Rivers of Doing, Becoming, Being, Belonging:

Exploring Occupational Therapist Identity

by

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Abstract

Occupational therapy is a profession that has struggled with defining its identity and the result is often difficulties with professional identity in therapists. A lack of a professional identity has been linked to role confusion (Finlay, 2001), work stress and burnout (Edwards and Dirette, 2010), and attrition (Rugg, 1999). In contrast, a strong professional identity can lead to increased job satisfaction (Öhlén & Segesten, 1998), commitment to the profession (Roberts, 2000), and improved team work (Molyneux, 2001). Using a hybrid methodology of constructionist grounded theory and narrative inquiry, this project sought to identify key traits and factors related to the formation of an occupational therapist professional identity, while using the Kawa model as a novel data collection and analysis method. In-depth interviews with five practicing occupational therapists were conducted to develop a theory of professional identity formation in occupational therapists and generate stories of "becoming an occupational therapist". Data were analyzed using narrative analysis as well as through the generation of representations of identity formation using the Kawa Model. A four stage model of identity formation was constructed. Five key identity traits were identified: spirit, pragmatism, ethic of care, habitus of occupation, and 'knowing how to play the game'. Contextual factors included personal context, institutional context, relationships with clients, relationships with occupational therapists, relationships with teams, and relationships with managers. Participants also reported three major barriers: role clarity and expectations, the field of medicine, and time. This model is represented using the Kawa, clarifying the relationship between elements. Results of this study can inform pre-professional recruitment, university programs, and practice sites in order to best recruit, educate and support occupational therapists in professional practice.

Keywords: professional identity, occupational therapist, Kawa model

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Dedication

This dissertation is dedicated to Sarah, Jacob and Trinity, who never stopped believing that one day I would be Dr. Mom, even when I didn't;

And to my dear friend, colleague, mentor, and the embodiment of an occupational therapist, Theresa Sullivan, taken from us all, far too soon. My river is shallower without you.

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Chapter One: Introduction

I thought how lovely and how strange a river is. A river is a river, always there, and yet the water flowing through it is never the same water and is never still. It's always changing and is always on the move. And over time the river itself changes too. It widens and deepens as it rubs and scours, gnaws and kneads, eats and bores its way through the land. Even the greatest rivers- the Nile and the Ganges, the Yangtze and the Mississippi, the Amazon and the great grey-green greasy Limpopo all set about with fever trees-must have been no more than trickles and flickering streams before they grew into mighty rivers. Are people like that? I wondered. Am I like that? Always me, like the river itself, always flowing but always different, like the water flowing in the river, sometimes walking steadily along andante, sometimes surging over rapids furioso, sometimes meandering with hardly any visible movement tranquilo, lento, pianissimo, sometimes gurgling giacoso with pleasure, sometimes sparkling brillante in the sun, sometimes lacrimoso, sometimes appassionato, sometimes misterioso, sometimes pesante, sometimes legato, sometimes staccato, sometimes sospirando, sometimes vivace, and always, I hope, amoroso.

Do I change like a river, widening and deepening, eddying back on myself sometimes, bursting my banks sometimes when there's too much water, too much life in me, and sometimes dried up from lack of rain? Will the I that is me grow and widen and deepen? Or will I stagnate

> *and become an arid riverbed? Will I allow people to dam me up and confine me to wall so that I flow only where they want? Will I allow them to turn me into a canal to use for their own purposes? Or will I make sure I flow freely, coursing my way through the land and ploughing a valley of my own? (Chambers, 2006, p. 317)*

I entered the Transformative Teaching, Learning and Leading doctoral cohort in education to understand the process by which someone becomes an occupational therapist. I did so because I wanted to understand what I was seeing in occupational therapy, why some people stayed, why some left and why for others occupational therapy became just a job to be left at the door at the end of a work day. What happened after students left the school? Why did some stay and some leave? How do we support our graduates as they enter the field?

As I worked through the doctoral process, I reflected more and more on my own process, on what it meant to be an occupational therapist for me. Occupational therapy may have started as a career choice, however somewhere along the line, it became much more. I am an occupational therapist. It is more than what I do; it is how I define myself. For me, occupational therapy has been more than a career; it has defined how I see myself and how I see the world. It has become my way of life; it is who I am. Occupational therapy has influenced my work (obviously), my marriage, my parenting, my friendships, my activities, indeed, most aspects of my life. It is not a separate identity within me; it is an integral part of all my identities. The values, beliefs, skills and practices of occupational therapy pervade my daily life in a myriad of ways that cannot easily be recounted. Occupational therapy has become more than a singular professional identity; it is an integral part of my all my identities. It is this identity that brought

me to graduate work, that maintains me within the profession during times of stress and that drives me to better understand what this identity means.

My experience is not unique. A strong professional identity has been correlated with commitment to a profession (Roberts, 2000), with career satisfaction (Öhlén & Segesten, 1998), with improved interprofessional collaboration (Molyneux, 2001) and with positive emotions (Beijaard et al., 2004; Cattley, 2007; Lamote & Engels, 2010). In contrast, weak professional identity is associated with planned career change (Williams, 2010), with burnout (Edwards and Dirette, 2010) and with lack of confidence and self-esteem (Hong, 2010). Given that professional identity appears important to the maintenance of professionals within a profession, it is also important to understand how professional identity is formed and maintained.

