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The Elizabeth Casson Memorial Lecture 2011: Occupational therapy – a profession in adolescence?

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Key words:
Professional concerns, professional identity, professional development, professional maturity.

The Elizabeth Casson Memorial Lecture 2011, given on 30 June at the 35th Annual Conference and Exhibition of the College of Occupational Therapists, held at the Brighton Centre, Brighton, Sussex.

Introduction

It is a huge honour to be asked to speak to you this afternoon. I have been absolutely thrilled, and not a little scared, by the opportunity to talk about a topic that has fascinated me for many years. I have been an occupational therapist for a long time and, while it may be that I am coming to my personal sell-by date, what my long career has given me is the opportunity to watch our profession grow and change while having the ability to be part of its development. Trying to understand our professional sense of self has been a personal exploration that has led me to many puzzlements and several light bulb moments, and has given me insight into the what and why of our profession's journey.

The joys and successes of occupational therapists are many, and this week we are rejoicing in them. We have seen occupational therapists honoured in The Queen's Birthday Honours List, and hear that much of what our profession achieves is so positive. We hear reports of the Prime Minister singing the praises of occupational therapists during a speech in Ealing Hospital in May this year (*Occupational Therapy News* 2011a) and, in the same month, of HRH The Princess Royal recognising that occupational therapists' ability to 'evaluate and measure in a much more constructive way has changed out of all recognition' since she became Patron of our professional body in 1987 (*Occupational Therapy News* 2011b, p10). However, parts of my exploration have been painful and, at times, personally embarrassing. We hear of occupational therapists being made redundant, of the loss of leadership posts and still of people asking: 'Occupational therapy? What's that then?'

So, what I want to share with you today are some of the outcomes of my exploration, which will hopefully help to explain where I believe the profession is in its journey and, more importantly, how we can use this knowledge to show us the way forward. If, as I would like to propose, we see our profession in a state of transition, we can then more readily accept our strengths and weaknesses, and learn from the ups and downs of our journey as we venture forth towards professional maturity.

In the grand scheme of things, occupational therapy is relatively young. But this young profession, now numbering over 32,000 practitioners in the United Kingdom, has, throughout its history, suffered crises of confidence and identity and, at times, has felt misunderstood and unappreciated by both colleagues and the public. In trying to make sense of its position, I have become aware that some of the issues that appear to concern us arise from within the profession itself. While our profession's sense of itself has, without doubt, improved over recent years, somehow the rising body of

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knowledge about the effectiveness of the therapeutic use of occupation on health and wellbeing has not altogether addressed our core issues of professional identity and confidence. Let me show you what I mean.

'I think occupational therapy is …'

To help look at this issue, I held a straw poll of the University of Northampton's brand new students, finalist students and practice educators. I asked them all to answer the same initial question, 'I think occupational therapy is …' On analysis, there appeared to be a consensus about what drives our professional thinking. To my delight, *brand new students*, polled in the first month of their course, talked about enabling people to use their potential, to take back control over their lives and to do what is important to them. They told me this was done through using meaningful activity. Pretty good, I thought.

Finalist students had, thank goodness, also 'got it'. They talked of enabling or empowering people to engage in meaningful occupations by facilitating occupational engagement. *Practitioners*, too, talked of enabling people's optimum function through the engagement in meaningful and purposeful activities.

So there appears to be no misunderstanding about what we are trying to do, what Higgins, when talking about identity in 1987, called the ideal self. What then are the issues? Let us look at what practitioners and finalist students said when asked if there were tensions between their perceptions of occupational therapy and the realities of practice. Several themes emerged.

Understandable concerns

Understandably, people talked about budget constraints, frozen posts, lack of resources and the tensions between organisations' drives and the profession's drives (Fig. 1a). These, I guess, are universal tensions, not only in our profession and doubtless not only in health and social care fields. While concerning, it is probably a 'given' in this challenging financial climate. Finalist students, in particular, were concerned that what they saw differed from what they learned, and I am certain that this is not a profession-specific phenomenon.

No, it was not these comments that necessarily concerned me. The themes that worried me most were not new.

Themes about perception and identity

First, they related to a perceived *lack of understanding about our role by other health professionals* (Fig. 1b). Sadly, this feeling has been around for many a year and the strength of the theme made me think that things are not improving – look at some of the things that were said. I was not fundamentally concerned about the fact that people felt that the profession was misunderstood; I imagine this is true of many professions. No, what concerned me was the link between misunderstanding and dismissal.

Professor Annie Turner, in a challenging Elizabeth Casson Memorial Lecture, talks of the tasks facing us if our profession is to reach maturity.

