short description of your experience of the history of the OT profession.
2. Describe your working environment and the circumstances in which you are working currently.
3. How did you come to study OT?
4. How did you experience your education and training as an OT?
5. How do you view the relationship between OT practice and education?
6. Describe how you see/experience the OT profession in relation to the:
    a) medical profession
    b) colleagues in other disciplines in the Health Care field
    c) corporate field
    d) public
7. What, in your view, is upheld as the major values/ethos in OT education and training?
8. How do you view OT's role, (within the context that you are working in), concerning the following concepts:
    a) bio-medical model
    b) science
    c) political arena
    d) administrative bureaucracy
    e) research
9. How would you describe the development of the OT profession since you have qualified as a member?
10. How do the following determinants, (in your view), impact on the OT profession (examples are welcome):
    a) age
    b) gender

c) class

d) race

11. If you could wave a magic wand, what would you change about the OT profession?

12. In your view, what role does creativity play in you daily practice and decision-making as an OT? [3]

5.2 Nature and Purpose of Chapter 5

Although the approach of this chapter does have an 'empirical' angle, it has to be emphasised however that its methodology remains *primary reflective, and an extension of the main methodology of this study, namely, that of a philosophical analysis of OT by means of ideology critique*. This implies that where such a(n) (empirical) chapter might have otherwise constituted the core part of an empirical *type* of study (within a traditional, positivist theoretical framework), the purpose and relevance of the current chapter - with reference to the context of this type of non-empirical study – is merely *supportive* of and secondary to the (already executed/completed) primary and core part of the present study.[4] Additionally, the core part of this study obviously entails the ideological analysis of the historical profile of the OT profession (Chapters 2 & 3) and a formal-structural analysis of the ideological issues of the OT profession as a whole (Chapter 4).

Furthermore, the purpose of these interviews is not to corroborate *if* ideologies are experienced by OTs in the field or *how many* OTs experience ideologies in their everyday life. That would reflect a positivist, quantitative approach and would not be appropriate to the nature of this study. Even if *one* OT experiences ideology in his/her everyday life, it remains a 'truth' and should therefore be considered worthwhile mentioning or investigating. Besides, ITM as a theory, has

[3] The final question about creativity was asked in view of the researcher's argument about seeking a central aspect of reality through which OT as a discipline can focus its core assumptions and pragmatic identity about occupation.

[4] Here, I refer back to Chapter 1 on the "methodological reasoning" of the study (Henning 2004: ix).

already demonstrated the pervasiveness of ideology and the fact that no person is actually able to escape its influence completely. However, the purpose of these interviews may be depicted as illustrating *how* these individuals experience ideology as practising professionals.

In executing an analysis in ideology critique, it is important to keep in mind that such analyses are not without complexity. This should be compared with the analogy of ITM as a map of ideologies. The connections and routes between each of the ideologies are many and complex. Some connections are obvious, others less so, but ultimately, all of the destinations (ideologies) are interrelated in some way.

Since the purpose of this chapter is to illustrate how ideologies impact on the lives of OT practitioners, the *main* ideologies within each of the participant's individual context will be presented first.[5] The transcriptions of the interviews in their totality are too lengthy to feature as part of this chapter, therefore it was decided to use appropriate excerpts from each interview that point to the presence of ideology. Nevertheless, it is important here that the reader realises that these excerpts are representative only of the ideological indicators and that the complete transcriptions should be consulted for the full context of the questions and the replies to them. (The complete transcriptions of each person's interview are attached in Appendix B). The second part of the chapter entails the most common ideologies that all or most of the participants experience in a similar fashion.

[5] Although several ideologies were identified from the interviews, only the main and most prominent ones were selected as excerpts in this chapter for the purpose of clear illustration.

5.3 Specific Ideology Concerns for (some) OT Practitioners

Allow me then to introduce Clare, Lerato, Monica and Jane:[6]

5.3.1 Clare – the Academic

Clare is a senior lecturer and, among other things, also the head of the school, which include the OT department at a university in South Africa. Much of her job description entails management tasks on a faculty level, although she still has a 'hands-on' involvement with the training and education of OT students. She is also engaged in the OT profession on a national and international level and has been practising OT for approximately 40 years. Clare is markedly passionate about the profession and feels strongly that all OTs have to be good role models and advocates for the profession.

In her working environment one of the main issues that Clare has to deal with is tension between racial groups; that is, tension between students and lecturers and between lecturers of different races. Since Clare also has many managerial responsibilities, and is considered as being part of a minority racial group, she obviously has to deal with interpersonal emotions such as decreasing morale. Note the following excerpts:

[6] All names have been changed to pseudonyms and also details about working places have been generalised in order to protect the privacy of the participants.

Excerpt A

"Describe your working environment and the circumstances in which you are working currently".

Students have a culture of 'rights', one of 'entitlement' and lecturers are sometimes put in a position where their integrity and credibility are doubted. That is limiting; it leads to having to have lots of structures in place; the staff needs to think about what they say and what they do. That causes low morale.

(Appendix B: p 174)

Excerpt B

"How do the following determinants (in your view) impact on the OT profession (examples are welcome):

- race"

At our university this is unfortunately a big issue. There are very rarely jobs for white people, regardless of experience and expertise. Often black employees receive special advantages such as time off to complete postgraduate studies, and we are told that new HODs need to be African. These are dilemmas - one understands that the mistakes of the past need to be corrected, but at this time, these are being experienced as difficult issues and are demoralising to professionals across many professional groups.

(Appendix B: p 182)

In terms of ideology analysis, this appears to be an example of the hypernormative functions of political power; one of the so-called 'steering powers' (see Chapter 4; p 100-105). Clare's circumstances seem like a case of political agendas overriding other norms, such as mutual trust between the lecturers and

students, basic respect for the discipline and being able to handle everyday problems without reducing them to 'racial' issues (Excerpt A). Here we see how an ideology is politicising the teacher-student relations; where a pure academic norm of the latter's relations are displaced or distorted by politicism. Note how this ideology becomes intertwined with another 'steering power': that of administrational organisation: "having to have lots of structures in place" (Appendix B: p 174).

Although the question asked in Excerpt B was related to the realm of social domination, this could be a good example of the political agenda of affirmative action filtering through into the lives of individuals working at an educational institution, hypernormalising career possibilities in academia. Here, this political aim is hypernormalising other goals of a university, such as competency, and a community service such as excellence in education, equal opportunities for staff members to perform research, as well as a positive working environment. This is an instance where the ideology of politicism is sometimes *needed* to try to undo the damage wreaked by *another* ideology: that of apartheid. Nevertheless, any kind of hypernormalising is always fraught with socio-cultural risks and dangers.

Without knowing, Clare delivered the following significant ideology critique with reference to a needed political corrective to the past ideologies:

Excerpt C

"How do you view OT's role (within the context that you are working in), concerning the following concepts:
- political arena".
Previously, during the Apartheid regime, OTs viewed themselves as apolitical, although in retrospect, we addressed issues of inequitable health by means of writing letters et cetera. We are [currently] more politically aware, and we should be - of legislation;

for example, we are legally bound to be more aware of human rights et cetera. We need to take a stand on issues of importance e.g. disability rights, HIV, poverty relief, et cetera. OTASA should be more vocal about these issues.
(Appendix B: p 179)

Turning now to the administration-organisational ideology as separate from politicism, it is clear that Clare views administrative bureaucracy as very problematic for OT:

Excerpt D

"How do you view OT's role, (within the context that you are working in), concerning the following concepts:
- administrative bureaucracy".
In my view, it is a source of burn-out for the profession; factors that lead to disillusionment of many young therapists. For example, a newly qualified therapist working alone in a psychiatric institution with 500 patients, finds it difficult to cope. Often the administrative obligations overshadow the clinical role and patient care – that leads to young OTs getting burnt-out, and us losing them to the profession. OTs often do the mundane administration and attend meetings while support staff deal with the patients.
(Appendix B: pp 179-180)

Excerpt E

"What about other professions using activity?"
We bemoan other disciplines venturing into vocational rehabilitation for instance, but how could we protest if we are not doing what needs to be done in this field? We sit in offices and do endless paper and pencil activities.
(Appendix B: p 225)

In both excerpts, Clare identifies, (without knowing ideology theory), how the ideology of administrative organisation supersedes occupational therapy goals of patient care and treatment, as well as the creative aspect of doing work. She also points out how managerial agendas, e.g. meetings, lead to OTs not having time for hands-on professional treatment and care of their patients or (as seen in Excerpt E), not being able advocates for the profession by *doing* OT creatively. We see how doing OT becomes subservient to administration, instead of the other way around.

This problem, as was mentioned previously, was raised in 1957 by a British OT, Margaret Barr Fulton, when she pointed out how administrative responsibilities took priority over patient contact and care (Wilcock 2002:112,113).

Having isolated examples of 'discursive' ideology, I now turn to the ideology sphere of relations of dominations (see Chapter 4; Diagram 4.5). Having a keen awareness and a very good knowledge of professional ethics, Clare indicates how the class and race related issues of poverty, (linked to the economic ideology), bring about ethical dilemmas and at times, seem to take priority over basic care and human rights:

Excerpt F

"How, if at all, has the following concepts changed in OT?
- economic considerations".

Poverty has always been an issue that we had to deal with when treating patients, (even if, in my view, patients are poorer now). An ethical consideration is that how a lack of such resources and basic needs impact on treatment of patients, in the sense of jeopardising care and treatment. This leads to ethical stress for a therapist. Aids/HIV also brings about serious ethical considerations in terms of patients who are terminal. Where beneficence and non-malevolence were previously primary ethical considerations, ethics in South Africa has developed to the point where autonomy and justice are the primary imperatives.

But OTs have the ability to cope with these changes and developments, because we always seem to make a plan – that is another place where our creativity comes in.

(Appendix B: pp 222-223)

It is important to note here that the factor of poverty may interfere with the *norma*l practise of OT, much as an ideological hypernorm also interferes with such practise. It should also be realised that the goal of social justice, meant to remedy social pathologies, may itself then attempt to hypernormalise OT practice. It is into these ideology-critical terms that Clare's intuitive perceptions may be translated, again illustrating the link between the 'theory' and the 'reality' of ideology critique.

5.3.2 Lerato – the Manager

Lerato qualified 9 years ago. After working at a government school for disabled children for 3 years, she was appointed to a management position, as an OT in the government health sector. She describes her job as being in "middle management" and co-ordinating the public (OT) health services of a province. Her roles involve supporting upper management, monitoring service delivery, the training and development of OTs and technical assistants and seeing that policies are in place and being implemented (Appendix B: p 185). Lerato is generally perceived as being an optimistic, outgoing, well-spoken woman. Her mother tongue is an ethnic language and she also speaks English and Afrikaans.

Lerato's appointment in her position, as she herself acknowledges, was partially one of affirmative action and she felt acutely that she had to prove herself and her abilities (Appendix B: p 193).

Besides the fact that Lerato still encounters gender domination in her working environment, she also experiences the bio-medical model being prominent in Health Care with OT being subservient to it; this, in spite of the OT profession's moving away from this model when it made a second paradigm shift in the 1980s (Duncan 2005:30).

Excerpt G

"Describe your working environment and the circumstances in which you are working, currently".
Challenging, very male orientated; doctors are in the forefront, OT is associated with infant services and neglected in terms of budgets and cost centres.
(Appendix B: p 185)

Excerpt H

"How do you view OT's role (within the context you are working in), concerning the following concepts:
- bio-medical model".
In general, concerning health in the government, this is still the central model. We [OTs] do use it to make diagnoses and so on, but in general, health begins with this model – even though we are veering into community health.
(Appendix B: p 191)

Note in Excerpt G how a certain relation of domination between two professional groups – doctors and OTs – seems to be implied here (with reference to the lower sphere of ITM; see Diagram 4.7 and Chapter 4; p 121) Related to this form of group domination, is that of patriarchy: the 'maleness' in 'medicalism' (Capra 1983:121-122). This type of domination has been identified continuously in the ideology analysis of the history of the OT profession and appears to be an extension of the imbalance of mutual recognition as discussed in the previous chapter. Concerning Excerpt H, it could be said that Lerato's experience resonates with Kronenberg's argument about a "prevailing bio-medical model" (Kronenberg, Simó Algado & Pollard 2005: xi) in spite of the OT profession's paradigm shift in the 1980s back to the focus of occupation over a reductionist focus (Duncan 2006: 30).

Focusing now (the following two excerpts) on achievement ideology (Chapter 4; p 109), Lerato indicates the darker side during her training as an OT. It seems that her comments again give us reason to make a distinction between ideology, and the normal expectation of recognition and just reward. She related both these

metaphors to her experience during her training as an OT, as well as something that perpetuates in her current career life.