This chapter provides an introduction to the profession of occupational therapy - some of its key beliefs and attributes, related specifically to the Canadian context. The remainder of this chapter serves as an overview of the research project that includes: the purpose of the study; the research methods and research questions addressed; and an outline of the chapters of this dissertation.

Understanding the Profession of Occupational Therapy

"Occupational therapists… view humans as occupational beings and believe that people's engagement in occupations that they themselves find meaningful and useful in their given environment, are as fundamental to experiencing health and wellbeing as eating, drinking and being loved" (Kronenberg & Pollard, 2005, p. 63). The promise of occupational therapy is to enable everyone to engage and participate in the occupations that they find meaningful. Occupational therapy is concerned with: occupational performance, engagement in valued

occupations and identity, examining how a person defines themselves, what roles, relationships and occupations are important (Duncan, 2011). Engaging in collaborative practice with clients, and through use of meaningful occupations and elimination or minimization of environmental barriers, occupational therapy aims to enable and empower people in their daily lives and in their daily occupations (Duncan, 2011).

The current definition of occupational therapy (in Canada) as defined by our professional association is as follows:

> Occupational therapy is the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life. (Townsend & Polatajko, 2007, p.2)

This definition can be found in a text which, in Canada, is considered the articulation of the nature of our practice. Indeed, the writing of this text was commissioned by the Canadian Association of Occupational Therapists (CAOT) to clarify the core concepts of our profession, and our domain of concern – occupation.

Professionalization of Occupational Therapy in Canada. Despite its formal history of almost 100 years within Canada, occupational therapy is considered a relative newcomer to the health system in comparison to the medical and nursing professions. Initially rooted in evolving social movements (the Moral Treatment and Arts and Crafts movements within North America) (Friedland, 2003) when occupations were used within asylums to make patients more easy to care for, occupational therapy in Canada came into its own immediately following World War I with the return of injured and distressed soldiers (Friedland, 1998).

It has been said that occupational therapy developed as a profession through the initial sponsorship of medicine (Maxwell & Maxwell, 1994). Occupational therapy was viewed by psychiatrists as a useful *technology* for treatment of mental illness and prevention of restraint of patients (Lynch, 1954) and the work was delegated to "ward aides". Indeed, it was doctors in the early post-war years who promoted the usefulness of "occupational aides" to treat soldiers with physical and mental health issues. This pre-professional occupational therapy became more formalized following World War I when medicine established a program for the training of aides to carry out this work in 1918 (Friedland, 1998; Maxwell & Maxwell, 1994). It is under the direction of medicine that occupational therapy became established.

It is clear from the early literature related to the profession that occupational therapy was viewed by medicine as a technology. Occupational therapy was not viewed as a profession or even a professional group so much as a means to treat the patients seen by medicine within the hospital setting: "one of the most valuable instruments in mental hospital treatment is occupational therapy" (Hincks, 1922, p, 823); "occupational therapy is a therapeutic resource, an assist to aftercare and must be used by the medical officer as such" (Marble, 1920/2009, p. 1398). Physicians delegated treatments that were carried out by the subordinate staff. These prescriptions were felt to be necessary, not only by physicians, but also by the therapists themselves. Physicians directed who would receive treatment and the nature and duration of the treatment that the therapist would then carry out. "The work [occupational therapy] should be under the direction of the medical staff …The needs and capabilities of each individual patient should be carefully studied, and the kind and amount of work prescribed by the physician" (Brannan, 1922, p. 367).

For physicians, the prescription was a means of control over the therapists and the technology they employed. For the therapist, the referral represented the support and recognition of medicine that lent to the status of the early profession. “In all these branches treatment is administered by the trained therapists on the prescription of the physician, and under his direction. Medical direction implies expert knowledge as in any other form of therapy” (LeVesconte, 1935, p. 6). Occupational therapy embraced the direction of medicine as it legitimized the profession. As occupational therapy benefited from this relationship, and posed no threat to medicine whose status was secure, this relationship benefited both groups.

As this “treatment” became more recognized and organized, more practitioners were needed to carry out the physicians’ prescriptions. Hospital aides (general hospital staff) and even nurses were considered as potential personnel (Dunlop, 1933; Hincks, 1922). To establish consistency, educational programs were required. Entrance to the programs was not based on academic merit or even their skills in handicrafts that would be used with patients, at least not in the early years of the profession. Instead, admission to the program was made based on those “who would be companionable, womanly and tactful and would meet every emergency in the right spirit” (Pringle, 1922, p. 48). This choice of early entrants had a profound effect on the profession for years to come. Trider (1971) suggested that these initial criteria led to the dependent, passive position that became a part of the identity of the occupational therapy profession throughout the next 40 years.