Secondly, comments related to the *quality of our perception by others* (Fig. 1c); again look at what was said. How sad that our finalists felt that occupational therapy is underrated and underused and that it lacked respect by others. What on earth has happened that has made a practitioner of 6 years standing say that occupational therapy is seen as lightweight and fluffy?

Lastly, and perhaps most concerning of all, were the *perceptions of ourselves* (Fig. 1d), our lack of passion and ability to promote ourselves. It would seem that some occupational therapists are really struggling in multiprofessional teams and have trouble with their unique identity. It also seems that finalists saw some occupational therapists as gap fillers, unable to articulate what drives their practice and, consequently, not being perceived as equals.

Fig. 1. The tensions between perceptions of occupational therapy and the realities of practice. 1a. Understandable concerns.

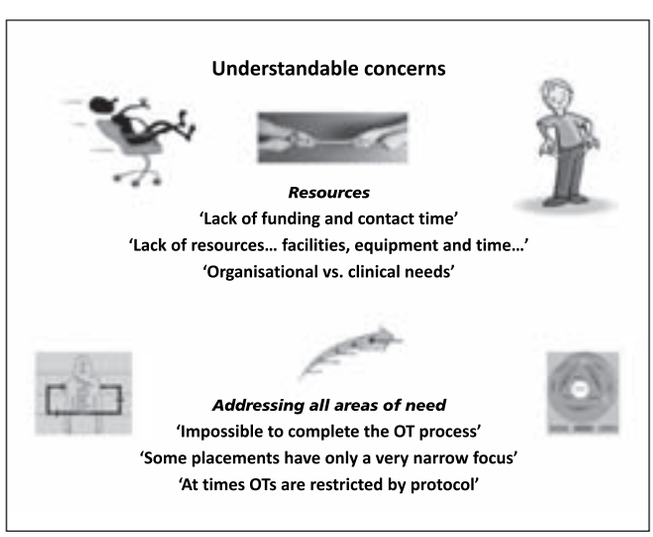


Fig. 1b. Understanding about our role by others.

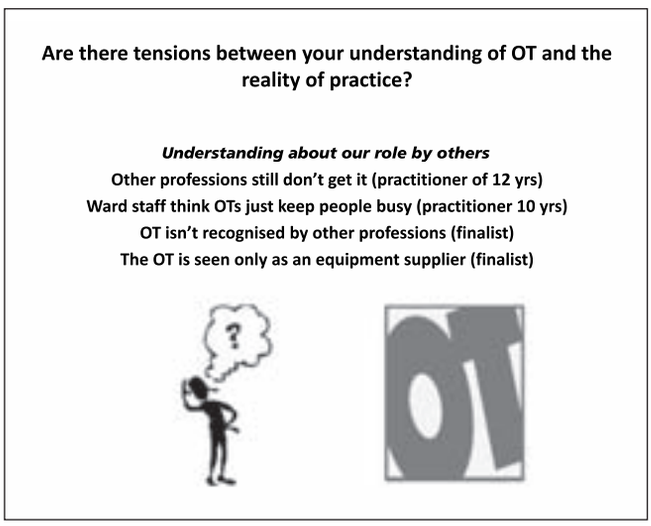


Fig. 1c. The quality of our perception by others.

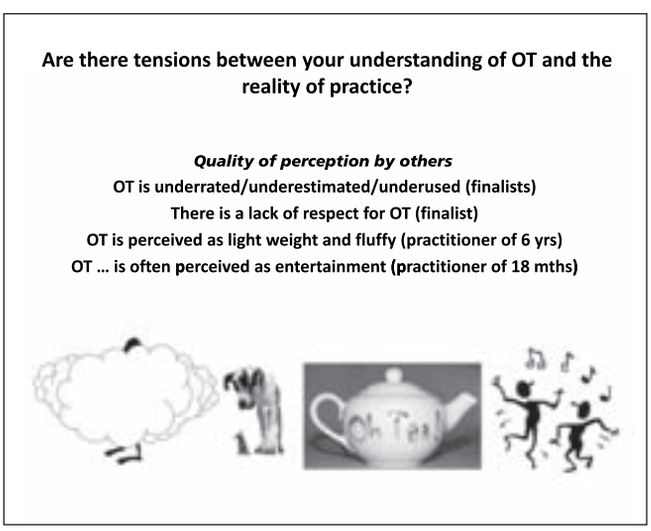
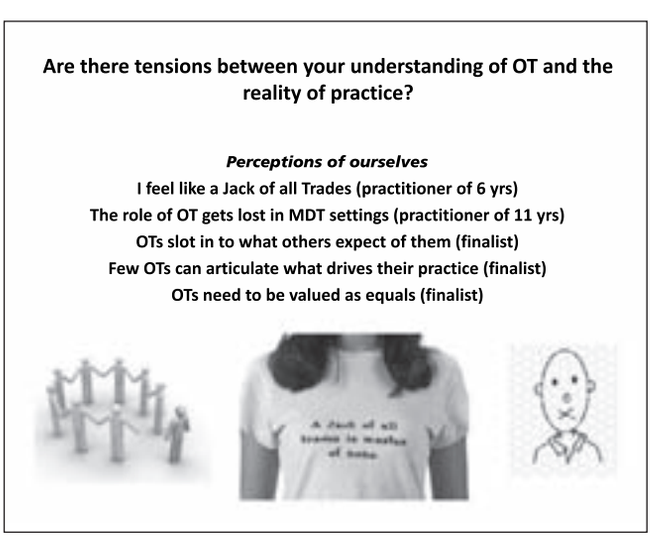