Excerpt I

"How did you experience your education and training as an OT?"

Hard, cumbersome, very loaded, [although I did receive] a lot of support from the OT staff and personnel. There was little time for yourself and the work never seemed to end. I never understood why we had to write those very long reports, then presenting a patient in 15 minutes - the result did not seem to even out the effort, you know. Later I realised the value of those reports; one is able to screen a patient rather quickly now. There was also not a lot of interaction with the classmates; there was no time, except when doing research. But I hear students have more group exercises now. During my student years, I really experienced the monster side of OT, the competitive side, no fun - it was expected that you cope.

Also the selection criteria of becoming an OT are so high, so much effort, one would expect a reward, just to realise that your pay cheque equals that of a clerk in government – nobody knows what an OT does.

(Appendix B: pp 186-187, 188)

Excerpt J

"If you could wave a magic wand, what would you want to change in the OT profession?"
I would like to get rid of the OT education-monster and change the work load, for example. Not doing that much less but just getting rid of a more do-able workload; get rid of the idea of no hope, no life for the years of your study and then of course the imbalances between effort and recognition and getting paid for what we do.
(Appendix B: p 196)

There are certainly many professions that could probably argue that their level of skill does not equal their remuneration. If one looks at the history of OT both in Britain and South Africa, this is an issue that has been raised formally many times.

5.3.3 Monica – the Medico-legal Specialist

Monica has been an OT since 1990, and she has many years of experience in private practice, specifically in medico-legal and vocational disability assessments. She established her own private practice in a hospital some years after she had worked at a government hospital in vocational rehabilitation and at a private paediatric practice. When Monica subsequently co-owned the former private practice, she also lectured at a university part-time. She and her husband decided to relocate, and she then worked for a private international company, performing vocational disability assessments and managing the aspect of work rehabilitation. During this time, Monica also lectured part-time for a period at the local university. Since 2006, she started again her own OT practice that

specifically specialises in medico-legal pracice. Monica has a calm demeanour and in view of her field of speciality, she has an astute disposition for critical thinking.

Monica strongly recognises that ample room exists for development in the OT profession, including in those areas that are close to her speciality. Her predicament however, is one of economic considerations and managing her business in such a way that is ethical but also generates an income. This, for her personally, points to the need for the further development of vocational rehabilitation in OT (for example), as well as conducting research to ensure the survival of the profession in a market-orientated, capitalist environment. She also recognises a pragmatic approach in her day-to-day working life: “I cannot always tell why something works – I just know it does” (Appendix B; p 200).

Excerpt K

“Describe how you see/experience the OT profession in relation to the

- colleagues in other disciplines of health care”.

We have to be sensitive to each other’s disciplines and what everyone does. I have become aware that there are other disciplines that do vocational rehab but does not know what OT does [that we very much also keep ourselves busy with this]. Concepts such as ‘job-coaching’ (also something that OT does), sound very nice to the public and then they grab hold of it – we have to educate people, and find out how other persons do the things they say they do; that way we can feel less threatened – we need to ask what their approaches are. We are so few [OTs], one gets tired to fight for the profession; often one just has to survive from day to day.

(Appendix B: pp 200-201)

"How do you view OT's role (within the context that you are working in), concerning the following concepts:
"- political arena".
It is about survival for OT in the political field. We have to re-position ourselves as such – advocate for OT, stand up for what we believe in and unite. Personally, I do not always have the strength for a "revolution". There, I have a lot of respect for our colleagues in the government services who have the political contacts.
(Appendix B: pp 204-205)

Excerpt L

"How do you view OT's role (within the context that you are working in), concerning the following concepts:
- science".
Being scientific is our future and our survival – we have to be founded in science in order to be paid and to continue as a profession.

"- research".
I think every OT has to take responsibility for research; maybe the implementation of CPD will help with that. The problem is for many there are not incentives to do research – it has no purpose for e.g. to have an extra qualification. Maybe incentives such as discount for registration fees or something like that might help!
(Appendix B: pp 204, 205)

Here we see an interesting interplay between economism and ‘survival’, a metaphor that Monica often uses. At times, difficult situations lead to the hypernormative application of ‘economic survival’. This goal becomes ideological when one (often without knowing), *has* to perform ab*norm*al tasks for the sake of ‘survival’. Unfortunately, one does not realise that these sacrifices are indeed tragic, because they cannot be justified *in principle*.

Concerning Monica’s thoughts about economic power (Chapter 4; p 108) it seems that Monica is working hard for economic survival and might be relating that metaphor to the OT profession as such. It also seems that a particular ‘economism’ might be playing a role in Monica’s life, but that she is also experiencing cognitive dissonance with this norm and other values and goals in her thinking. Note how she refers to OT having to ‘survive’ in the political field, but also adds that OTs need to stand up for what they believe in (Excerpt K). Yet she also mentions that OT has to be scientific to be *paid*; yet there are not enough reasons for OT practitioners to initiate their own research (Excerpt L). The manifestation of the economic hypernorm might offer an explanation for the lack of research that has often featured as one of the main problems in the history of the OT profession (see Chapters 2 & 3).

5.3.4 Jane – the Life-skills Specialist

Jane has been an OT for twenty-five years, and has been working in private practice for all of her career life. As a newly qualified OT in 1981, she was recruited by a senior OT who started one of the first paediatric private practices in South Africa. Jane gained 14 years of experience in this field before relocating. In 1997 she started working for a private practice again, in the field of short-term psychiatric rehabilitation. She became a partner and currently owns a successful practice that specialises in this field, situated in a larger facility in a town. She

describes her job satisfaction as “optimal” since the patients she works with usually improve within a few weeks (Appendix B: p 209). Jane appreciates that the setting she works in allows for the recognition of the OT profession, as OT administers the standard programme and is a central part of the facility and services provided to patients (Appendix B: p 209).

For Jane though, the biggest daily struggle in her working life is an unhealthy competition between two OT practices at the facility. (This is a result of two previous major units of psychiatric services in her town deciding to consolidate their services at one facility). This creates tension for her, as OTs working in this kind of context are also under great pressure to maintain good relationships with all involved psychiatrists, psychologists and other team members. In this setting, OT is also dependent on the referrals that they receive from the psychiatrists.

Excerpt M

“If you could wave a magic wand, what would you want to change about OT?”

I wish so that competition was not a factor. It is hard for us to realise that our job is also a business. I find myself not wanting to talk about the business part of my job. But the issues are palpable; it is present all the time and you have to unexpectedly deal with it there and then. For example, a psychologist deciding that I, as an OT, could mean more to his patients than the competition. One could see how parties are canvassing for referrals or, as in the case of my opposition, seeing one day how the patients of a psychologist who usually referred his patients to her, suddenly come to see me. She [the other OT from the opposition practice] would then come to me saying :”I heard that Luke decided to refer his patients to you because he feels that you will be better for them than I”. This is difficult. Often, we also have to handle the (political)

decisions that doctors make; we have to know how each doctor prefers doing things. Some doctors like to have feedback, others do not. There are a lot of ethical aspects to deal with, but actually there is enough work for everyone.
(Appendix B: p 219)

Here we see the workings of the pervasive achievement ideology (Chapter 4; p 108) coupled with the goal of economic survival. Competitiveness is very much a characteristic of capitalist values and we can see here how the goal of getting referrals for the 'economic survival' of the practices, may come to dominate other interpersonal, professional and ethical norms and values.

Note that Jane implies that the competition is not *really* for economic survival: "actually there is enough work for everyone" (Excerpt M). But it is exactly in such circumstances that 'competition' takes on the form of 'achievement'. Also note (the last part of the excerpt), the subtle power of medicalism and OT's subservience to it; something that adds to Jane's psychological tension. I will return to this issue below.

Without knowing it, though, Jane delivers a remarkable piece of ideology critique through countering the hypernormative effects of capitalism and ultimately practising 'good business':

Excerpt N

And then of course the medical aids that is an ongoing struggle; we have a lot of problems of one of the bigger aids again now. But [in our practice], we see a lot of patients for free. Sometimes that is

necessary; I cannot get it over my heart for a patient to sit in his room while a group is held, if he really needs it. But I have learned to judge correctly; most people we make a compromise with, such as writing off one week's groups or giving discount, or making an arrangement to pay it off. But there are also plenty people that we see for free. My argument is that I have to do the group anyway for 10 people; one person is not going to make a difference. Some say that I cannot think like that, but that is how we do it.
(Appendix B: p 216)

Another factor that Jane is identifying here as being an issue for OT in private practice is that of getting paid for services by medical aids. She recognises that in terms of hierarchy, OT and psychiatric services often enjoy less priority (in terms of benefits), than the 'physical' profession and other major services. All of those can provide 'hard evidence' of being necessary to the health profession:

Excerpt O

Concerning the medical aids, in comparison with other areas of health, psychiatry often comes last.
We have to be able to prove that what we do works. We need research that shows that OT groups work – we know group therapy as a whole works; research about that has been done, but we don't know about OT specifically. Medical aids want evidence; there is a great need for us to do research.
(Appendix B: pp 216, 215)

Here we can see how the theoretical paradigm of positivism (Chapter 4; p116, Diagram 4.6.) impacts on Jane's life, in the sense of getting paid for the OT services that she delivers to clients. We may also see another example of positivism standing in a certain relation to the powerful medical paradigm, as well as the interrelation between money and research. We see how corporate institutions judge scientific "evidence" (Excerpt O), by the number of benefits being paid for.

Excerpt P

"Describe how you see/experience the OT profession in relation to the
- medical profession".
If we could get the patients when they start to have difficulty to cope with stress, and consult their GPs for anti-depressants and so on, our input could be of much greater preventative value and that would make a huge difference to patients.
(Appendix B: p 212)

One could say that this is also an example of how the medical paradigm coupled with the goal of economic survival impacts on the *freedom* of OTs to be creative in their treatment, which may to a certain extent explain why many OTs often veer away from the 'occupation' in occupational therapy. Fisher (2003:193-194) points to some generic examples where this occurs in practice, including experienced OT practitioners who exclusively make use of psychodynamic principles in treating patients with psychiatric disorders. While I have to agree with Fisher's notion that the answer to this phenomenon might be complex, one might also consider that one of the reasons for OTs allowing the 'occupation' to

take leave from ‘occupational therapy’, could indeed be related to the ideologies identified.

5.4 Common Ideology Concerns for (some) OT Practitioners

The above section has illustrated how ideologies pertaining to both realms of ITM, impact on the individual lives of OTs in the work field. The following themes are discussed as common concerns among the OTs who participated in these interviews, because of the similar ways in which they experience these issues in their daily lives.

5.4.1 Moral consciousness

Morality and moral consciousness are an integral part of the historical origin of the OT profession, as Clare explains:

Excerpt Q

“How, if at all, have the following concepts changed in OT?
- moral consciousness”.

That is still an integral part of our profession, doing well. This moral consciousness is part of the Christian ethic, if you look at the vast majority of OTs qualified, the service ethic, care for others and the underprivileged, the sacrifice of time and effort, making the best of a given situation, ‘loving’ the patient, showing concern and empathy – these are all basically Christian ethics.
(Appendix B: p 222)

Basically the ethos (of OT training) is that of
- service provision – doing what’s in the best interest of client/patient, ensuring that we send competent practitioners out into the world – our ultimate responsibility toward our patient client,

- feminist ethic – fighting for what is right for the disadvantaged, disabled individual. Feminist ethics are based upon 2 pillars; namely, fighting for the disadvantaged/marginalised persons' rights and the acknowledgement of the value of care and nurturing as well as always seeing the patient within a context of lifestyle, interpersonal relationships and 'occupations'.
(Appendix B: p 178)

Moral consciousness seems to be a fundamental part of the identity of the OT profession, which is essential for a service profession. It implies being able to provide authentic care, being empathetic and genuinely connecting with the person with whom one works (Taylor 1991). Monica points this out as follows:

Excerpt R

I have come to learn that patients often share things with me that they have not shared with any one. Because they know I view what they have to say as important, there is an element of authenticity (in the way that we approach patients).
(Appendix B: p 206)

In fact, one might argue that morality in a service-providing profession actually has two sides. The one is the qualities that a practitioner already has to possess, as well as those that she has to *acquire* in her 'doing-good'. The other side comprises 'uplifting' the client to a better quality of life. However, from an ideology-critical point of view one should always be aware that moral consciousness, as with any other value or goal, might attenuate or oust other

equally important values such as the very personhood of the people that we work with. It might also dominate other important and core values of OT practice, such as a client-centred approach, where we *collaborate* with our clients, as opposed to prescribing, in choosing occupational activities that are meaningful to them as a therapeutic vehicle.[7]

In ITM, the selective prioritising of morality is analysed as one of the pastoral havens where an individual finds comfort and meaning. (Other pastoral havens are work, sexuality, the art of consumerism, for example). (see Chapter 4; p 113 and Diagram 4.5). Such a pastoral haven often provides a certain energy to the person, who embraces it. In occupational science, this is referred to as "flow" (Emerson 1998: 37-44).