Following the First World War, associations were established by medicine to promote occupational therapy and more permanent programs were set up at the University of Toronto, under the direction of medicine (Dunlop, 1933). While the Canadian Association of Occupational Therapists (CAOT) was established by the early occupational therapists, it was led

by a physician as president from its inception in 1925 until 1966 (Ernest, 1972), with physicians in positions of leadership within the profession (Maxwell & Maxwell, 1994). Those within the profession felt that occupational therapy would benefit from the relationship with medicine, lending its prestige to the fledgling group (Ernest, 1972) and enabling the developing profession increased status and recognition within a relatively short period of time, obtaining several necessary steps in the professionalization process almost simultaneously, rather than over a period of many years (Maxwell & Maxwell, 1994).

While this sponsorship afforded some initial rewards for the profession, sponsorship was not without costs. While the goals for the profession as established by physicians were significantly useful to the development of occupational therapy as a profession, they were undertaken and obtained by physicians, rather than by occupational therapists themselves, reinforcing occupational therapy as a domain of medicine. Additionally, Maxwell and Maxwell (1994) suggest that the assumption of the leadership by physicians early on rather than by therapists themselves may have contributed to a lack of political awareness and skill, as well as an absence of a tradition of leadership for the profession, once the profession no longer had this sponsorship. This void in leadership would have significant impact on the profession in limiting or delaying the development of leadership and advocacy skills within the profession itself (Gill, 1982; Maxwell & Maxwell, 1994).

Through their sponsorship, medicine also exercised significant control over the profession, placing occupational therapy in a dependent role in relation to medicine and limiting the new profession's control over its education and work. A decision to merge the educational programs of physiotherapy and occupational therapy in the 1950s by the Canadian Deans of Medicine (Gingras, 1956) was made against the strenuous objection of both groups (Maxwell &

Maxwell, 1994). The result of this merger had profound impacts to occupational therapy. For a profession that had struggled with its identity from its inception, its merger with physiotherapy only further complicated the issue. The two professions became equated and were in fact used as substitutes for each other, that persisted beyond the separation of the two programs and persisted long into the late twentieth century (Brown & Greenwood, 1999) and indeed continue to present day resulting in role overlap, blurring and identity challenges.

The influence and control of medicine, and occupational therapy's embeddedness within health and the health care system has served to shape and control the profession over time. Despite this, occupational therapy had developed its own culture and practices that are acquired through socialization within occupational therapy programs and integrated through practice.

Culture of Occupational Therapy. While occupational therapy is and has been traditionally embedded within the health context and the under the influence of medicine, occupational therapy as a profession has its own culture, (Watson, 2006). Iwama (2006) identifies that occupational therapy has:

> a shared specialized language, common learned values, and certain tacit and expressed rules of conduct, common social practices, and a developing body of profession-centred knowledge. A visit to almost any occupational therapy practice settings will reveal many of its cultural *artefacts* (p. 6).

For example, occupational therapy-specific language (use of the words occupation, occupational performance) is meaningful to occupational therapists and communicates a focus for occupational therapy practice. At times these can be assets, aiding in the articulation of our scope of practice; at others, these can be liabilities, isolating us from other team members who do not use or understand the meaning of the language. Even the name occupational therapy can be

problematic. While for therapists this articulates our domain of concern, the word occupation in modern English is generally used to mean “work” or “vocation” rather than as it is used by occupational therapists to mean activities which occupy one’s time. Other artefacts such as crafts, woven baskets and stacking cones, represent a history of practice – one that is often shunned by newer practitioners – but that are persistently associated with the profession, both from within and by outsiders.

Language which is not readily understood, and tools that can seem simplistic and unscientific can place the profession on the margins of a health or social care team. Therapists are often required to explain their background, their role, and their technologies, something that is not required of a doctor, a nurse or a physiotherapist. The breadth of the domain of concern of the profession (human activity) renders it difficult to explain readily; it also leads to overlap with other professions, leading to role blurring. Given the unique nature of the profession and the cultural differences between occupational therapy and the other professions with which the profession interacts, it is important to understand how professional identity develops in order to best support and develop occupational therapists who can enact their professional identities and realize the potential of the profession.

Purpose of the study

The intent of this project is to understand how occupational therapists conceptualize their identities as occupational therapists and how this identity came to be. While professional development is frequently discussed in the occupational therapy literature (Abreu, 2006; Ikiugu & Rosso, 2003; Wilding & Whiteford, 2008) it is rarely defined. Research to date on identity has focused on specific work contexts (Hanson, 2009), or educational settings (Ikiugu & Rosso, 2003; Jung 2010). The development of a professional identity is of growing importance in the

ever-changing context of health and social programs (Méthot, 2004) in order to develop the profession and participate effectively in interprofessional practice (Molyneux, 2001).