Fig. 1d. Our perceptions of ourselves.



These last three sets of themes really saddened me and made me determined to find out more about what is going on. Our confusion and lack of conviction about our identity set me off on the trail of researching how identity is developed and maintained, and what may have gone wrong for some occupational therapists.

The importance of self-identity

In 2005, social psychologists Hogg and Vaughan, working with theories of social interactionism, proposed that a sense of 'self' is constructed as we develop and that it is shaped by our social interactions in a way that reflects how we believe others see us. They saw that the ideas that we carry round about what other people think of us are a fundamental part of our identity and if, as we appear to be seeing, interactions with others can be less than positive, this builds in us a poor sense of self. It is easy, so easy, to be negative and to moan when we feel our professional identity is threatened. It is easy to dismiss this evidence as the straw poll that it is. Nonetheless, it seems that occupational therapists' issues with their identity remain an underlying theme.

Erik Erikson, as we know, also studied the development of identity in the 1950s and proposed that our past shapes our future. He felt that while the past cannot be changed, exploring the meaning of what has happened helps us make sense of it and underpins our future identity. In 1999, Christiansen, an occupational therapist, argued that self-esteem is related to our beliefs about our self-efficacy, in that effective action (in our case our professional practice) leads to social approval and an enhanced sense of self. How important it is then for us to achieve a strong, positive professional identity by ensuring that our professional actions are clearly and uniquely identified, proven to be effective and relevant to our current society. So, mindful of Erikson's idea, I set forth to search for an explanation of our position.

Heritage and environment

From my explorations, I began to believe that a large part of our issues has arisen from a tension between our heritage and the environment in which we were grown. I began to see that a profession, like any individual, needs a nurturing environment and a strong heritage to grow in stature. To gain self-esteem, it needs respect, affirmation and a sense of identity and purpose, and so I began to explore our heritage, beginning my journey with two Greek gods.

Asclepius

For the first line of occupational therapists' conceptual heritage, I began with Asclepius, the Greek god of medicine and healing. Asclepius had skills in surgery, drugs and love potions. This lineage of healing through medicine and cures for sickness, a paradigm that has long held strong sway over Western thinking about health, can, perhaps,

for the purposes of our debate, be viewed as occupational therapy's paternal heritage.

Hygeia

I felt that the maternal line of our conceptual heritage came from Hygeia, who was seen by contrast as the guardian of health, cleanliness and sanitation. She symbolised the prevention of disease and the promotion of a healthy and sane life in a pleasant environment. Initially, the Greeks celebrated these two cults together. However, as the status of healing, medicine and disease evolved, the cult of Hygeia was reduced to the status of handmaiden.

Champions of the paternal line

If we fast forward to the 17th and 18th centuries, we can see, in the West, the emergence of reason and the start of modern philosophy. This rationalism gave rise to modern science in many forms and science began to dominate and change our environment and thinking. To an extent, we in the West still live in a world dominated by science, in which evidence and fact hold sway and command status.

Towards the end of the 18th century, however, the maternal line of Hygeia began to raise its head. The French physician Philippe Pinel took an enlightened view to the treatment of mentally ill people, releasing the inmates of asylums from their shackles and advocating exercise, occupations and labour as treatment. Here, then, was the manifestation of health through doing, the concept of self-health advocated by Hygeia.

Social philanthropy

As a reaction to the dominance of science, the 19th and early 20th centuries saw the rise of the Romantic Movement, which celebrated the freedom of human thinking. John Ruskin, an art and social critic, believed in the dignity, pleasure and identity afforded through creating objects by hand.