It has to be clarified yet again that any pastoral haven, including morality, is not ideological *per se*, but has the potential of becoming so and therefore one should be constantly aware of the possibility of such a pastoral haven superseding and dominating other equally important values. What the previous analysis has shown is that morality and moral consciousness indeed have the potential of acting in a hypernormalising way. (see Chapter 2; sections 2.3.2 and 2.3.3 & Chapter 3; sections 3.1.1 and 3.7).

However, while ITM treats moralism as a pastoral haven for the individual, it seems to me that this issue should be approached on the level of a collective value system for the OT profession as such. To my mind moralism may be linked to the relation of domination that exists between the medical profession and OT (as well as other 'para-medical' professions, such as nursing and physiotherapy) as two professional groups. This relation nevertheless, also represents a

[7] Considering the definition implied in the term: *occupational therapy*, it is thus important to make a structural distinction between the 'moral' *aspect* in OT practice as opposed to viewing 'morality' as such, as being synonymous - hence *defining* of OT. This argument can be related to the modes of aspects as outlined by Dooyeweerd (Kalsbeek 1975) and will enjoy further attention in the Epilogue.

paternalistic kind of 'protection'. (see Chapter 2, p 62) This will be explored/illustrated further, below.

With reference to the ITM framework, I believe that moralism might also be considered to be on the same level as 'selfism', an integrating discourse that was briefly mentioned in the previous chapter (p 108). Selfism (the concern with self-creation, self-expression, self-discovery etc.), is a fairly recent integrating discourse that originated in the 1960s with the explosion of social consciousness and the re-awakening of individualism (Taylor 1991). Prior to this time, I would argue, the reigning ethic was not selfism but a kind of duty-moralism, which is, in fact, the opposite of selfism. This analysis of moralism explains how the latter could impact on OT as a profession and not just a group of individuals with certain 'pastoral' inclinations.

With reference to the interviews, all the participants, mostly without knowing, indicated the effects of an overly active moral consciousness for the profession and its ability to make the most of any given situation, which often leads to OT being excessively compromising:[8]

Excerpt S

Clare: *As far as OTs having to deal with a seemingly ongoing lack of resources, also among patients: OTs seem to be over-accommodating; they compromise because they can deal with it.*
(Appendix B: p 182)

Lerato: *My manager told me that OTs* never *complain – we have a mindset that we can cope with the minimal and that we* always *compromise – even to our*

[8] Note that although Excerpts S has the same theme in common, the questions to these replies were different.

patients we sometimes provide the minimal, like a hand-made splint made out of scraps for example. The medical profession never *compromises.*
[W]hy do we have to make a splint from "afval stukkies" [scraps] that looks like it - if we can order a proper pre-fab[ricated] one? We often compromise on behalf of and at the cost of out patients – because we 'can cope with the basics'.
(Appendix B: pp 189, 190)

Jane: *We have to keep doctors and nurses happy, everybody wants to have a say and OT are often caught in the middle – and often we are the ones who have to compromise.*
(Appendix B: p 210)

Note how Lerato points to a crucial potential danger of OT being overly accommodating and compromising at the cost of the very person she is trying to care for. This clearly illustrates how a certain kind of moral concern can work to the detriment of its object.

During the World Federation of Occupational Therapists (WFOT) international council meeting in Cape Town, it was stated that the profession shows a world-wide tendency of not marketing itself sufficiently (Appendix B: p 244). It seems that the profession's moral consciousness might be linked with this problem. Couple this with our ability and *mindset* always to make the most of a given situation, and it seems that we may be preventing ourselves from making demands for the sake of the profession in the world of business:

Excerpt T

Clare: *We don't market ourselves enough and properly, probably because we think what we do is so ordinary that we do not promote, the 'doing-goodness' in us, maybe prevents us from doing so.*
(Appendix B: p 177)

Lerato: *This comes back to where we don't have OTs in levels where decisions are made; where we can get an agenda and where our agendas can be looked after. Certain professions develop faster than others because they have representatives, we will be complaining about the same things in years to come if we don't get people in these positions.*
(Appendix B: pp 191-192)

Monica: *We need to show them [corporate representatives] why they should be willing to pay for our services. In the corporate field, health is not a 'moral' issue; it is either because of legislation or because the workers can become more productive to make more money [for the consumer] – we OTs need to understand that.*
(Appendix B: p 201)

5.4.2 The protective power of 'Medicalism'

As mentioned above, there seems to be a close link between the OT profession's hypernormalised morality and another level of ITM; the level just 'above' pastoral havens: that of protective power. There are many examples of protective power as has been pointed out in the previous chapter about the systematic structure of ITM. (see Chapter 4; p 112) Examples include the institutions of physical or mental health, or the loving environment of the family, or the knowledge environment of the university. All of these institutions dispense a kind of existential protection or security for the modern individual, comparable to the security that the church dispensed in the pre-modern times. Obviously such protective power may assume ideological proportions. It could be argued that OT also shares in this therapeutic power, which people may access.

But the protective power function of medicine also has another side to it: in terms of the relation of the paternalistic domination that exists between it and something like OT. In the ideology-historical analyses of Chapters 2 & 3, we saw how a young fledgling OT profession made a strategic alliance with the male-dominated medical profession, eventually becoming subservient to its domination in the field of health and positivist science (Capra 1983:121-122; Wilcock 2002:91).

In the following excerpts, the effects of the above relationships are illustrated in the sense of OT's subordination:

Excerpt U

Clare: *In 40 years OT has become more independent from the medical profession, in the old days OT was more subservient/subordinate to the medical profession. We could only treat based on referrals up until 1992 all professional Board decisions were vetoed by the Medical & Dental Council; we were controlled by the medical model. Now we can expect OT to be more independent.*

(Appendix B: p 179)

Lerato: *The medical profession still believes that OT keeps patients busy. I thought we're past that. It seems that we still have to market ourselves, but I don't know if it is going to help; I think it is about the attitude, of the doctors, for example.*

(Appendix B: p 188)

Jane: *One has to work really hard to get referrals, and then you have to work hard to keep them – to keep the doctors satisfied.*
Doctors still do not know what an OT does, especially GPs. There is still an attitude among most of them of looking down on us, but we also need to market ourselves properly. Doctors either do not know what we do, or have a limited idea of what our job entails, e.g. I heard a doctor saying, "Oh yes, I know the OTs organise the wheelchair rally on campus each year", or "yes, my neighbour is an OT and she works at a school".
Often, we also have to handle the (political) decisions that doctors make; we have to know how each doctor prefers doing things.
(Appendix B: pp 209-210, 212, 220)

However, it also has to be pointed out that OT's relationship with the medical profession is currently not one of exclusive domination and that some growth has occurred:

Excerpt V

Clare: *This [bio-medical] model is not defining of OT anymore. It has its place but lost its prominence about 10-15 years ago. It is now part of a whole approach. We have moved away from institutional care to community-based care.*
(Appendix B: p 178)

Monica: *It has become clear to me recently that when I have to write a medico-legal report, I rely on the medical information to give an opinion about the activities and roles that a person can or cannot engage in. I need the medical information to form a whole picture. In general, I do not experience negativity from the medical profession. We also have to get more involved with occupation and how it fits into the bigger picture of a person.*

The role of the medical model in OT is what makes me different from a social worker or a psychologist. But knowing the medical part makes a difference; it puts a person's occupational problems in context, it helps me to understand why a person does an occupation/activity in a certain way, why he walks in a certain manner and why he needs certain assistive devices. It helps me to understand his disability.

(Appendix B: pp 200, 203)

5.4.3 Gender and Race/Culture

Moving again to the social realm of ITM (group relations of domination), I shall, for the purpose of illustration, focus on two of the determinants concerning this part of the model: i.e. the role of gender, and race or culture.

The issue of gender manifests itself differently in the lives and contexts of the OTs who have been interviewed. While Clare's experience is one of 'maleness' not featuring at all anymore, Lerato's experience relates to the difference in the dynamics between women, when men are not present. Monica and Jane point to the dominating relations of the male corporate and medical professions over an OT profession that consists mainly of females:

Excerpt W

Clare: *I don't think that maleness is an issue at all anymore – maybe so in the old apartheid time.*
Women play such a prominent role now in most sectors.
There are certain cultures in which one can argue that a male clinician might have been perceived as being more credible, it was felt that males would stabilise the work force (they don't have babies!) But nowadays, the poor men

seem to lose out most of the time (!) and women are fulfilling major roles and senior posts.
(Appendix B: p 181)

Lerato: *Still an issue unfortunately with women working together there are different dynamics than with men; a different frame of reference. We need more men in managerial positions as women do not want to take the risks in this regard.*
(Appendix B: p 194)

Monica: *[I]f an OT can get into the corporate field many of the decisions are made by men; the OT profession is women. We have to understand the language of business; one has to continue to prove oneself.*
In the corporate world it is important that you have the right image, especially since it is mainly men and also especially in the field of vocational rehabilitation and industrial rehabilitation – one cannot arrive in high heels at the harbour! Concerning the OT profession, we need more OTs in positions where decisions are made on a political level, people who make decisions are men and things are approached differently in a man's world.
(Appendix B: pp 201, 206)

Jane: *Maybe there is a greater kind-disposition toward a woman being in psychiatry. I do not think doctors would have treated us in the same way if we were men. Doctors can walk over you though; some doctors just assume that you are always available to organise things for them.*
(Appendix B: p 218)

Once again, one can see the links with maleness and a capitalist society, of organisation and competition, in which terms such as “management”, “decision-making” and “positions” are evident.

The other obvious and very relevant determinant in the social realm of ITM, with reference to the world of OT, is that of cultural differences. Here we can also see the foreseeable links between gender and culture, which adds to the complexity of the interrelations on this level. We have already seen how the issue of race impacted on Clare’s working life on an individual level, coupled with a political agenda. How have the other interviewees experienced it?

Excerpt X

Lerato: *For me, OT remains to be a predominantly white profession that trains people individually in institutions […] Phuthaditjhaba has had a hospital for years, yet no white OT has ever worked there. I think the issue with race is as much one of gender: the profession still consists of white females, although there are educational institutions that are more geared to the education of Blacks and Indians*.

(Appendix B: p 194)

Monica*: Also in practice, culture is often an issue. For example, one day I saw a Zulu man and before I had started with the evaluation, I put on some lip ice, and he sniggered, which he would not have done, had I been a man.*

(Appendix B: p 207)

Jane: *It’s difficult. Normal development in terms of culture is different e.g. the concept of self-image with black patients. There, black therapists would have*

been better, but then again there are many black patients that remain seeing white doctors (while we have had a few black psychiatrists on the staff). And then again, the issue of gender within culture; some cases I know for example, that a Black Zulu man would have a lot more respect for a male OT than a white female one.

(Appendix B: p 218)

I also asked the question whether in each of the participants' opinion, they think that cultural competence received enough attention in the education and training of OTs. All of the interviewees concurred that this was not the case (Appendix B: pp 182, 195, 208). As a Black OT who studied at a mainly white academic institution, Lerato provided the following insight:

Excerpt Y

"Do you think that cultural competence is addressed sufficiently in education?"
Nooo… you know, you had to write those long and thick reports which included a section of community resources, family dynamics et cetera. But not once, nowhere were we required to write a paragraph on the patient's culture: what his/her preference of occupations is, if he/she would prefer to see a white, black, male or female OT: culture is never known or explored formally.

(Appendix B: p 219)

Having not experienced racial discrimination as such in the OT department, she adds contemplatively: "But then, the ugly sides of race, gender and age are issues that need to be combatted in any workplace; in any profession…" (Appendix B: p 219). However, this also needs to be seen in the context of the historical origins of the OT profession's ethics in Christianity and Feminism.

These ethics' main focus is, in essence, inclusive of different groups. We saw this with the founding of Hull House which Jane Addams established in Chicago in 1889 with a view to providing occupational relief to immigrants in the age of industrialisation (Wilcock 1998:174; Wilcock 2001:389).

5.5 Conclusion

In this chapter we have seen a merging of the structural component of ideology analysis, (in this case, the ITM framework) with the socio-historical component of analysis (looking into the socio-historical experiences of the interviewees). This chapter attempted to demonstrate, that although some abstraction is present in the formal-systematic analysis of ideologies, those ideologies are as real and pervasive in the lives of individuals as ITM suggests.

Clare voiced her opinion on how politicalism affected the education and training of OT students. She pointed out how the domination of administrative power not only impacts on patient care and treatment, but also leads to OTs leaving the profession burnt-out. Finally she showed how economic imperatives impact on the ethical considerations of health practitioners, as well as the human rights of the patients with whom we work.