Method

A hybrid qualitative methodology was selected for this study. This study combined constructivist grounded theory (Charmaz, 2005) and narrative research (Polkinghorne, 1995; 2010). Both methodologies have been used to examine identity in a number of contexts and across a number of identities. Constructivist grounded theory (Charmaz, 2005) differs from traditional grounded theory in that it moves away from the positivist paradigm that provided its origins and recognizes the constructed nature of reality and experience. Both are rooted in the qualitative research paradigm, suited to the exploration of "the lived experience" of the individual in his or her context. Constructivist grounded theory allows for the development of a preliminary model or theory about how an occupational therapist professional identity is formed, while narrative research allows for the collection and examination of the stories that occupational therapists tell in constructing their identities. Both contributions are important to furthering the knowledge base on identity in occupational therapy. Consistent with qualitative methods, data was collected via extended, intensive interviews with occupational therapist participants over time. Additionally, participants engaged in a reflective process through the exploration of a river metaphor for identity formation, using an established occupational therapy model – the Kawa (Iwama, 2006). Artifacts generated through this reflection were collected and themed. Data collected was analyzed using constant comparative methods as well as thematic analysis and categorical analysis methods.

Research questions

This project examined three research questions:

1) What are the characteristics of an occupational therapist identity? This has not yet been articulated in the occupational therapy literature. While occupational therapist identity is discussed, what this identity is has not yet been clarified.

2) How is an occupational therapist identity formed? While there is literature concerning similar professions such as teaching, nursing and medicine, there is limited literature that focuses on the acquisition of an occupational therapist identity.

3) What are the stories occupational therapists tell about becoming an occupational therapist? Identities are constructed and re-constructed in the stories we tell ourselves and each other. These stories have the potential to educate students of occupational therapy as well as newer graduates who are still early in the process of identity work. Perhaps by identifying common stories and elements, these stories can provide a source of inspiration to the newer members of the profession and assist them with the formation of their own occupational therapist identities.

Outline of the Dissertation

This dissertation consists of five chapters (excluding this introductory chapter), covering all aspects of the research process.

Chapter Two consists of a literature review examining the literature related to the profession of occupational therapy and the current state of knowledge regarding occupational therapist professional identity. Relevant sociological and philosophical literature is also examined to provide an introduction to key concepts related to identity and identity work. The conceptual framework for the research project is also included.

Chapter Three reviews the research methods that were used throughout the project. This includes a discussion of the main research questions addressed by the project, the over-arching design, methods for data collection and analysis and ethical considerations in the project.

Chapter Four is the first results chapter and consists of two parts: narrative analysis of the participants' identity formation, and a proposed identity course for identity formation in occupational therapy

Chapter Five is the second results chapter and covers the themes identified related to occupational therapy identity characteristics and key influences in the formation of an occupational therapy identity.

Chapter Six includes the discussion and conclusion of the project. It includes recommendations resulting from the research as well as identification of the limitations of the study.

Chapter Two: Literature review

This chapter provides a review of the literature related to professional identity in general, and within occupational therapy specifically. Current understandings of professional socialization and the influence of the self are then presented. Finally, this chapter introduces the conceptual framework which guided the research project.

Defining Identity

Holland, Lachicotte, Skinner and Cain (1998) describe identities as personal understandings of the self that have "strong emotional resonance" (p. 3) for a person. In their conceptualization of identity formation, they articulate a view of identity continually being formed and re-formed within a person's context using the resources afforded to or withheld from the person. Using Holland et al.'s theories, Urrieta (2007) indicates that identity is "about how people come to understand themselves, how they come to 'figure' out who they are, through the 'worlds' that they participate in, and how they relate to others within and outside these worlds." (p. 107). Their theory emphasizes the significant impact that a person's context and culture have on creating and negotiating identity. This process is uniquely individual based on personal attributes and the resources, constraints and supports within an environment at a given point in time.

In the teacher education literature, professional identity is much discussed, though a consensus on a definition of identity is still missing. Beauchamp and Thomas (2009) provide a definition of professional identity that includes "'how to be', 'how to act' and 'how to understand'" (p. 178) as well as recognizes both the personal and professional components of identity and the shaping and re-shaping of identity with experience. They stress however that their definition is only a place to start when considering identity and that theory and research

continue (and need to continue) to inform the definition of a teacher professional identity. Timoštšuk and Ugaste (2010) use a definition based in situated learning theories in which identity is conceptualized as "learning, experiencing, doing and belonging" (p. 1568). It emphasizes both the practice related to the professional identity (experiencing, doing) and the emotional aspects as well (belonging). Based in situated learning theory, it acknowledges the influence of the social on the formation of identity, though they do not describe this influence explicitly.

Within the health professional literature, Fagermoen (1997) found a lack of consensus in the nursing literature as to a definition of professional identity in nursing. Her synthesis of the literature identified three main concepts that appear to be most consistent: professionalism, or the work role within context, including status of the profession; perceptions of role, or the actual work done; and self-concept. Ultimately, she defines the professional identity of a nurse to be "what it means to be and act as a nurse; that is it represents her/his philosophy of nursing" (p. 435). She further clarifies that professional identity is the values and beliefs held by a nurse that guide thinking, acting and interacting. MacIntosh (2003), while not articulating a definition of professional identity appears to support Fagermoen's (1997) conceptualization and clarifies that the process of professional socialization in educational programs and work contexts is the means by which such a professional identity is acquired.