Ruskin purchased three slum houses where Elizabeth Casson worked, espousing the ideals of philanthropy, creativity and engagement. When she later trained as a doctor, she reflected on this philosophy and said that she found it very difficult to get used to the atmosphere of bored idleness on the wards. She was convinced that occupation should be integral to treatment. Dr Casson, as we know, established the first occupational therapy school in the United Kingdom, having inculcated the ideas of both Arts and Crafts and medicine, and thus becomes the manifestation of the conception and birth of occupational therapy from a brief union of rational and romantic paradigms.

Occupational therapy's development

So, in the early days of the 20th century, the profession of occupational therapy was born in the United Kingdom: the child of dual heritage, inheriting doctrines from both medicine and moral treatment. To help explore its progression, I want to chart its growth against theories of child development (Fig. 2).

*Fig. 2. Our profession's developmental life stages (*based on Lougher 2001).*

The profession's development ?

Developmental stages*	The profession's development
Infancy: Develops attachment to care giver. Adults have power and need to be obeyed.	**Early C20:** OT is attached to both maternal and paternal sides. It obeys the rules, set mainly by dad.
Childhood: Care givers are role models. Delight in learning. Achievements lead to self worth. Failure leads to over compliance, a feeling of never being good enough.	**1930s-60s:** OT eagerly learns theories of other professions. Never quite meets dad's approval though adopts his ways and words & tries to appease.
Early adolescence: Seeking to know who they are and what they are worth. Tension between adolescent/parents & high/low esteem. Self worth related to peer value. Questioning and gaining education.	**1970s-80s:** OT tries hard to find out who it is and what it's worth. Tensions with relationship with mum and dad. When answers to its queries are not positive it develops severe loss of self worth. It looks around to see how its peers value it.
Late adolescence: Transition and change. Establishes personal identity in preparation for adulthood. Peer group opinions paramount. Tension between adolescent autonomy & parental authority. May defy parental values. Sense of excitement & challenging the old order.	**1990s-?:** OT begins to establish its own identity, language, friendship groups and ways of doing things. Sense of excitement and challenging the existing order. Begins to renegotiate its relationship with dad. Mum's values become more respected.

*Lougher L 2001 Occupational therapy for Child and Adolescent Mental Health Churchill Livingstone, Edinburgh

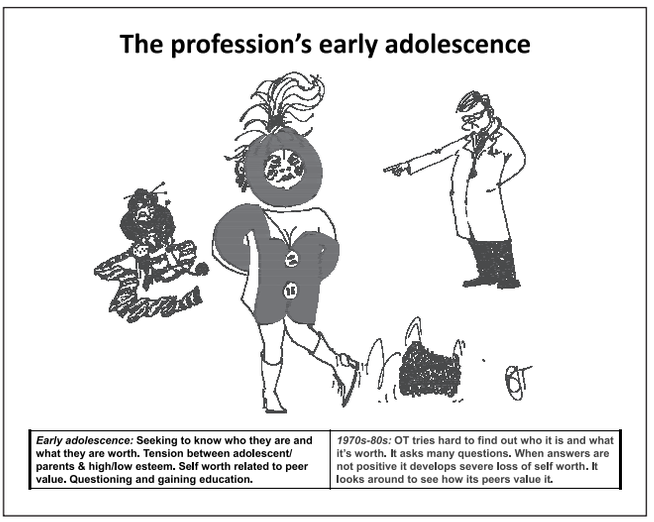
Occupational therapy as an infant

As a dual heritage child, both Ward (2006) and Bracey et al (2004) showed us that occupational therapy was likely to have issues of self-esteem and identity, and thus it proved to be. Occupational therapy was established and staffed almost exclusively by relatively well-to-do women, and early occupational therapists embraced Hygeia's ideals of self-fulfilment and growth through creativity, although working in hospitals meant that they were dominated by the rational ideals of medicine. They used craft almost exclusively as the medium for treatment and were proud of the part that they played in the rehabilitation of wounded soldiers. However, in 1925 Haas, an American occupational therapist, directed that 'the work must necessarily be carried out under medical direction' (cited in Turner et al 2002, p12), and so our technically skilled occupational therapists lacked any sense of professional autonomy and vision, keeping the profession's relationship with medicine as that of a dependent child.

Occupational therapy as young child

With the status of the pioneering developments in medical science outstripping that of self-health, occupational therapy gained its status vicariously through its father's side, but had difficulties inculcating his values and beliefs. At this time, then, occupational therapists became, in effect, a minority group within medically dominated health care, and I wonder to what extent this remains the case? As Inman et al (2007) and Derrington (2005) showed us, the effects of being a member of a powerless minority group can cause issues of poor identity, lack of guidance and status. In 1940 for example, Cooper, an English occupational therapist, reported that it was important that occupational therapy projects 'would not spoil tables and make a mess' or

Fig. 3. Occupational therapy as an early adolescent.