Lerato showed how the combination of medicalism and economism lead to the OT profession's difficulty of delivering proper services in primary health care and community based care. She also pointed to the imbalance of effort in the achievement-driven discourse in the training of OT students, and the (economic) recognition that OTs generally receive in the public sector.

Monica's views resonated with this experience and added that OTs need to understand the image and language of the business world in order to obtain economic recognition. She also illustrated how economic survival impacts on her

knowing and wanting to explore further avenues in the OT profession, something like vocational rehabilitation for instance, which is an area in OT that is susceptible to a take-over by other disciplines.

Jane demonstrated how competition among OTs (a result of the capitalist achievement ideology) creates a lot of tension for her, as well as having to play a pleasing and subservient role to the medical specialists on whom they are dependent for referrals. She further pointed out how the positivistic criteria of medical schemes determine which treatment their members may receive, unless they wish to pay for it themselves.

With reference to ideologies that OTs experience in a similar fashion, we have seen how these participants painted a picture of how the hypervalue of morality leads to the OT profession's reputation of being able and willing to compromise unconditionally, to adapt and make the most of a given situation, often and unknowingly at cost of the people who they care for and treat. We have seen how there might be an interrelation between OT's moral imperative and the patriarchal protective power of a male orientated medical profession. Once again, it was pointed out that this morality not only might contribute to OT's inability to market itself enough, but that it also creates difficulty for the profession in sustaining itself in a capitalist business orientated society. Finally, in the social realm of ITM, it has become clear how these OTs experience gender and culture in their everyday working lives.

Ideologies overall impact ultimately on the *creativity* of OT, which for me is the core of this profession, especially if we want to relate our discipline to a basic aspect of reality, as it is the case of many other disciplines that offer training at a university as opposed to a technical institution. This theme will also form the central part of the following and final part of this study: the Epilogue.

EPILOGUE

> *All human knowledge begins with intuition, goes from there to concepts and ends with ideas* (Kant 1781, Critique of the Pure Reason).

In view of the third and final part of a three-dimensional ideology analysis (Thompson 1990: 307-313), this epilogue will serve as the summary of a creative interpretation of the foregoing analyses of OT's ideological profile. This profile consists of a socio-historical dimension (historical analysis and interviews) and a more formal structural (theoretical) dimension. Before embarking on the actual interpretation and possible suggestions for the de-ideolisation or 'treatment' of OT ideology, allow me to give a concluding summary of the previous chapters.

1. Concluding Remarks: Chapters 1-5

It has been argued several times in earlier chapters that the character of the research questions that led to this study, possess a philosophical disposition. The link between the OT profession's identity-dilemma and critical self-reflection was posed in the Introduction. Part of the preparatory discussion was also to show that ideology critique may serve as a systematic tool for critical self-reflection, offering a limited but penetrating perspective on the 'deep structure' of OT discourse.

Chapter 1: Arguing a novel methodology for OT

Accordingly, the first chapter involved an argument of a new methodology for the type of research that was called for to investigate the ideological profile of the OT profession. It was explained that the study had to move away from the usual, so-called 'empirical paradigm', a type of research that is viewed as traditional and often clothed with absolute authority within the field of the health sciences. The study design was then identified as a philosophical analysis, using ideology critique as the method of analysis. In attempting to remain true to the theme of ideology critique, I also pointed to the dangers of absolutising any kind of research, arguing that a prescriptive methodology could not, as such, be defining of OT or of any discipline for that matter. One of the reasons for this is that methodology is always subservient to the purpose and type of the research question and not conversely.

Chapter 2: A socio-historical ideology analysis: the meaning of occupation

Chapters 2 and 3 both entail a socio-historical analysis of the OT profession's origin and development. As the historical context of human occupation unfolded we saw how various hypernorms changed and often distorted the perception of what constituted 'meaningful occupation'. We saw how the time of pre-industrialisation was, in many ways, conducive to the separation of work and labour for the ideological purposes of achievement and prestige or survival. Work/labour became coupled with economic hypervalues and in the process, was robbed of its original intention of providing meaning in the exercise of creativity. This not only led to class domination but also to the domination of those who were physically or mentally disabled. Moral Treatment emerged as a sort of 'automatic' ideology critique of the inhumane treatment of those who were not able to contribute to economic opulence. Although this approach, in terms of

its occupational emphasis on health, did not last long, the period is nevertheless, seen as the advent of a social (and moral) movement, the prelude to OT as we know it today.

The establishment of the Arts and Crafts Society and later Hull House (Chicago) in the late 19th century also represented a piece of eminent ideology critique of the lack of creativity and freedom that a certain class of people had to endure during the Age of Industrialisation. World War I provided the opportunity to demonstrate the value of occupation for convalescing troops for example, but it also created the conditions for a mostly female profession, submitting to the patriarchal and paternal domination of the male medical elite. Although OT's ties with pragmatism offered some philosophical base, the field became increasingly practically orientated and subsequently showed a lack of theoretical principles in its education of students.

Chapter 3: Socio-historical perspectives: the ideology shadows of a new profession

The historical ideology analysis continues in this chapter. We see how the OT profession's alliance with the medical profession caused both beneficial and detrimental effects to the former. The OT profession also had to prove itself as a legitimate science (read: natural science) at a time when medicine and technology was making gigantic advances. However, here we can observe how these advances became an ideological hypernorm as OT overcompensated and underwent its first paradigm shift; from a paradigm where occupation was the central viewpoint to a mechanistic paradigm in the 1960s. OT underwent another crisis in the 1980s, when it was realised that reductionism as a paradigm is problematic and a more holistic viewpoint was called for.

In the 1980s the *College of Occupational Therapists in Britain* addressed the self-doubt of the profession that had emerged during the previous decade. The Blom Cooper report revealed an astonishing piece of ideology critique, which included criticism of the OT definition as being too unspecific, as well as commenting on an outdated image of seemingly 'do-gooding volunteers'.

The chapter concludes with a summary of the major ideologies that were identified in the historical profile of OT, as well as a very brief historical account of OT in South Africa.

Chapter 4: The topography of OT's ideology environment

Here, the ITM model of ideology critique was systematically surveyed as a model of OT's ideology environment. In its broadest sense, the model consists of a realm of discursive domination and a realm of social domination, both of which were analytically explored and related to the OT profession in general.

Concerning the discursive realm, the discussions illustrated how main steering powers such as techno-scientism and the hypernorm of *efficiency* may have come to stand between OT practice and authentic patient care. The absolutisation of *administrative efficiency* was linked not only to the deterioration of hands-on patient care, but also to the infiltration of our educational institutions, when teaching come to stand in the service of *organisational administrative power,* instead of the other way around. It was also demonstrated how *political economism* may erode the intrinsic values of educational institutions, such as academic freedom.

It was seen how the supporting ideals for steering powers such as the ideal of *'happiness'* coupled with *capitalism* may give rise to important questions of the roles of OT within these social constructs.

It was shown how integrating discourses like a fixation on *achievement* may subvert the profession: its practitioners, as well as the people to whom therapy is offered, especially when it is coupled with the protective powers of medical institutions.

Staying within the sphere of social-cultural domination, the researcher finally points to the potential perils of the hypernormative functions of pastoral havens, where the workings of the main steering powers may filter down to the micro levels of individual lives e.g. the potential hypernormative function of *creativity* within *work*.

With regard to the sphere of theoretical paradigms, the possible dangers of hypernormalising paradigms such as *positivism* and *pragmatism*, were also highlighted.

Moving on to ITM's realm of social domination, OT's relation to various forms of group domination such as *patriarchy*, *paternalism* and *racism* was critically explored to the extent of general explanation.

Chapter 5: When ideologies become existential

This chapter shows how ideologies are a presence within the everyday lives of OT practitioners. This was done through four semi-structured interviews. We saw how various ideologies impact on the lives of OTs specialising in the fields of academia, management on a provincial level, medico-legal consultation, and life-skill training, respectively. Ideologies that were identified in the previous analyses, such as politicism, economism, medicalism and achievement ideology were illustrated. The participants, by implication, all in different contexts, pointed to the influence of moralism in the OT profession. This was linked to OT's

marketing problems and its innate willingness and ability to compromise, arguably, often (unknowingly), at the ultimate cost of the patient. (Here, I wish to point out again, that the purpose of these interviews is not to prove the existence of ideologies – that is being done by ITM itself. The purpose of these interviews is merely to *illustrate,* as opposed to ‘corroborate’, how ideologies manifest themselves in the lives of ordinary OTs.)

2. Possible Strategies for Treating the Ideology Infection of OT

So what do we do? What is the use of being aware of the dangers of ideology if we are unable to *cure* them? Cure we cannot, but we may find much meaning and value in the acute and constant awareness of the potential traps of ideological hypernorms. These hypernorms may distort and dominate other equally important values, aims and objectives on the levels of practice, theory and education in the OT profession.

Aspect theory as a means of counteracting ideology

I have briefly referred to the various aspects of reality a few times throughout the study. In the present context, I wish to refer to this theme again, as a possible tool for recognising ideologies. (I hope to explore this more comprehensively in future projects.)

Philosophers from different paradigms distinguish – explicitly or implicitly – various 'aspects of the world' (for example: Chomsky, Ricoeur, Habermas, and Dooyeweerd). It is Dooyeweerd, a philosopher from the previous century, who probably developed the most comprehensive model of what I call an 'aspect theory'. Aspect theory is thus another tool to systematically analyse all the various aspects of the world or 'reality'. Dooyeweerd distinguishes aspects such as the physical, the biotic, the formative (creative), the social, and the ethical. All of these aspects are *unique* and *irreducible,* although there is a very strong *coherence* between them. This means that when one of these aspects is overemphasised or hypernormalised (the technical term used in ITM), at the cost of another, an imbalance is effected in the interpretation of reality, which amounts

to a distortion thereof. This kind of imbalance converges in important respects with what the present study has identified as ‘ideology’.

Aspect theory and OT

> *Occupational therapy is a profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation* (WFOT 2005:3).

The above quotation is the first of four paragraphs of the well known definition formulated during a WFOT council meeting in 2004. Based on the analysis of the historical profile of OT, it is evident that virtually all definitions of OT attempt to encompass the extensive and complex role of OT as clearly as possible. All of these definitions have one characteristic in common however, which is the attempt to ‘juggle’ many keywords in order describe OT.

The fact is that many different sciences concern themselves with the phenomenon of human occupation, such as economy, psychology, sociology etc. I have argued in a previous chapter that each of these disciplines however, also views occupation *from a different aspect of reality*. For example, economists view it from an economic aspect, sociologists from a social aspect, medical professionals mainly from a biotic and physical aspect, and so on.

Conversely, there is no single aspect that OT focuses on when looking at a person with a disability. This is clearly reflected in the many issues that we attempt to juggle in our definition – which is evidently detrimental to the *unified*

approach that a field or a discipline should ideally have. Sometimes we look at a person from the physical aspect to solve a problem, or from the psychological, or even from the social aspect, for example. This still leaves the discipline in a potential predicament of having to defend its relevance at an academic institution where other disciplines appear to be aspect-specialised. There is currently no aspectual point of departure that OT regards as its central concern and from which all other components concerning 'occupation' may be viewed.

Proposing 'creativity' as a core concept for the 'occupation' in Occupational Therapy

Creativity has always been an integral part of OT, even if often associated by outsiders with a vague idea about what it is that OTs do. The formal use of the concept within the profession appears to be mostly limited to 'creative activities' as *one* approach to treat the people with whom we work. However, to me the value of 'creativity' appears to be integral to and interwoven with all of OT's theory and practice.

In terms of considering creativity as a possible core concept in OT's paradigm, one might be able to distinguish between 'true creativity' as an ideal state and creativity as a realistic aim (e.g. to achieve independence in order for a person with a disability to be placed in a job). Perhaps it may be said that OT is the appropriate profession that would be able to construct a bridge between the two aims of not only attending to the disabled person's creative independence, but also assisting him/her to realise the fullest and greatest creativity in his/her work.

Nevertheless, given the fact there is currently no discipline in academia that studies creativity *per se,* as an aspectual point of departure and as a fundamental aspect of human nature, one has to argue that for now, some of the above seems to be somewhat idealistic. This however, does not detract from the

fact that OT is probably the best positioned to embark on the investigation of this aspect. Perhaps we might in the future, see a differentiation in OT: one part concentrating on the meaning of creativity for human existence in general, and the other part holding on to the more traditional concerns of OT.