This concept of acquisition and enacting of skills, values and behaviours as central to professional identity beginning with the early educative process is consistent with the literature from medicine (Kenny, Mann & MacLeod, 2003). Adams, Hean, Sturgis and Macleod Clark (2006) in their study of health and social care students define professional identity as the "attitudes, values, knowledge, beliefs and skills shared with other within a professional group

and [relating] to the professional role being undertaken" (p. 56). However, other considerations are also discussed by Kaiser (2002) who also includes the concept of belonging or an allegiance as discussed but includes another aspect of this belonging. For Kaiser, professional identity involves a process by which a person recognizes and adopts shared characteristics with the profession, thus forming an allegiance. As a result of this bond between person and profession another element is also expressed – exclusion. Professional identity does not mean solely identification with the group, it also includes the exclusion of those who do not share this allegiance. This conceptualization emphasizes the relationship between professional self and 'other'. By defining identity in relation to the other and ultimately excluding the other, power enters the definition of identity.

Within the occupational therapy literature, a definition of professional identity is difficult to find. What is often discussed is the broad identity of the profession itself, rather than a personal professional identity. Hanson (2009) in her dissertation of occupational therapy professional identity in acute care settings draws upon Fagermoen's (1997) definition and applies this to occupational therapy. For her, an occupational therapy professional identity includes what it means to be and act as an occupational therapist – to be able to define occupational therapy, its role and to enact this in practice. She further expands on her definition to discuss key influences on its formation and enactment using Tornebohm's theory of personal paradigms (as cited in Hanson, 2009). The four concepts include: a) the world view of the occupational therapist that includes the knowledge and assumptions of the therapists, fundamental occupational therapy language and concepts and the setting (practice area, clients, role, work), b) field of action view that includes what is and should be the concern of the therapists, how these are addressed, the demands on the therapist and tools of practice, c) competence, meaning what can the

occupational therapist do and her/his ability to act in relation to the field of action, and d) interests, being what the occupational therapist does. Consistent with the definitions from other professions, professional identity is a complex concept related to the person, the work of the profession, and the environment in that the work is enacted by the person. Finally, Mackey (2007) discusses professional identity in occupational therapy "as a device for establishing, defending, explaining, and making sense of one's behaviour and career" (p. 133). For Mackey, an occupational therapist professional identity is a means of making sense of one's self over time, to understand how one relates to others and to make oneself included.

But is there a separation between personal identity and professional identity? Do they (can they) exist as separate entities? Wilcock (1999) indicated that the philosophy of a profession must be at a minimum consistent with that of the person, or the person will choose to leave. It is possible that the relationship between the two is stronger than just consistency; the two are mutually influencing. Nias (1996) discusses that for teachers, personal and professional identity come close to merging, as teachers invest their "selves" in their work. I would argue that within occupational therapy (an educative profession) something similar occurs for therapists. Similar to teachers, we work daily to build close and very personal relationships with our clients and invest highly in their success. We attach strongly to the values and beliefs of our profession and what we see as our unique perspective on health and wellness. This merging of personal and professional identity is also supported by Akkerman and Miejer (2011) who reject the idea that personal and professional identity are separate entities. Instead, they embrace a postmodern view of identity as being multiple rather than singular, with these identities being "in dialogue" and influencing each other in all circumstances. Jung (2010) described professional identity as a

"complex construct that involves integration and negotiation of multiple identities" (p. 177), reflecting personal and professional identities as integrated concepts.

Influences on Identity

As the above conceptualizations of identity reflect, identity is not something that is believed to be static or innate. It is something that is more fluid, developing and changing over time, and influenced by the context and the person. While a number of influences on identity development are discussed in the social and psychological literature, three commonly identified influences will be discussed: personal characteristics, emotion, and context.

Personal characteristics. The personal characteristics a person brings to a profession most certainly have an impact on the development of professional identity. Their world views, experiences, and personality will all influence their professional identities, partly explaining the resulting complexity in understanding identity. The influence of personal characteristics becomes increasingly complex when one considers the socially constructed nature of some characteristics such as race, ethnicity, and gender. These complexities have made research into personal characteristics and identity difficult.

The health literature, including that specific to occupational therapy, suggest that those entering professional educational programs begin with personal characteristics and attributes that are consistent with the profession they seek to join (Adams, et al., 2006), and identify personal goals and beliefs that are consistent with their profession (Danka, 1993). This would imply that students may enter programs with a pre-exiting level of professional identity, which could, in turn, influence their internalization of the professional identity during their education. (Adams, et al., 2006; Danka, 1993). Adams, et al (2006) suggest that personal traits including gender, familiarity with the profession being entered and previous work experience in healthcare are significant contributors to pre-academic professional identity.

Mackey (2007) found that those occupational therapists who were able to engage in reflection related to their practices demonstrated stronger professional identities than those who were not as reflective. Reflective practice was felt to enable the therapists to internalize professional concepts in relation to their personal context, leading to a more flexible identity that was adaptive to multiple contexts of practice.