'antagonise [the] nursing staff'; clearly, appeasement became one of occupational therapy's early tools of the trade.

So, to gain acceptance in their paternal world, occupational therapists began to adopt the appearance and corporate values of the illness agenda, focusing on the remediation of impairment rather than the development of self-health. However, I believe this childish strategy formed the basis of many of the identity issues we carry today.

Within general medicine, craft was slowly dismissed and occupational therapists jumped on the bandwagon of technical machinery, borrowing theory bases and specialist techniques from other professions in an effort to prove themselves to be 'scientific'. While, following the Mental Health Act of 1959, occupational therapists played an important role in returning people to the community, their slowness in transferring to community-based practice until much later saw them remain based in hospitals, suffering the consequences of the continued need for medical direction and approval. In addition, our registration under the Professions Supplementary to Medicine Act in 1960 did little to assuage the feeling of subservience: the handmaiden status was publicly kite-marked.

Occupational therapy as an early adolescent

The profession continued to struggle to find its identity and vision for the future during the 1970s and 1980s (Fig. 3). This early adolescent profession did not understand its mother's values and was at odds with the dominating values of its father. It even considered changing its name in an effort to give itself meaning, but did not know how to articulate its needs or where or how to look beyond itself. As the profession was still, in effect, functioning and thinking like a child, dependent on others for its actions and focusing on the here and now with no vision of the way forward, it had neither the skills and networks nor the confidence to direct itself towards an independent future.

As with many early adolescents, however, a range of small changes began to have an impact on the profession's sense of itself.

Occupational therapy educates itself

The change of pre-registration education to first degree level potentially gave occupational therapists the knowledge and skills to begin to explore, articulate and measure their professional practice. While initially this academic growth was unfocused and tended to involve more and greater understanding of the theory bases of other professions, occupational therapists slowly began to question who they were by exploring and critically appraising their unique contribution to health through the use of occupation. As qualitative methodologies developed, they were capable of producing more meaningful evidence about their contribution to human wellbeing, and as they gained confidence more people began to publish.

Occupational science

The emergence of occupational science has enabled occupational therapists to create a language and concepts of our own, and has begun to allow us to explore the evidence base about the occupational nature of humans that we had craved for so long. As a profession, we have long held a well-defined philosophy, but a philosophy is somewhat ethereal and hard to defend. Occupational science, on the other hand, enables the growth of an evidence base to defend our philosophy, contribute to practice-based research and support everyday practice. It also has a comfort of fit with the scientific paradigm in which we exist, but I believe we must take care.

Grasping at new knowledge and skills, which may be partly understood or carelessly applied, will not help our profession and, like an adolescent, grabbing new knowledge and using it carelessly, or without the wisdom to evaluate it, does not necessarily lead to maturity. Occupational science itself, of course, is still in its infancy and, as yet, lacks critical appraisal by our profession. In our enthusiasm to own a unique theory base, we must take enormous care that we do not indiscriminately jump on another bandwagon that appears to be passing our field of vision. I personally believe that occupational science has much to offer occupational therapists, but we must contribute to its growth and application with caution and scholarship and with our eyes wide open.

Late adolescence

As it matured, occupational therapy developed its own United Kingdom and international colleagues who were hugely influential, as you would expect in these teenage years. It began to see that while international colleagues held the same values, they might go about things in a very different way. Seeing occupational therapists in other countries work with the occupational needs of street children, in war zones and with the homeless and immigrants, for example, has given us insights into a very different way of practising our profession that is readily in tune with our philosophical beliefs. It has helped us begin to evaluate our relationship with our parents, taking from them the best they have to offer and, more importantly, rejecting those values and practices that do not fit or take us where we want to go. I believe that this is where occupational therapy's development has reached, and that what it needs to do now is to mature into adulthood.

Remember adolescence?

Erikson tells us that identity is seriously addressed in late adolescence. Seeing our profession at this developmental stage may, perhaps, help our emerging sense of identity, and assuage us from the guilt we feel that we cannot always maintain our sense of self when we find ourselves engaging with stronger, bigger and longer-established groups. If we think back, we can remember how passion, angst, self-doubt, peer group pressures and blaming others for our misfortunes are normal features of late adolescence. The concept of a profession in transition from adolescence to adulthood allows us to consider what it is we have to do to gain professional maturity, a strong, unique identity and a sense of purpose and drive.

The maturing of occupational therapy

Having come to this conclusion, I then wondered how we should go about identifying and tackling the path ahead of us. Of course, to strive for maturity we need to know what we are striving for. What is this Holy Grail of professional maturity that we seek? For me, our mature profession will practise true to its beliefs about the impact of occupation on health and wellbeing, working autonomously in a wide range of contexts in adult relationships with service users and strategic allies.