‘I have a dream…’

Imagine if we lived in a world where OT is globally considered as fundamental to the human rights of health and the well-being of all; a world where other disciplines such as the health sciences, political science, anthropology and economics consult the vital discipline of OT to inform their understanding of what humans perceive as meaningful occupation; a reality where, because of these collaborations, OT is in a position to actively contribute to the making of political and administrative decisions that promote occupational justice for all humans.

APPENDIX A

Informed Consent

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Department Of Occupational Therapy ♦ Faculty of Health Sciences ♦ P O BOX 339, Bloemfontein, 9300 ♦ Republic of South Africa ♦ Tel: (051) 4012829 ♦ Fax: (051) 4013288

INFORMED CONSENT: PARTICIPANTS

You have been asked to participate in a research study.

You have been informed about the study by Mrs Tania van der Merwe.

You may contact the following individuals at any time if you have questions about the research:

Prof. Johann Visagie	Study leader	Head of Philosophy Department	(051) 401-2237
Mrs Rita van Heerden	Co-study leader	Head of Occupational Therapy Department	051) 401-2829
Mrs Tania van der Merwe	Researcher	Lecturer at Occupational Therapy Department	(051) 401-2829

You may contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 4052812 if you have questions about your rights as a research participant.

Your participation in this research is voluntary and you are free to refuse answering any of the questions. All of the information obtained by means of the interviews will be handled anonymously. Transcriptions of the interviews that will be conducted verbally will be sent to you for member checking. Your input and participation and is highly regarded. If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

Participant: The research study, including the above information has been verbally described to me. I understand what my involvement in the study means and I voluntarily agree to participate.

_____ _____

Signature of Participant Date

INFORMATION DOCUMENT

Dear Sir / Madam,

As your participation is a portion of the research that will be either directly or indirectly included as part of a master's thesis, the following core information of this study is provided.

Title:

Occupational Therapy and Ideology: A Critical Investigation.

Background:

Every profession has its problematics, which might or might not lead to the profession moving forward, growing and remaining relevant.

In the quest of finding some answers to these questions, the researcher will apply a philosophical tool namely ideology critique. This tool is about investigating the power relations that are distorted on both a conceptual and social level of all social and individual structures as this forms part of society, and will - pertaining to this study - be applied on the profession of Occupational Therapy.

The hypothesis of the research is that because the Occupational Therapy profession also forms part of society, ideologies have had and are and still have an influence on the professional standing of occupational therapy and might therefore to some degree account for the problems in this profession.

The research process, which is called ideology critique, involves gathering information from various sources including literature, and (where your input comes in) informal, semi-structured interviews with expert/s in various fields of the occupational therapy profession. After these interviews have been transcribed, each individual's interview will be sent to the relevant participant for member checking. This information will then be viewed and analyzed through the lenses of 'ideological spectacles', using a sophisticated model of ideology theory, in order to compile an analysis of ideology critique as is relevant to the occupational therapy profession.

APPENDIX B

Interview Transcriptions with Ideology analysis

INTERVIEW	IDEOLOGY ANALYSIS (ideology = < >)
1. Clare (the academic) Transcriptions **1.1. Please state your current OT job and give a short description of your experience history in the OT profession.** Head of School of Audiology, OT, and Speech – Language pathology at a University in South Africa. Senior Lecturer in OT. Qualified as an OT in 1965 – 40 years experience, mainly in psychiatric field of OT. Full-time at the University since 1991. **1.2. Describe your working environment and circumstances in which you are working currently.** University setting, faculty management setting. I am working in a supportive, nurturing environment, enjoy management, teaching and clinical supervision. Challenges: workload, sometimes create my own problem because I take on too much. Also, students has a culture 'rights', one of 'entitlement', lecturers are sometimes put in position where their integrity, credibility are doubted. That is limiting, it leads to having to have to have lots of structures in place, staff need to think about what they say and what they do. That causes a low morale.	<politicism> <administration>

1.3. How did you come about to study OT? Essentially I was interested in medicine but also art, then someone suggested that I consider OT – I knew that is what I wanted to do, it's been a wonderful profession – couldn't / wouldn't want to be anything else.	
1.4. How did you experience your education en training? Positive, very enriching. It equips one to do anything. I think the same then than now, enables one to develop holistically, provides enormous experience.	
1.5. How do you view the relationship between OT practice and education? Interactive. Practice has to feed into training and training into practice. Currently it is probably not working as good as it should.	
Academics behaved previously as 'know-it-all': like medical practitioners we were very paternalistic although benevolently so. Now consumer input is more required in the development of curriculum and non-curriculum ventures for example, as well as the input from clinical stakeholders and consumers are involved.	<elitism> <paternalism> <capitalism>
Service-learning is VERY IMPORTANT – community should contribute, enable the training to benefit from the knowledge and experience of community members and consumers.	
It is very important that OTs practice reflectively	

for adequate development, important that they understand the theoretical underpinnings of their practice. The training centre should work hand in hand with the clinicians and professional forums, the better this relationship, the better the training.	
1.6. Describe how you see / experience the OT profession in relation with the	
a) medical profession In 40 years OT has become more independent from the medical profession, in the old days OT were more subservient / subordinate to the medical profession. We could only treat only based on referrals up until 1992, all professional Board decisions were vetoed by the Medical Dental Council. We were controlled by the medical model. Now we can expect OT to be more independent.	<medicalism>
-Do you think the respect is mutual? Sometimes there is mutual respect. If an OT does her job properly, there is usually respect. The profession has considerable respect to think in terms of treating of psycho-social patients and learning and physical rehabilitation and hands.	
b) colleagues of other disciplines I don't know if they view OT's as grand, but in mental health where OT delivers a significant role, they are viewed as essential.	

As with other disciplines, it depends on what is seen - what OT does, what they experience. Obviously, if OTs do not do their job, that is experienced as such, it becomes their perception of OT. Other disciplines are seen as 'poaching' on our scope, e.g. physios and nurses saying that they do vocational rehabilitation. We unfortunately don't' always do what we should be doing.	(aspect)
c) corporate field I don't know. There is lots of potential. There can be done more and it can be done better such as helping with accommodation in the work place; promote and preventive programs – but these need to be developed.	
d) public They don't know anything about OT – very little really but it's better that 20 years ago.	(definition)
We don't market ourselves enough and properly, probably because we think what we do is so ordinary that we do not promote, the 'doing-goodness' in us maybe prevents us from doing so?	
Often other disciplines stumbles on something 'new', but old to OT, then it is depicted as amazing, while OT has been doing it for years! We often do not view what we do as amazing, which it is. The problem is that should we market the profession better, it would also create a need that we are unable to fulfill due to limited numbers.	<moralism>
Sometimes OT is also seen as 'elitist', as it so	<achievement>

difficult to get accepted for training. **1.7. What in your view is upheld as the major values / ethos in education and training?** 60% of students accepted for training is affirmative action, the rest there is lots of competition with high expectations. Basically the ethos is that of - service provision – doing what's in the best interest of client / patient, ensuring that we send *competent* practitioners out in the world – our ultimate responsibility so toward our patient / clients, - feminist ethic – fighting for what is right for the disadvantaged, disabled individual. The feminist ethics are based upon 2 pillars namely fighting for the disadvantaged / marginalised persons' rights and acknowledgement of the value of care and nurturing as well as always seeing the patient within a context of lifestyle, interpersonal relationships and 'occupations'. **1.8. How do you view OT's role (within the context that you are working in) concerning the following concepts:** **a) bio-medical model** This model is not defining of OT anymore. It has its place but lost its prominence about 10-15 years ago. It is now part of a whole approach. We have moved away from institutional care to community based care.	<achievement> <medicalism>

b) science OT now have occupational science, we're more scientific – we have a greater understanding of what we do and why we have theoretical framework according to which we teach and practice. There is still not enough research – not enough to impact on the OT profession, enough to make a difference we need to research more collaboratively, and less only 'what each and everyone wants to do'. Technology, yes it has become more relevant – it can be used to assist the patient / client e.g. AAC.	<scientism> vs academic freedom
c) political arena OT's politically more aware (but not party-politics – I don't think that is acceptable). Previously during the Apartheid regime, OT viewed themselves as apolitical, although in retrospect, we addressed issues of inequitable health by means of writing letters etc. We are more politically aware, and we should be of legislation, we are legally bound to be more aware of human rights etc. We need to take a stand on issues of importance e.g. disability rights, HIV, poverty relief etc. etc. OTASA should be more *vocal* about these issues.	(Ideology critique)
d) administrative bureaucracy In my view it is a source of burn-out for the profession, factors that lead to disillusionment of	

many young therapists e.g. a newly qualified therapist working alone in a psychiatric institution with 500 patients, it is difficult to cope. Often the administrative obligations overshadow the clinical role and patient care – that leads to young OTs getting burnt out, and us losing them to the profession. OTs often do the mundane administration and attend meetings while support staff deal with the patients. **e) research** I think we discussed it already. **1.9. How would you describe the development of OT since you have qualified as one?** When I qualified as an OT we had learnt many activities for therapeutic purposes, in fact we had 300 hours of weaving. There were also a lot of emphasis on ADL's and assistive devices, also leisure and crafts. Then the focus went to work preparation and treatment on a continuum or input until an individual is again integrated in society. Recently the focus has become more on theoretical constructs and underlying theories for practice. There is more emphasis from the direct service provision to development of indirect service provision, service management of support staff, OT contributes a broader field, but at the same time we have become also more specialised in many fields. Also development of CBS (community based	<admin> <capitalism>

services) – true to the Social Model.	
1.10. How do the following determinants (in your view) impact on the OT profession (examples as welcome)	
a) age	
I have learnt that it is not so much experience that counts it depending on the person's attitude. It is about commitment, very young newly qualified OTs can made a major contribution, but experienced OTs are needed to support, nurture and guide the juniors.	<female- politicsim>
b) gender	
I don't think that maleness is an issue at all anymore – may be so in the old apartheid time. Women play such a prominent role now in most sectors. There are certain cultures that one can argue that a male clinician might have been perceived as being more credible, it felt that males would stabilise the work force (they don't have babies!) But now a days, the poor men seem to lose out most of the time (!) and women are fulfilling major roles and senior posts	<gender>
c) class	
My perception is that patients are poorer (in terms of low socio-economic) now than previously – we are dealing with true disadvantaged population but there could be several variables that might contribute to this perception.	<economism> <politism>

As far as OTs having to deal with a seemingly ongoing lack of resources, also among patients: OTs seem to be over-accommodating, they compromise because they can deal with it. It is changing a little bit, since we are admitting students who seem to be more assertive and less willing to compromise.	<moralism> (justice vs equity)
d) race At our university this is unfortunately a big issue. There are very rarely jobs for white people, regardless of experience and expertise. Often black employees receive special advantages such as time off to complete post-graduate studies, we are told that new HODs need to be African. These are dilemmas - one understands that mistakes of the past need to be corrected, but at this time these are being experienced as difficult issues and are demoralising to professionals across many professional groups.	<politicism>
- Do you think that cultural competency is addressed sufficiently in education? No, I do not think so. It is easier when a student community is integrated such as at our university when they are together. But I don't think that OTs are equipped enough to deal with implication of performance areas of different cultures or how to adequately treat needs and habits that are culturally bound – a national survey conducted on perception and experiences of	

OTs doing community service revealed a need for greater knowledge of and sensitivity to cultural diversity and traditions and beliefs.	<individualism-capitalism>
1.11. If you could wave a magical wand, what would you want to change in the OT profession?	
That everybody in OT does a good job and be a good role model – we need those. There are many who are unfortunately not committed or dedicated.	
I remember when being a young OT, everyone in OT seemed to have a strong sense of responsibility to promote OT and to let it go forward. This does not seem to be the case anymore, OTs just want to work to earn money.	(definition – aspect)
OT can make an enormous difference, we are the one profession that can do that – there is little that OT cannot do well, maybe I am idealistic....	
Also we are in dire need of OTs that become more involved in mental and psychiatric health. According to a study only 5-12% of OTs (worldwide) works in these settings – we need to increase this focus.	
Also our image in the public eye need to be enhanced – the public need to know what incredible quality we can bring, we need to advocate ourselves properly.	
1.12. In your view, what role does creativity play in you daily practice and decision making as an OT?	
It seems that as clinician I used to use creativity	

more, but I need it as a human being, it is what keeps me going. I cannot imagine OT without creativity – if I do I can only see a large black hole! That is how we really contribute, we need to nurture our creative ability that goes with flexibility and experimenting.	