Emotion. Emotion is one of the influences on identity that was overlooked for many years within the literature on identity (van Veen & Lasky, 2005; Zembylas, 2003). Over the last 20 years, there has been an increasing interest in the effect of emotion on identity. Zembylas (2003) describes emotions as the "glue of identity" (p. 222) connecting a person's thought, beliefs, and judgements. As such, they play an important role in how we understand the world, our own values and our relationships with others. Emotions provide meaning to experience and are central to the construction of identity. Our emotional experiences not only shape our behaviour, but the social "rules" relating to emotion also shape our identity. We internalize rules about emotions in our personal and professional lives that guide our behaviour: what are "good" and "bad" emotions, what emotions can be expressed in which situations and how much emotion is acceptable.

In the limited literature on occupational therapist identity, a need for emotional support for students and new graduates experiencing transitions has been identified (Jung, 2010). Jung (2010) found that stress, fear and anxiety were common in newly graduated occupational therapists and led to uncertainty about their role and identity. In the teacher professional identity literature, Hong (2010) related emotions to the concept of professional identity. She found that emotion was highly related to the decision to leave the profession. Feelings of burnout and stress were common among teachers choosing to leave the profession, which would seem to indicate

that these emotions significantly affected their teacher identities. Strong emotions, both negative and positive, and the teachers' responses to these, appear to be linked to teacher identity (Cattley, 2007; Timoštšuk & Ugaste, 2010). Studies of pre-service teacher identity identify that negative emotions in teaching are inevitable and that as a result, teacher education programs and supervisors of novice teachers must be prepared and able to support these individuals when negative emotions arise to assist them in processing these emotions (Cattley, 2007; Timoštšuk & Ugaste, 2010). Several studies (Beijaard, et al., 2004; Cattley, 2007; Lamote & Engels, 2010) describe the link between emotion and teacher self-efficacy: the more positive the emotion, the greater the self-efficacy the teacher experiences. In their review of the literature on teacher professional identity, Beauchamp and Thomas (2009) found that emotions can broaden or constrain development of a professional identity and the influence of emotion on professional identity is often under-acknowledged in the literature.

Social/contextual. Most of the recent literature on professional identity discusses the social construction of identity, in contrast to earlier theories that emphasized the personal cognitive nature of identity. However, much of the literature that discusses the effect of context, or the social, does so only briefly, often focusing on the personal experience of the social rather than identifying specific influences on identity.

In occupational therapy, Hanson (2009) identified that acute care hospital environments shaped the identities of occupational therapists, based on the roles that were available to them. Physical and temporal constraints in the environment limited the role of occupational therapy and therefore limited their identities "as lived". The effect of the environment on identity was supported by Jung (2010) who found that the environment (physical and social) produced

emotional responses (fear, anxiety, confidence) that affected the professional identities of new graduates.

Role blurring and ambiguity among the various professionals on a team has been found to have a negative impact on professional identity formation (Davis, 2006; Edwards & Dirette, 2010). When blurring and boundary crossings occur, occupational therapists have difficulty articulating their unique role within the team, leading to poor identity formation and internalization and lack of understanding of occupational therapy among other team members (Davis, 2006; Edwards & Dirette, 2010; Tryssenaar, 1999).

When professionals are based in practice settings that differ from their core philosophies, professional identity development can be challenged (Hansen, 2003; Mrdjenovich & Moore, 2004). Occupational therapists are often situated in practice settings that are defined by theoretical models that are not based or, consistent with, occupational therapy philosophies or models of practice (Wilcock, 2000). The medical model that predominates most health settings can contribute to a loss of professional identity in occupational therapists when it becomes central to their practice (Wilcock, 2000). Internalizing models that are incongruent with occupational therapy philosophy can lead to fragmented and inconsistent professional identity development and expression (Hansen, 2003).

While the occupational therapy literature has begun to articulate what is meant by professional identity, there remains limited research that identifies what is an occupational therapist identity and how it is formed. Studies often focus on the student development of professional identity (Ikiugu, 2003; Jung, 2010; Rotert, 2008) but no study to date has examined occupational therapist identity formation beyond the early years of education and practice. This study aims to fill that gap.

Significance of identity

Not acquiring an occupational therapy identity could have significant effects on both the individual and the profession. Withdrawal from or avoidance of activities that may expose an identity can limit the person's ability to improve knowledge and skills or acquire the necessary networks to advance a career (Jackson, 2000; Costello, 2005). Edwards and Dirette (2010) found that burnout in occupational therapists was related to the strength of their occupational therapy identity. Costello (2005) indicates that distress, depression and anxiety can result. Personal identities can be significantly injured when previously successful students are unable to perform to their expectations, especially when unable to understand the reasons they are not performing.