In 2000, Pour and colleagues explored the growth of maturity of a profession. They felt that a mature profession possessed nine infrastructure components: a recognised body of knowledge; professional societies; a code of ethics; a professional education system; accreditation of educational programmes; skills development for those entering practice; continuing professional development programmes; certification of professionals by the profession; and government licensing of professionals. Their analysis gave me much to ponder when I applied it to our profession. We are, I believe, well on the way. It was comforting, when I looked at the analysis by Pour et al (2000), that we fulfilled all elements to some extent, although what my analysis confirmed for me is that we still need to work on our identity, defining our uniqueness and ensuring this drives our practice, wherever it may take place. Shored up by this analysis, I went on to explore how we go about achieving these goals, and found work by Roisman and colleagues (2004) that seemed to point the way – things were beginning to fall into place.

Roisman et al (2004) proposed the need for adolescents to have completed three salient tasks successfully in order to gain success as they mature into adult life. I have applied his three tasks to our profession, looking at academic success as the tasks facing education, appropriate conduct as practice competence, and building and maintaining friendships as the construction of strategic alliances.

Task 1: Tasks facing education

First, let us look at academic competence. As an educator, I could bore the pants off you about what I consider to be the issues that face occupational therapy education – but I promise I won't. Instead, I want to look at just two aspects. In their article, Pour et al (2000, p2) also proposed that 'A major symptom of a not-quite-mature field – is the wide gap between education and practice'. This gave me food for thought indeed. When I reflect on the thinking needs of occupational therapists and our ability to work with concepts and tacit knowledge, I am convinced that building a concept-based workforce, with the ability to appraise, critique and manipulate ideas, to practise according to its doctrine and vision and to be supported by a range of transferable skills and reasoning, is the most powerful strategy for our profession. It holds far greater potential for future development than educating a predominantly skill-based workforce, which suits the here and now but lacks the ability to read and affect the future. However, if we educate graduates who cannot produce the goods in the current field of practice, we do everyone a disservice. For me, a symbiosis between education and practice is one of our profession's ongoing challenges – to instil our graduates with a cast-iron professional identity and a passion and vision for our profession that will serve them in the future, while at the same time ensuring that they have the expertise to enter the present workforce. If we can crack that one, and we all have to trust and respect each other to do so, we will be well on the way.

To hold and develop this vision, passion and reasoning, we have to ensure that we have the right people on our programmes. Of course we need primarily to ensure that they have the right personal attributes to make a good occupational therapist, and of course we admit people through a range of academic criteria, but my explorations of A level entries proved very interesting (Fig. 4). If we track the ever-rising national trajectory of A level results, we see that in 2010 52% of students gained A or B grades – over half of all entrants! When I looked at occupational therapy's entry requirements, our national norm is asking for one B and 2 C grades – and it appears from my colleagues in education that this has not changed significantly over the last decade or more.

Fig. 4. National trends on admission criteria.

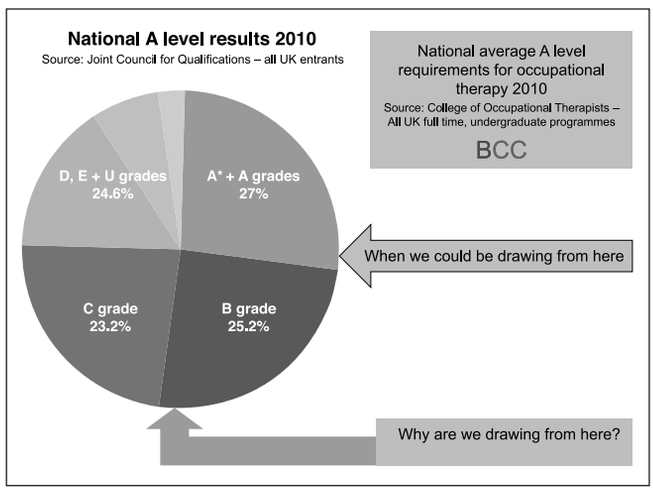
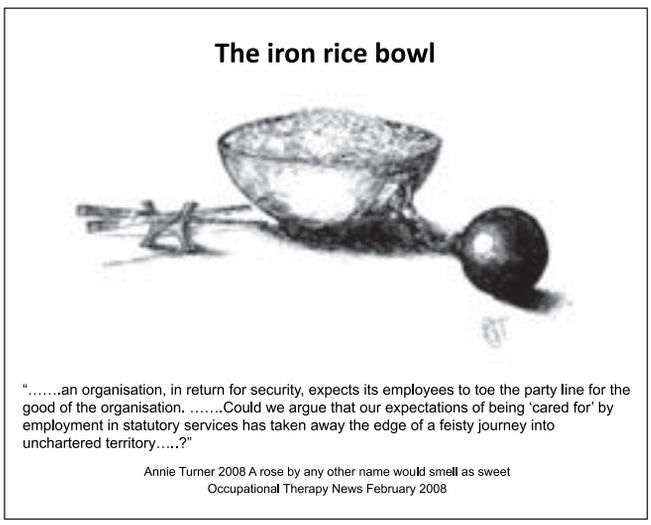


Fig. 5. The concept of the iron rice bowl (Turner 2008).