2. Lerato (the manager) Transcriptions **2.1. Please state your current OT job and give a short description of your experience history in the OT profession** I qualified 9 years ago. 3 year experience at school for CP children and the rest in management. Sotho-speaking. Is responsible for co-ordinating services for province, including institutional, training, community and strategic planning issues. I have 4 roles: 1) Support: (development of services), support of CEO's, appointment of personnel 2) Monitoring: evaluation of service delivery 3) Training & development: of OT's and technical assistants 4) Policy and development: strategic developments, implementation by managers **2.2. Describe your working environment and circumstances in which you are working currently.** Challenging, very male orientated, Doctors in forefront. OT infant services and neglected in terms of budgets, cost centers. Very administrational, many administrational procedures before action can be taken.	<gender> <medicalism> <economism> <admin>

One has to think of how it all connects, how it fits together and links with the bigger the picture. Middle management involves getting no/little credit / recognition for being the pathfinder. Little guidance though from my manager, maybe it's a generation thing. My frustration is that everybody in the field wants an answer, what to know where things are going – I'm only the facilitator – decisions are made upstairs. Higher middle management is unfortunately a lack of competencies, lack of managerial know-hows. Little room for development of the post, but much room for development of the self.	<politicalism> <ethno-nationalism>
2.3. How did you come about to study OT? I know I wanted to work with children [after finishing school], I did a year of bridging. One day I went to see Boicuthco, Work assessment at FPC and an old age home with one of the lecturers at the university and I knew I had to study OT. I wanted to work with people, help people and something in the medical field but not the medical profession.	
2.4. How did you experience your education en training as an OT? Hard, cumbersome, very loaded. All classes in Afrikaans, material in English. A lot of support from the OT staff and personnel. But in many medical classes not though, classes were too big there.	<politicalism>

Pure medical subjects were difficult, such as Biophysics was terrible! You had little time for yourself, and it never seemed to end. I never understood why we had to write those very long reports, then presenting our patient in 15 minutes; the result did not seem to even out the effort, you know? Later I realised the value of these reports, one is able to screen a patient rather quickly. There was not a lot of interaction with class mates, there was no time, except when doing research, although I hear students have more group exercises now. During my student years I really experiences the monster side of OT, the competitive side, no fun, it was expected that you cope. I would have liked to have one mentor in the department, with whom I had a regular, set appointment through out the 4 years, talking about how I'm coping with the OT as well as maybe personal issues.	<achievement-admin / management> <achievement>
2.5. How do you view the relationship between OT practice and education?	
I wonder about all the medical subjects – why do not learn more about management in OT such as gathering data to manage OT, HR related issues, information systems Too much focus on *therapist directed* individual care in institutions – what about community health, where	<medicalism / scientism>

you learn to work *client-centered* with the • individual, in his • physical environment in the • community Seeing patients at home – that is how you get to understand his needs. Also the selection (for becoming and OT) criteria is so high, SO much effort, one would expect a reward, just to realise that your paycheck equals that of a clerk in government – nobody knows what OT does.	(lack of recognition)
2.6. Describe how you see / view the OT profession in relation with the **a) medical profession** The center of health remains to be doctors, but with medical doctors their effort at least even out their effort. They are the leaders in health care, although I'm not too sure if the decisions they make are the best decisions for the patients or for them (self-serving agendas). The medical profession still believes that OT keeps patients busy – I thought we're pass that. It seems that we still have to market ourselves, but I don't know it is going to help, I think it is about the attitude - of the doctors - for example. But OTs also assume a role of submissiveness, we choose to rather re-vamp an oncology ward than to make decisions about policies for example.	<scientism-capitalism> <medicalism> <elitism> (recognition)

b) colleagues of other disciplines There is still a lot of tension between OT and Physio - although I sometimes enjoy it [/find it amusing]! It seems that that taking/stealing from us, stealing our stuff [our area]. They incorporate activities – my fear is where will it end? We should rather come together, see where we complement each other, establish where the clear boundaries are. We are not rehab services (i.e. OTs PT ect), we need to keep our entities separate from one another. Our uniqueness needs to be preserved. However, often though in the community where services and facilities are limited, OTs sometimes have to do what physios do for example, like pain care - what can you do? The patient needs help. **c) corporate field** There are few, if any managers in OT. We do not want to be leaders. We do not want to make decisions. We need OTs as CEOs, OTs in decision-making positions. We need OTs as representatives in government e.g. if there is a pharmacist in government, the budget for their services and for them is increased. We need these representatives not only for OT but also for Health. My manager told me that OTs never complain – we have a mindset that we can cope with the minimal and that we *always* compromise – even to our	<scientism/capitalism> <medicalism> <patriarchy-paternalism> <moralism)

patients we sometimes provide the minimal like a hand-made splint made out of scraps for example. The medical profession *never* compromise. I told my father that I want to be surrounded by beautiful things, he says that is shallow – but I told him that I worked hard for it and being surrounded by beautiful things makes be FEEL beautiful – we should be able to do this for our patients as well, why do we have to make a splint from "afval stukkies" that looks like it - if we can order a proper pre-fab[ricated] one? We often compromise on behalf of and at the cost of out patients – because we are known to be able to "cope with the basics".	<elitism> <moralism>
d) public The public does not know our role. Maybe we need to focus on key things in OT instead on too many things. But someone in management said: "Yes, but then we will not get referrals" – we are not getting maximum referrals anyway because people do not know what we do and not do. OT seems vague and watered-down to others – it's too broad.	(aspect)
2.7. What in you view is upheld as the major values / ethos in education and training? I think we covered that – there continues to be a premium on "performance" and "coping".	<achievement>
2.8. How do you view OT's role (within the context you are working in) concerning the following concepts:	

a) bio-medical model In general health in the government this is still the central model. We do it to make diagnoses and so on but in general health begins with this model – even though we are veering into community health.	<medicalism>
b) science The majority of us do not understand the 'science' of OT, or what the core of OT is. Only a few people [in the academic world] understand this, very few other OTs understand this however.	
c) political arena In the political field we have to focus on CBS OT- that is the way of the politics. That is positive and new for OT, because that is what we do anyway – psycho-social intervention, we learned to do that on an individual basis, now we just take that to the community where it is more accessible to everyone, although we need more persons in the field. We need more assistance that can do the hands-on, where OT needs to fulfill the role of facilitators and managers more. It is going to be challenging in meeting the demands of mid-level workers and to find ways in developing these levels.	
d) administrative bureaucracy This comes back to where we don't have OTs in levels where decisions are made, where we can get	

an agenda and where our agendas can be looked after. Certain professions develop faster than others because they have representatives, we will be complaining about the some things in years to come if we don't get people in these positions.	<moralism>
e) research This is one area that we need to embrace and work harder in. A lot of research that is done is individually interest based though, and I think we need more collaborative research and research that serves a purpose for those how does it. Research that will enhance their practice for example or where research becomes an element of standardised practice where one can look at quality standards. Research for example of the role of OT in public care. It need not be complicated, it should be seen as this big mountain - maybe other incentives?	<capitalism> (definition)
2.9. How do you describe the development of the OT profession since you have qualified as one? I do not know… I have realised that forces have changed. E.g. more monies are allocated to community health and less to institutions, but then we do not have enough people there. Now though we have community-based OTs and other therapists, which is great, that is probably the biggest development in transformation for OT.	

We still have a way to go, there remains to be lack of people and facilities and resources in the community. Also the first group that did the community service year said that they had a great need for direction and so on – now it seems that there is a more independent type of therapist out there.	
2.10. How do the following determinants (in your view) impact on the OT profession:	
a) age	
It seems there is a big difference between younger and older therapists. The older therapists seem to be more institutionally based, the younger one more the go-getters and there seem to be more younger therapists out there.	<ageism>
When I got the management job, there was a sense that I had to prove myself in the beginning from a paternal point of view, and there was some animosity because my appointment was a affirmative action one.	<ageism> <paternalism>
Also there might be some rigidity form the older ones – if you'd come with an idea they might say that they had tried it years ago – but one has to have the confidence that the project is beneficial to EVERYONE – everybody will benefit from it. Having said it though once you do gain the trust of the older members they tend to be on board and going ahead.	<politicalism>

b) gender Still an issue, unfortunately with women working together there are different dynamics than with men – different frame of reference. We need more [OT] men in managerial positions – women do not want to take the risks in this regard.	<female>
c) class OT has always been non-discriminative, there is never an issue of class. Some therapists that had to start doing community services protested about going into the areas and so on, but that has always been part of OT's values. I see the values as follows: • Equitable services (justice) • Reasonable care • Dignity and privacy of our patients • Undivided in terms of giving to the community.	
d) race For me, OT remains to be a predominantly white profession that trains people individually in institutions. Therefore there is still a lack of accessibility - OT is still more urban based. For example Puthaditchaba have had a hospital for years – yet no white OT has ever worked there. I think the issue with race is as much one of gender: white females, although there are educational institutions that are more geared in the education of Blacks and Indians.	<white, female> <ethno-nationalism>

- Do you think that cultural competency is addressed sufficiently in education?	
Nooo… you know you had to write those long and thick reports which included a section of community resources, family dynamics ect.	<culture>
But not once, no where were we required to write a paragraph on the patient's culture: what his preference of occupations are, if he'd prefer to see a white, black, male or female OT – culture is never known or explored formally.	<policalism> <moralism>
But then, the ugly sides of race, gender and age are issues that need to be combatted in any workplace, in any profession…	
2.11. If you could wave a magical wand, what would you want to change in the OT profession?	
• I would like for OT to sharpen their professional skills – like with meetings you don't want to ask "Nou wie kom daar aan?" – we need to be more professional in the corporate sense, especially we there is talk about money. If one has to decide whether you are going to give money to an OT who's full of finger-paint as opposed to someone who is presentable and understands the business language – the decision is obvious.	(professional) <capitalism – image> <moralism>
We need to create an *image* that allows us to make demands, that allows not to compromise constantly.	<moralism>

• I would like to get rid of the OT (education) monster and change the work load for example. Not doing that much less but just a more doable workload, get rid of that idea (from other students) of no hope, no life for the years of your study and then of course the imbalances between effort and recognition and getting paid for what we do.	<achievement> <administrational/ efficiency>
2.12. In your view, what role does creativity play in your daily practice and decision-making as an OT? It is the core essence of OT, the one skill that OT has developed in me and that I can take with me no matter where I go – even if I would leave the profession – e.g. a colleague of mine (an OT) also studied MBA, she said that the creativity that she had learned in OT allows her to put together a creative business plan – creativity is the essence of OT.	

3. Monica (medico-legal consultant)

Transcriptions

3.1. Please state your current OT job and give a short description of your experience as an OT

Qualified 1990. For the 1st two months after qualifying I was unable to get an OT job, so I worked in the bank. After that I got a job at the psychiatric unit at National Hospital for one year and then at the vocational rehabilitation unit for 2 years. In 1995 I started working at a private practice in pediatrics and medico-legal. Then I started working at another private practice as co-owner at the hospital in 1997. During that time I also held a part-time job at the university lecturing half-day for 4 years did all of this until 2003 when my husband and I decided to relocate.

I then worked from home for an international company being a case manager - in getting people back to work with occupational disabilities for 2 years. O also part time lectured and gave clinical supervision at the local university. Currently (since beginning 2006) I am the sole practitioner of a private practice doing medico-legal work only.

3.2. Describe your working environment and circumstances in which you are working currently

I am working for myself, I am the sole owner of a private practice in medico-legal. Twice a week I

drive to the a major district government hospital where I make use of the test standardised equipment, I pay a monthly fee for this and since my practice is still young, this suits me well. I see 4 clients a week at the most (as writing reports) take the most time. I would like to get more involved with vocational rehab including on-site analyses and ergonomics. But I simply do not have the time – there is a great need for medic-legal work.

I enjoy being alone in practice in terms of management and administration. I enjoy the more contact with clients, and would probably like to have more contact with other therapists – the feeling of cohesion. I might to consider to approach another therapists in sharing the testing facilities, but I would still like to keep sole-ownership of he practice. But the idea of 'cross-fertilisation is beneficial.

3.3. How did you come about to study OT?

My parents took me for an aptitude test to a educational psychologist and OT was one of the professions that were recommended. I made the decision of only applying for OT and only at one university. I guess it was the road that was intended for me.

3.4. How did you experience your education en training as an OT?

It is easier to answer the question now that soon after your studies! I have appreciation for what I have learned.