Professional Identity Formation in Context

> *"Forming an identity on intimate landscapes takes time, certainly months, often years. It takes (and makes) personal experiences to organize a self around discourses and practices with the aid of cultural resources and the behavioural prompting and verbal feedback of others" (Holland, et al., 1998, p. 285)*

Identity is about who we are within our social context (Holland et al, 2009; Lave and Wenger, 1991). Identities are about how we come to define ourselves in relation to and participation with the others who make up our figured worlds. "Identities are lived in and through activity and so must be conceptualized as they develop in social practice….identities [are] psychohistorical formations that develop over a person's lifetime, populating intimate terrain and motivating social life (Holland, et al, 1998, p. 5). They are formed and re-formed continually, throughout our lifetimes, shifting and changing in response to the resources and discourses afforded to us by our context. Holland, et al (1998) liken the self to water in a container. When water is held in a container, it is restricted to the boundaries of that container: if

it is small, the water is condensed and restricted; if it is large, the water is free to spread to fill the container.

Professional identity, as with other forms of social identity, is developed in participation with others. More than just the learning of work skills and tasks, the development of professional identity involves the internalization of ideologies, attitudes, values and behaviours of the profession. The professional identity then becomes one of a person's many identities influenced by the professional context, other professionals and the self.

Legitimate Peripheral Participation. In 1991, Lave and Wenger put forward a conceptualization of learning related to participation within a group or community. Rejecting the notion of learning as an activity of purely transmission in which the learner is a passive recipient of the knowledge of an expert, they discussed learning instead as a situated, relational activity between old-timers (experienced members) and newcomers (those seeking to enter) within a community. Their situational view recognizes that learning is not simply a cognitive activity but it involves the whole person, situated within a specific context, learning to participate alongside old-timers, masters and other newcomers. For Lave and Wenger, learning is more than an interactive process that transfers knowledge; learning is an embodied experience resulting in transformation and change.

Lave and Wenger (1991) use the term "legitimate peripheral participation" (LPP) to describe the process by which a newcomer to a community of practice becomes a member of a "community of practice" (CoP). LPP provides a means of access to the community by newcomers. They are granted status to participate, peripherally, in the community, acquiring the knowledge, behaviours, skills and social practices of the group through increasing participation and interaction with the community and its members. LPP provides a process for newcomers to

become part of a community; through experience and participation with the old-timers and masters within the community, newcomers learn and develop their identities as a recognized member of a community. Full membership both requires and provides access to the full range of activities, members, resources and opportunities for participation. Through the learning associated with LPP, newcomers are able to absorb and be absorbed by the culture of the CoP, moving toward full participation in its practice.

"Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wenger, 2006, para 4). Members pursue a common interest, interact regularly to learn and develop, and share a common repertoire of skills, language, and artefacts (Wenger, 1998). The knowledge, skills and discourse of the CoP does not rest in a single individual; it rests in the organization of the CoP of which the old-timers are a part. This shifts the view of learning from one of teaching in the didactic sense to one of use and structuring of the communities' resources to provide opportunities to learn and participate. The members are actively, collectively engaged in a generative process of creating their own futures and the future of the community through a reciprocal relationship between new and experienced members. CoPs have their own lifecycles and reproduce themselves through the transformation of newcomers into old-timers. The CoP requires newcomers to enter and reproduce the CoP; the newcomer needs the old-timer to provide access to the CoP in order to enter.

In the reciprocity, there is also tension: the newcomer will eventually replace the old-timer. In this way, LPP also provides a means for the newcomer to make the culture of the CoP their own. This is the dilemma of the newcomer. Newcomers need time and access to learn the practices of the CoP and become full members. However, they also have a stake in the

development of the CoP. They must be able to establish their own identity within the CoP. The establishing of an identity is not straightforward as it occurs as an interaction between the self and the community of practice. Each newcomer comes with his or her own experiences, history and identity. As a result, there is variation of identity within the CoP: "knowers come in a range of types, from clones to heretics" (Lave & Wenger, 1991, p. 116). Newcomers, as they acquire the practices of the CoP and the identity associated with its membership then have the ability to reproduce the CoP "as is" or to shift and change the CoP in new directions.

Davis (2006) discussed the importance of a CoP on the development of an occupational therapist identity in students. The participation in the occupational therapy CoP by these students led to experiences that either drew them closer or inhibited their identity development. Experiences with supervision, and the ability to develop relationships in a professional context were found to be influential in how the students were able to participate. Davis' study also indicated that the responsibility for the development of a professional identity in the newcomer occupational therapist lay with both the student, and the CoP. The influence of the practice context and the old-timer/master (practicing therapist) could either facilitate or inhibit the students' participation.

Contribution of the Self

Lave and Wenger's (1991) explanation of situated cognition recognizes the contribution of the individual to the development of identity within a CoP. The self is agentic within the CoP as one is actively involved in both acquiring the identity of the profession as well as in re-producing the CoP. At its most simplistic understanding, the self can be thought of as "who I am". Social constructionists view the self as socially constructed (Holland, et al., 1998). The discourses of the society in which we live become integrated within us. We build our sense of selves, of who we are through interactions with others. What it means to be male/female, of

low/middle/high class, heterosexual/homosexual, etc. is defined by the cultural discourses and practices. We then use our understandings of these categories to define and describe ourselves, ultimately shaping our behaviour within society, and our understanding of our "selves".