What message does this convey? If I have worked hard to gain A and B grades, will I consider a profession that is asking less than that? Why do not we hunt out these bright students? If our argument is that in doing so we will miss a number of potentially capable occupational therapists, this seems to me an emotional rather than a rational response. Are we not already missing potentially excellent occupational therapists amongst those high achievers we fail to attract?

Task 2: Practice competence

In terms of conduct, I also believe that we have started well but have a way to go to maturity. Currently, wherever we practise, huge and unspecified changes are coming, especially within statutory services. Redundant occupational therapists, lost contracts, financial constraints, staff shortages, lack of professional leadership and undefined futures make us feel very uncertain and worried about what is happening to our profession, and rightly so.

When reflecting upon our current situation, I thought how easy it would be to get tangled up in the minutiae of current legislative, organisational and fiscal change. Trying to predict the details of future change is pretty impossible at the moment, but what I thought we must do is to look at the tactics we can use to ensure that we ride the storm towards practice maturity. But where to start? To help us I would like to present two concepts, introduced to me by occupational therapists, that have often helped me explore and debate how we might take our profession forwards.

The iron rice bowl

Kit Sinclair, the previous president of the World Federation of Occupational Therapists, first introduced me to the concept of the iron rice bowl during an international occupational therapy conference, and it was a real professional light bulb moment (Fig. 5). The idea of the iron rice bowl helps us to explore how an organisation expects its employees to toe the party line to help meet its own objectives, even where these are at odds with their employees' personal philosophy. In return, it gives back just enough to make them stay, even though, in their heart of hearts, they may like to practise differently.

Letting go of personal security and taking a leap of faith into employment in new pastures is, of course, scary and requires considerable bravery. I sometimes wonder if this is the relationship we have, in some areas, with statutory services. Without doubt, some areas enable us to practise true to our philosophy and the results are excellent. Fantastic role emerging placements organised for our students give them insight and experience into new ways of working. But in some cases, as we have seen at the beginning, that is not the case. When I have discussed this concept with both practitioners and students, the frustrations of not being able to practise according to our professional beliefs are often expressed quite forcibly. However, when we discuss the idea of establishing new services beyond the boundaries of statutory organisations, the most frequent, and understandable, response is about finance – paying the mortgage, setting up in uncertain times, lack of business acumen and other very realistic fears that keep us tied to the status quo.

Whatever the changes to health and social care in the near future, there is, we can well imagine, going to be a shrinkage in services. Those in need of support and long-term help, if we study our demographics, will certainly expand, but increasing numbers are likely to fall outside the remit of whatever new criteria are set. So out there, in this hinterland of need, will sit all those whose occupational needs will be unmet by statutory care. Is this not where we need to be? Is this not where we need to sell our skills?

In times of change, we need to be brave or we will end up as the flotsam within the system – and we are worth more than that! Could we argue that our expectations of being 'cared for' by an employer whose philosophy is at odds with our own will leave us disaffected within the service and disconnected from those who can most benefit from our skills? If enough of us do not make that brave move out of the rice bowl, it is our profession that will suffer occupational apartheid! A mature profession, surely, needs to offer its services to those who will most benefit from its unique skills, rather than languish in the comfort of what is here today, but faces an uncertain tomorrow. Mature professional practice is not always comfortable, and mature professionals have to make difficult choices – and, yes, the ride may be bumpy, but who is to say that those who brave change, along with those we seek to help, will not benefit in the end?

The instrument and the music

The second concept that I really love was introduced to me by Frank Kronenberg, occupational therapist and author. Isaac Stern, the violin virtuoso, talked about not confusing the instrument with the music (Stern 1981). He felt that it is easy to be dominated by the instrument, which is for us the professional context in which we deliver our services. But using his concept we can see that the power of our professional practice, our music, lies in our belief and understanding

of the impact of occupation on human health. In other words, the music of occupational therapy comes from our practice being driven by practitioners' belief in occupation, regardless of the instrument on which we play it. We, the practitioners, are the musicians and must have the confidence and vision to play our own notes at all times. I just love the imagery in this concept and have used it many times to explore the extent to which the context in which we work is the 'instrument' of our professional practice. For me, maturity in practice is the point at which we, the musicians, use our beliefs to play our profession's music.