There were gaps such as Creative Participation (which I think still is). But I satisfied with my education. In my opinion our group had very good training in psychiatry – it could also be because of the co-incidental clinical exposure that I had. But it seems that we had less exposure in physical evaluation and rehabilitation. It was a full course, very busy. But in relation to current reality, it was a care-free time. I have made friends that are still deep friendships today. I have good memories. It was stressful with the medical subjects for example – and did not want to disappoint my parents.	
3.5. How do you view the relationship between OT practice and education? When I started working in a government setting, I received enough supervision- in the government that is beneficial – there are structures to support you. Currently considering universities, e.g. some universities' focus is very theoretical, and their practical training much more focused on community that the university that I trained at. There is advantages and disadvantages to both sides. Another university that I know of – their students still write very lengthy reports in detail, I feel sorry for the students. There is also many OTs that leave the profession, I know of many that I studied with. Continuing education is very important for OT – we are spread so thinly though, that we often do not have the time.	(aspect) <practicalism/ pragmatism> <admin efficiency>

Fortunately, CPD might help to make that easier. I think a field like psychiatry is not black and white – I cannot always explain why the things work that I do, I just know it does work.	<pragmatism>
3.6. Describe how you see / experience the OT profession in relation with the	
a) medical profession It has become clear to me recently that when I have to write a medico-legal report I rely on the medical information, to give an opinion about the activities and roles that a person can or cannot engage in – I need the medical information to form a whole picture. In general I do not experience negativity – we also have to get more involved with occupation and how it fits in the bigger picture of a person. Doctors are claiming that they are increasingly becoming 'holistic' – we have to work TOGETHER, it is nice to know where OT fits in.	(aspect)
b) colleagues in other disciplines of health care We have to be sensitive to each other's disciplines and what every one does. I have become aware that there are other disciplines that do vocational rehab but does not know what OT does (that we very much also keep ourselves busy with this). It is not necessarily a problem that other people also might do the things that OT does, but we have to establish and know the boundaries.	(mutual recognition)

Concepts such as 'job-coaching' (also something that OT does) sounds very nice to the public and then they grab to it – we have to educate people, and find out how other persons do the things they say they do, that way we can feel less threatened – we need to ask what their approach are. For example in our church they asked if there are people who wanted to give life skills in a disadvantaged community – I chose not to come forward. A member of the congregation who is a social worker came to the fore, and now she is known as an expert in groups. We are so few (us OTs) one gets tired to fight for the profession, often one just has to survive from day to day.	<survivalism>
c) corporate field They have increasingly become aware of us. We need to show them why they should be willing to pay for our services – in the corporate field Health is not a 'moral' issue – it is either because of legislation or because the workers can become more productive to make more money – us OTs need to understand that. Also if an OT can get into the corporate field many of the decisions are made by men, the OT profession is women. We have to understand the language of business, one has to continue to prove yourself.	<moralism> <capitalism> <gender> <positivism>
d) public The main question remains to be "what is OT?"	(definition)

When clients come see me for an evaluation for medic-legal purposes, 99% of them do not know what OT is or why they were sent to come and see me. We (the profession) are not known, I see with friends also, some of them think you are almost a doctor. If one mentions in one sentence that OTs see children and geriatric people, they do not understand that, it does make sense to them though if one tells them that you help people to go back to work after an injury. I explain OT as follows: It is in the same sector as physiotherapy and speech therapy. OT works with 3 main aspects of humans: a) the way you that you care for yourself and your environment (personal care) b) one's work and c) what one does for enjoyment And if one becomes ill or injured OT helps people to do these tasks again.	
3.7. What in your view is upheld as the major values / ethos in education and training? In my education as an OT the main value is: respect for ALL people, to approach every one as if they have potential, disregarding of what their disability has taken away from them – each person has potential.	(Christian & Feminist Ethics) <moralism>
Concerning "achievement and excellence" – if I do not deliver work of a high standing quality – then I do not get work / referrals. So excellence for me is important in terms of quality work but also in terms of	<achievement>

my business approach e.g. my reports have to be on time. Excellence is the nature of a profession, and it is about being professionally ethical. I have heard some things that some colleagues do that let my hear stand on end. But then again we have to be careful before we judge – we need to have our facts e.g. a colleague used a standardised test in another way as according to the rules of the test – one of the other colleagues confronted her and it came known that she used it for another reason – to observe something else. Maybe it is also about the Afrikaans attitude – we are more conservative, we do these things - it is difficult to separate out personal and professional values. OTs try to get the whole picture – that is how we are taught to approach people.	<professionalism>
3.8. How do you view OT's role (within the context that you are working in) concerning the following concepts: **a) bio-medical model** The role of the medical model in OT is what makes me different from a social worker or a psychologist. But knowing the medical part makes a difference – puts (a person's occupational problems) in context, it helps me to understand why a person does an occupation / activity in a certain way, why he walks in a certain manner, why he needs certain assistive devices, it helps me to understand his disability. I suppose it also depends on the field that you	

work in – such as community might also be different and so much with the medical aspects as the social aspects. **- What do you think of Blair & Robinson who says that OT is in on the margin of the social and medical professions?** Yes, it might be true – we might associate social issues and medical issues with occupation, but it has its advantages as well – it is not necessarily something only disadvantageous. **b) science** Being scientific is our future and our survival – we have to be founded in science to be paid to continue as a profession. A politician made a remark the other day toward the scientific proof anti-retroviral medication as opposed to traditional health "cures" and said: scientifically proven according to which science – there is only one science! **c) political arena** It is about survival for OT in the political field. Politically speaking, in hospitals we are politically seen as being part of the health in hospitals, social workers are seen as a profession that makes a difference in the community – not OT. We have to re-position ourselves as such – advocate for OT, stand up for what we believe in and unite. Personally I do not always have the strength for a "revolution".	<positivism, capitalism, survivalism> <survivalism>

There I have a lot of respect for out colleagues in the government services who have the political contacts. We need representatives in the government who understands the importance of OT, and steps need to be made in the direction of legislation – e.g. there needs to be a legislation which states that before a person can come back to work he needs to be seen and treated by an OT who rehabilitates him before he returns to work. **d) administrative bureaucracy** This is very important in my business – there is no sense in seeing clients and writing the reports but not sending the accounts and statements – you know how it is. **e) research** I think every OT has to take responsibility for research, maybe the implementation of CPD will help with that. The problem is for many there is not incentives to do research – it has no purpose for e.g. to have en extra qualification. Maybe incentives such as discount for registration fees or something like that might help! **3.9. How do you describe the development of OT since you have qualified as one?** There is increasing focus on occupation. Contemporary students seem to have better scientific foundations, maybe less practical hands-on skills.	(NB!)

I do not know if more people know what OT does – I seem to know about the people who did not.	
3.10. How do the following determinants (in your view) impact on the OT profession (examples are welcome):	
a) age	
It seems like it is easier the older I get! [to work with clients].	
One has less anxiety with older clients, or to address emotional problems for example, one's confidence and skills increase, one learns to establish boundaries.	
As a student it seems that one has to be able to do everything, and say yes to every request, like you have to know everything.	<moralism>
I have come to learn that patients often share things with me that they have not shared with any one - because they know I view what they have to say as important – there is an element of authenticity (in the way that we approach patients.	(authenticity) <protective power>
b) gender	
In the corporate world it is important that you have the right image, especially since it mainly men and also especially in the field of vocational rehabilitation and industrial rehabilitation – one cannot arrive in high heels at the harbor!	<maleness>
Concerning OT profession: we need more OTs in positions where decisions are made on a political	

level, people who make decisions are men, things are approached differently in a man's world.	
c) class OTs sees everybody the same and believe that everybody has something to offer, no matter their class. We approach every person as unique person. Also as an OT in education and practice we are exposed to people of all levels. In fact, I often times I feel quite intimidated by rich people (when having to treat them), it feels as if I have to hurry – because they are important. As OTs we deal with everyone poor and rich and everybody has a story to tell – it does not make a difference because for an OT the ultimate question is: "What occupations do they do and how?" You can work with a poor person who is unemployed but very involved in the community or a rich person who is egocentric, only thinking about himself.	<moralism>
d) race Something you have not mentioned is culture. It is very important to understand a person's culture e.g. if a person sits around at home, doing nothing (it seems to us) we need to understand why they are not doing certain activities. Also in practice, culture is often an issue sometimes e.g. one day I saw a Zulu man and before I started with the evaluation I put on some lip ice, and he sniggered, which he would not have done, had I been I man.	<culture> <gender>

- Do you think that cultural competency is addressed sufficiently in education? There is a huge emphasis on tolerance, but I think that contemporary students experience a larger form of integration and transformation.	
3.11. If you could wave a magical wand, what would you want to change about OT? Concerning vocational rehab, we need to find more channels for empowering OT if we want change e.g. if someone got hurt on site, and OT has to notified immediately we need to promote more. Also we need to get to be paid for our services, which are currently not regarded as essential. At least in medico-legal OT does get recognition there.	(recognition) (aspect)
3.12. In your view, what role does creativity play in your daily practice and decision making as an OT? It has an incredibly important role, we have to think and adapt all the time, that is why a 'recipe' does not work when we treat people – people are different, so one has to have creativity and flexibility – I can't see how OT can function without creativity.	

4. Jane (life-skill training specialist) Transcriptions **4.1. Please state your current OT job and give a short description of your experience as an OT** Qualified 1981. 14 years pediatric experience. 2 years not working. Since 1997 I have been at a private practice in a hospital and step-down facility working in psychiatric setting with high level patients. **4.2. Describe your working environment and circumstances in which you are working currently** On the positive side: working at facility where OT plays a central role – it is the core of the treatment structure, OT gets recognition, roles are not threatened by other team members e.g. psychologists. Often pts are referred for OT only, or come in as an out-patient for OT only OT is the 1st person making contact with the patients and walks a road of healing with the patient – improvement, getting better within a few weeks. Work satisfaction is optimal. On the negative side: competition among fellow-colleagues, because there is more that one practice on the premise. OT is dependent on referrals from doctors, so there is competition for referrals. One has to work really hard to get referrals, and then you have to work hard to keep them –	(recognition) <achievement> <elitism>

to keep the doctors satisfied. Also, the involvement of other disciplines threatens to cross the boundaries of professional therapy, they want their inputs into the program, or want to have a list of what exactly is going on in the standard program – that makes it difficult because now one has to establish boundaries. Often nursing personnel (e.g.) want to get involved with groups – but they do not understand the nature of the groups that OT presents	<capitalism>
We have to keep doctors and nursing happy, everybody wants to have a say and OT are often caught in the middle – and often we are the ones who have to compromise.	<moralism>
4.3. How did you come about to study OT? I started studying teaching. In my days the only professions that were marketed were teaching and nursing for women, and medicine and theology for men. But I had a friend who were a physio and who studied OT. That is how I heard.	
4.4. How did you experience your education en training as an OT? Diploma in Pretoria – I was one of the last that had the diploma training. The following year they changed it into a four year degree course. The diploma course was really tough, there were 30 allowed but only 11 graduated. Especially the 2nd year was very cramped with all the odd subjects. The final year was practical. It was enjoyable tough, but we worked hard.	

Also we had the medical subjects in the second year along with the 4th year medics – we received info on pathology for example but would not understand or have knowledge about the processes involved in something such as septicemia for example. So they offered extra courses at the college so that we can come around. In my view we really did not receive much training in high-level psychiatry for example, or adequate pediatric experience. I did not enjoy the physical areas, the therapists worked there because they had to.	<natural scientism>
4.5. How do you view the relationship between OT practice and education? As a student I suppose it is impossible to learn everything at university that one needs to practice as an OT. OT is too broad for that. In the times that I have studied, there was an enormous difference however between what we learned at varsity and what we needed to know to practice. I started working in the (the 1st in the country) pediatric private practice, working for a senior therapist. Fortunately there was someone who taught me how to evaluate and treat children. One had to perform, there were no time to waste, one had to see a child for 40 minutes, have his homework ready and give feedback to the parents. People were paying for treatment and one had to show that the child is progressing.	<achievement>

This was incredible pressure, probably not to my benefit in the long-run, it reinforced my over-'responsibleness'. We even had to see children in holidays as they came from all over the country. In terms of "achievement", there is no grey area, one has to perform at the optimal level, sometimes at the cost of yourself. In terms of the connection with the university, I enjoyed the journal discussions the university had once.	
4.6. Describe how you see / experience the OT profession in relation with the	
a) medical profession	
Doctors still do not know what OT does, especially GP's. If we could get the patients when they start to have difficulty to cope with stress, and consult their GP's for anti-depressants and so on, our input could be of much greater preventative value and that would make a huge difference to patients.	<medicalism, elitism>
There is still an attitude among most of looking down on us, but we also need to market ourselves properly, Drs either do no know what we do, or have a limited idea of what our job entails – e.g. I heard a doctor saying, "Oh yes, I know the OT's organise the wheelchair rally on campus each year.", or "yes, my neighbor is an OT and she works at a school".	<elitism>
b) colleagues of other disciplines	
Neither do other disciplines know what we do such as the psychologist. Currently there is an attitude	

among nursing at the facility that they can present the same type of groups than we can – unfortunately they do not understand the complex dynamics that us OTs are able to use in groups, they think we only give lectures and information. Often it seems physios are often threatened by us, if I see how often they do things that we usually do. The boundaries are grey. But then also, us OT's are often also not available such in a surgical ward for example. I had a back operation recently, there were no OT to tell me how to cope with ADL's – the physio told me to stand and eat. We was the OT? The specialist says that an OT once gave him an entire compiled 'book' of what OT can contribute with the rehabilitation of back patients, yet no OT is available to see these kind of patients. **c) corporate field** I still think we can play a huge role there, especially on a preventative level such as stress management, life skills, recognising the early signs of stress. On a Monday at the facility we let the patients fill out a questionnaire of the signs of stress that they have been experiencing. Most of them will stand in amazement saying:" they never knew they were experiencing serious stress. If people in the corporate field can learn to acknowledge the early signs – OT can play an important role here. Often times I have had clients from Telkom, or Eskom or Banks that say: "I whish my colleagues can learn what I have learnt." One client actually invited me on a work	(aspect)

weekend to present some groups at his company - Unfortunately I could not do it, I do not have the time. **d) public** Still a lot of ignorance. They do not know what OT does, except maybe that we work with children. Some psych patients for example even think that we teach people to read and write, until they come to the groups. Then they often say: "I cannot believe that you guys do these types of things" **4.7. What in your view is upheld as the major values / ethos in education and training?** I do know really. I know as students talk, many of them are afraid that they don't get a job after they have qualified, they are uncertain about the future. Some who are going overseas say they don't know if they are coming back because where will they find work? And many young therapists are worried about medical aids – if it will be viable to work in a private practice. **4.8. How do you view OT's role (within the context that you are working in) concerning the following concepts:** **a) bio-medical model** Patients have a bigger struggle with medication and are often prone to stopping to use medication	<medicalism, positivism, capitalism>

too soon , not using it correctly or stopping to take it as soon as they start feeling better. Many of the patients will rather come to OT than taking medication. But on the day that they are usually discharged, we make sure to relate to them the importance of taking their medication and taking it properly. The first intervention usually determines the prognosis, so if they use the medication incorrectly that could end up in them being ill for a much longer time. The patients who usually do not want to come to the groups are similar professions such as social workers, psychologists, and pathologists – I had 2 of those – these are the difficult patients, because they say they don't have to go to the groups, they "know what to do". But if they did, they would not have been there in the first place.	
b) science We have to be able to prove that what we do works. We need research that shows that OT groups work – we know group therapy as a whole works, research about that has been done, but we don't know about OT specifically. Medical aids want evidence, there is a great need for us to do research.	<positivism, capitalism>
c) political arena Can we add this to the section of 'race'?	
d) administrative bureaucracy Because OT is the core program at the facility, we have to administrate everything regarding the	

program. There is so much that one does that you get nothing for, not that it is about money – there is no compensation. And then of course the medical aids that is an ongoing struggle, we have a lot of problems of one of the bigger aids again now. But (our practice) we see a lot of patients for free. Sometimes that is necessary, I cannot get it over my heart for a patient to sit in his room while a group is held, if he really needs it. But I have learned to judge correctly, most people we make a compromise with such as writing off one week's groups or giving discount, or making an arrangement to pay it off. But there is also plenty that we see for free. My argument is that I have to do the group anyway for 10 people, one person is not going to make a difference. Some say that I cannot think like that, but that is how we do it. Concerning the medical aids, in comparison with other areas of health, psychiatry often comes last.	(morality) <positivism, medicalism, capitalism>
e) research We need a lot of research, that will be the survival of the profession, and that is the only way we will get paid for what we do.	<ditto above>
4.9. How do you describe the development of OT since you have qualified as one? Tremendous development, and continuously so! If I think about an area such as medico-legal, that was non-existent when I qualified.	

And about the constant advances in pediatrics for example. One has to keep with it all the time, if one leaves the profession, it is very difficult to get back into it again. Even with my experience of pediatric OT of 14 years, it would be very difficult for me, to try and get back into that now after 10 years. One has to stay involve the whole time. **4.10. How do the following determinants (in your view) impact on the OT profession (examples are welcome):** **a) age** In psychiatric field, doing the kind of job that I'm doing, young therapists are unable to step into it straight away. Somehow it requires a kind of life-experience. Often times, patients also say that a young therapist is only a child. It depends on the field I think. But for example how does a young, unmarried OT counsel an older man about marital problems? I have found though, that sometimes young teenagers like to consult with a younger therapist, on other side, a teenager told me that she appreciates an older therapist, because of a need of the 'mother-role'. I have thought about when I should retire! Sometimes there are older therapists though that has been out of the profession for some time and have not stayed with it, then they want to come back - they do the profession harm.	

b) gender Maybe there is a greater kind-disposition toward a woman, being in psychiatry. I do not think doctors would have treated us the same way if we were men. Doctors can walk over you though - some doctors just assume that you are always available to organise things for them.	<patriarchy, paternalism> maleness, <medicalism> <elitism>
c) class I do not think OT's judge on that level. We have empathy for people who suffer, we have a softness, we try to involve them where we can. And when we give discount for example we handle that with sensitivity.	(moral ethics)
d) race It's difficult. Normal development in terms of culture is different, e.g. the concept self-image at black patients. There black therapists would have been better, but then again there are many black patients that remain seeing white doctors (while we have had a few Black psychiatrists on staff). And then again the issue of gender within culture, some cases I know for example that a black Zulu man would have a lot more respect for a male OT than a white female one for example. We once had the case of a Sotho woman from Lesotho that held a high corporate position, and she had an attitude problem because she felt that we did not treat her with the respect that she deserved because in her culture her community members	<culture>

would have extra-ordinary reverence and respect for her. For us it is just another job.	
Do you think that cultural competency is addressed sufficiently in education? I think there is a gap e.g. I have seen therapists growing up on a farm that is able to connect with black patients in another way than OT do that grew up in the city. But then again, not all black patients should be treated the same way than blacks who have worked on a farm. My husband tells me that I am too good – in many African cultures being nice and good is seen as a weakness and then it is abused, combined with being a woman.	
4.11. If you could wave a magical wand, what would you want to change about OT? I wish so that competition was not a factor. It is hard for us to realise that our job is also a business. I find myself not wanting to talk about the business part of my job. But the issues are palpable, it is present all the time and you have to unexpectedly deal with it there and then. For example a psychologist deciding that I as an OT could mean more to his patients than the competition. One could see how parties are canvassing for referrals or as in the case of my opposition seeing one day how the patients of a psychologist who usually referred his patients to her, suddenly come to see me. She [the other OT from the opposition practice] would then come to me saying :"I heard that Luke [pseudonym] decided to refer his patients to you because he	<achievement, survivalism, capitalism>

feels that you will be better for them than I". This is difficult. Often we also have to handle the (political) decisions that doctors make, we have to know how each doctor prefers doing things. Some doctors like to have feed-back, others do not. There are a lot of ethical aspects to deal with, but actually there is enough work for everyone.	<elitism>
4.12 In your view, what role does creativity play in your daily practice and decision making as an OT? I think it plays a continuous role, because we have to make decision from moment to moment. Every patient is different, from moment to moment one has to creatively solve problems, Many patients have depression, but each has it for a different reasons. Every moment (you have think creatively) when having to answer questions I groups, during therapy (dealing with each individual case), giving different tasks to each patient according to each individual's unique circumstances. Creativity is like moss – it grows on you as you go along and becomes part of who are – it is the whole time with you.	

The following interview was also conducted with Clare in view of obtaining some information about the historical development of OT in South Africa.

Clare

Interview B

1. How as OT changed?

- From one to one to population service provision
- We went from direct to indirect service provision
- From hands on to management services
- From using person resource to community resource
- We advocate for the disabled
- From independent professionalism to clinical reasoning evidence
- From hospital / institutional approach to community based approach
- From the medical model to the social model
- From that we could do what we felt was right to a required awareness and knowledge of legislation and policies
- Spirituality of the patient is also more recently acknowledged as integral to true recovery of the person.

There are phases:

Meaningful activities – then we went into

Techniques and everything around that then

We obtained a balance of doing meaningful occupation with our clients, a more scientific

approach. **How do you view purposeful vs meaningful?** An activity can be purposeful without being meaningful. Meaningful occupation is a personal experience for a patient. That links with client-centered approach. **2. How if at all, has the following concepts changed in OT?** **- moral consciousness** That is still an integral part of our profession, doing good. This moral consciousness is part of the Christian ethic, of you look at the vast majority of OTs qualified, the service ethic, care to others and underprivileged, sacrifice of time and effort, making the best of a given situation, 'loving' the patient, showing concern and empathy – these are all basically Christian ethics **- economic considerations** It seems that it always have been a struggle, I cannot remember that we ever had an abundance of resources. Poverty has always been an issue that we had to deal with when treating patients, (in my view patients are poorer). An ethical consideration is that how a lack of such	<economism>

resources and basic needs impact on treatment of patients, in the sense of jeopardising care and treatment, this leads to ethical stress for a therapist. Aids/HIV also brings about serious ethical considerations in terms of patients who are terminal. Policy and legislation is affecting us to a greater extent, how we do what is not pre-determined. Where *beneficence* and *non-malevolence* were previously primary ethical considerations, ethics in South Africa has developed where *autonomy* and *justice* are primary imperatives. But OTs have the ability to cope with these changes and developments, because we seem to always make plan ("maak 'n plan") – that is another place where our creativity comes in.	
- pragmatic approach I cannot see how we can do without that in practice, we have to be pragmatic in the kind of job that we do. I do not see this concept in opposition with science, but we need also to be theoretical and analytical, otherwise we may only function as occupational therapy assistants.	<pragmatism>
- research When I qualified in 1965, the concept of research seemed vague. More emphasis has been placed on this but we still have a far way to go, there is an urgency to do adequate research, which in my view should be more qualitative because we work with people.	

EBP has a role, but it is not the be-all or end-all. In principle it is good and correct but in practice it is difficult to execute, especially in SA it is time-consuming when one has many patients or clients, valuable time that could rather be used on patient care. **- education** A lot has changed, it has become a collaborative effort, also interactive, problem-based. The methods have changed also. We need to cope with students with different educational preparedness levels. **- bio-medical model** already covered **- functional approach** I is part and parcel of being an OT. Intervention must be planned in collaboration with clients - what is needed to be functional – it is at the same time meaningful to them. **- creativity** One could probably say that someone who practices poor OT, lacks creativity. **- inter-disciplinary relations** I think this has probably developed the least of all. There is still a lot of suspicion, a lot of old issues of who is better than the other.	

Often however, these issues become non-relevant when we work TOGETHER – but can still get heated up about our “turf”.	
How do you view the dilemma necessary at time inter-disciplinary work where resources are extremely limited? There are serious ethical considerations here and guidelines that are prescribed by the board (HPCSA), it required serious thinking. The question is who is benefiting the most – the patient or the therapist? Inter-professional practice is only acceptable in seriously disadvantages areas such as only having one health professional in a certain district (e.g. one OT or one PT). This person is often needed to perform acts from the scope of other professions e.g. some speech therapy. It is however unacceptable where it is only for he benefit of the practitioner and rich clients, e.g. PT making hand splints or using acupuncture – who controls the quality?	
What about other professions using activity? Anybody can use activity, we do not have single rights on this BUT if we do OT properly, we need not to be defensive of this, OT and what WE do with activity will speak for itself.	
We bemoan other disciplines venturing into vocational rehabilitation for instance, but how could we protest if WE are not doing what needs to be done in this field? We sit in offices and do endless paper and pencil activities.	<patriarchy-paternalism> (aspect) <admin>

3. Main current trends in OT?

- Shift from the medical to the social model
- Increased awareness in ethics, policies and legislation = and we have to be
- Movement toward management of services – this is hard for OT,

we have a broader focus on community development, our roles has changed to a more facilitating role.

- we could also play a bigger role in medico-legal practice and the insurance industry
- we should also be moving much more strongly into the 'work area' even for non-ill individuals

4. Major obstacles in OT profession?

- poor role models, which contributes to an OT image that is poorly defined
- lack of marketing (this is a world-wide problem for OT) – according to WFOT council meeting in Cape Town, 2004.
- Increase in alternative therapies that is taking over many of OT's scope. These people are often not trained adequately or even not qualified – they tap into a consumer-awareness that we should be doing – we need to look at that.

  Examples are people that manage income-generating community projects,

  Stress-management, job coaching, life coaching.

The effect of this is that while we are trying to move more from Hospital and Institutional based care into community health promoting areas, these 'alternative therapies' are pushing us back to the former.

We need to take initiative - because this lead to us going back to the medical model, so to speak.

We also have limited posts in community settings and too few OTs available: 30-40% of posts in DOH are vacant at present.

5. OT definition

OT enables an individual to cope with his/her life roles and tasks at his/her highest possible level of performance. When seeing a patient, one question can be asked:

What must this person be able to cope with?

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