Task 3: Developing strategic alliances

In the 1960s, Paul Simon and Art Garfunkel sang 'I have no need of friendship, friendship causes pain'. But I think they were wrong. A profession that tries to go it alone is unlikely to succeed. Friendships in adolescence are the bedrock of life; they test our image of ourselves, lead us to good habits and bad, and introduce us to people and to ways of thinking and doing that we have not come across before. Adolescent friendships help us to define ourselves, and lead us towards new territory and maturity.

Initial alliances

Occupational therapy has made a good start in forming alliances. Its childhood dependence on its parents was initially combined with strong alliances with groups within health and social care, and we began to see the strength in having a group voice. However, these alliances are pretty safe and, helpful though they are, they do keep us focused on familiar home fires.

So I began to wonder if we need to begin to form strategic alliances with groups who will help us as we address our roles and challenges in the new hinterland we identified earlier?

Alliances groups that do not gel

We have identified that there are groups with whom we make solid, reliable alliances. But there are others with whom, try as we might, we just do not gel. Sometimes we can put loads of effort into getting along with certain groups but the magic just is not there, and I believe we have to be honest about those alliances that do not serve us well and move on. Perhaps one of the tasks that we can set ourselves is to identify any outdated or unprofitable alliances that we perpetuate in our workplace and decide what to do about them.

New and future allies

Most important, however, are those allies that we are just beginning to make, and ones that we have yet even to consider. Out there in our brave new world are allies, possibly yet unidentified, who are fitted for our future. When we mix our ideas, they will just take us to places that we have never even dreamed of. What we need is the buzz and the glow of new combinations of ideas that will help us to fulfil our vision and drive the passion we need to get there. For me, this is the great alliance task ahead of us, as individuals and as a profession, but we must look beyond our existing allies and form strategic alliances with powerful groups in politics, business, marketing, law and education. We need to ensure that we are present at the tables and in the offices where decisions are made that affect our future, in order to direct where we go rather than to be the recipients of hand-me-down conclusions.

Heading for the maturity of young adulthood

So, where does that leave us? I believe that in the United Kingdom we see a profession in late adolescence, hoping to head for the secure identity and maturity of young adulthood. But my fear is that we have much to do if we are to reach adulthood, and time is not on our side if our profession is to survive. If we do not take responsibility for our position, and addressing our issues, it may be too late. If we do not ensure that all our graduates have a cast-iron identity, are business savvy, and have passion, confidence and a sense of where they want the profession to go, our future practitioners will be controlled by those people and organisations who will shape it for us – and if this is the case, just let us hope that their idea of our future is what we would wish for ourselves.

If our practice is not driven at all times by the theories and evidence of occupation's impact on health, we will truly lose what identity we have. If we are not quick, brave and smart enough to establish services where we can shine as we practise true to our philosophy, someone else will. If we bury our heads in the sand because we are grateful for our salary – regardless of the professional compromises we have to make to earn it – scenarios of redundancy, lack of professional leadership and being replaced by cheaper options will not go away. If we do not form a clear vision of where we want to go, and set about making the right alliances to take us there, we will continue to perpetuate the here and now, and forfeit our growth to maturity.

To do: take action

So, exciting and uncomfortable as this journey has been, it has helped me to see that we are at a stage in our development where questioning, insecurity and the need to consolidate our identity are part of the natural, developmental tasks we need to undertake. Some of what I have said today may resonate with you and will hopefully get you thinking. Some you may not agree with and some may even make you cross! But you know what? That's OK. Few really good developments were ever made by a group of people who always agreed with each other. No, progress comes from critical debate and disagreement; harmony comes from discord. So let us have the debates, let us hear the irritations

Fig. 6. Three salient tasks (based on Roisman et al 2004) that our profession needs to address in order to reach the maturity of young adulthood.

and pose the questions, because if we walk away from today thinking 'Oh, that was interesting [or boring, as the case may be!]' and then take no further action, we are guilty of allowing our profession to drift towards a future that others decide for it. But if we return to work on Monday and begin to ask where we want our practice to go, how we are going to ensure it gets there and which factors support and inhibit occupation-based practice, we will have made a start (Fig. 6). If we begin to debate who our unhelpful alliances are and where we should be forming new ones, we will be taking steps in the right direction. If universities and local services continue actively to consider the symbiosis of education and practice, we will continue on our path to maturity.

Then, when I am an old woman (not long from now), being helped with my autonomy by an occupational therapist, I shall turn to my mates and say, 'You know, I was an occupational therapist too', and be very, very proud.

Thank you.

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