In pursuing a career within a profession, we often seek those who hold the same, or similar, values, belief and assumptions to ourselves, or who provide a match between our expectations of work and the reality of the work (Patton & McMahon, 2006). Similar to Lave and Wenger's (1991) conceptualization of a CoP, Patton and McMahon (2006) discuss a systems theory framework related to career development. Using systems theory, career development consists of recursive, interactive processes within the individual and context as well as between the individual and context. Selves are understood and constructed in relation to others within the work or professional context. Within this theory, the person is viewed as a unique complex adaptive system, shaped by their personal abilities, gender, socio-economic status and other influences. These selves both influence and are influenced by the profession over time. Specific influences of a component self will depend upon the relationship between that self and the context (e.g. conceptualization of female in a Western context), as well as the relationship between that component self and other component selves (e.g. female, wife, mother, student).

Mezirow (1997) describes the influences of these selves (the beliefs, thoughts, feelings and assumptions that they produce) as "frames of reference" that we use to understand the world around us, to evaluate both our own behaviour and that of others, as well as to evaluate information being presented. The self then contributes to professional identity development by providing frames of reference that are used to evaluate, and assimilate or disregard new information, as well as negotiate the way through the social practices of the CoP (Vélez-Rendón, 2010). The self further contributes to professional identity through its influence on choice

(Cohen-Scali, 2003). The opportunities to pursue certain careers or professions can be enhanced or limited by such things as gender or social class, or one's concept of their abilities or intellect. Stereotypes of professions, as well as stereotypes of factors such as gender, race or class, influence who will, and who will not, pursue a career or be granted access. For example, because teaching is characterized as a female (and therefore of lower prestige and power) profession, men will often choose not to, or be counselled not to, pursue teaching as a profession (Benton DeCorse & Vogtle, 1997).

"People do not come in neat little categories, nor do they have only one identity. People are multidimensional, complex beings with identities that shift, grow and change with the context" (Khayatt, 2000, p. 263). Identities of gender, race, class, ethnicity, orientation, etc. do not constitute a complete self but are central to a sense of self (Khayatt, 2000). Each of these contributes to our sense of who we are as individuals and are reflected in how we understand the world around us.

Bourdieu (1993) puts forward the concept of *habitus* as a way of understanding both our identities and how the self integrates our experiences. Habitus is seen to be made of four key elements, acquired through time and experience: 1) a worldview, that provides our unconscious understanding of how the world works (issues of power, relationships, responsibilities, etc.); 2) tastes, such as sights, sounds, sensations that are preferred; 3) embodied identity that includes nonverbal expressions, body movements and mannerisms; and 4) emotional identity that involves the internalization of emotional responses and orientations. Each of these elements of habitus is affected by our experiences with and understandings of our many identities.

In his study of professional schools, Costello (2005) points out that our understanding of our selves and our identities is not always on a conscious level, consistent with Bourdieu's

(1993) concept of habitus. Costello (2005) described what he termed identity consonance and identity dissonance in the acquisition of a professional identity (drawing on the psychological concept of cognitive consonance). As individuals, we are always managing multiple identities, some that co-exist with no issues, others that may be in conflict. This may occur with our own personal identities (such as being a conservative religious member and gay). People entering professional programs can also experience conflict between their personal and professional identities. Professional roles require an individual to take on the world views, behaviours and emotional orientations of the profession (habitus). If these are compatible with those of the individual, they will experience consonance; if they are in conflict, the person will experience dissonance. Costello describes the experience of identity consonance as smooth and often out of the person's awareness. Those who experience dissonance experience discomfort and employ a number of strategies to manage this dissonance. Costello's analysis for the experience of the self within a professional program provides a useful method of analysing occupational therapy professional identity.

Occupational therapists are inducted into the profession through a process that could be conceptualized as legitimate peripheral participation within a community of practice. Individuals enter the profession as students. They begin to learn the practices and knowledge of the profession through gradually increasing participation both in classes and in fieldwork environments. Their behaviour is shaped in interaction with professors, educators, occupational therapists and their peers. In this process they acquire the identity of occupational therapist, absorb the values, beliefs, assumptions and general discourse of the profession, as well as the behaviours, dress, speech mannerisms, and emotional responses expected of the profession

(habitus). If granted full participation, they then re-produce these through their ongoing participation, or have the ability to challenge or change the discourse of the CoP.

Conceptual Framework

The conceptual framework developed for this study is based on the preliminary understandings of identity formation gathered from the review of the literature. Environmental influences and relationship figure predominantly in the current understandings of identity formation. Even definitions of identity are based in the social; identity of the self is often understood in relation to the context, the moment and the others in the environment. In developing this conceptual framework, I draw from a conceptual model of occupational therapy used to understand the interrelated nature of the person with time and space – the Kawa model (Iwama, 2006) – as well as a well-known sociological/psychological theory – social constructionism –that views knowledge as socially constructed. Together, these two theories ground my preliminary understandings of identity formation and guide the process of data collection and analysis.

Kawa Model. Identity development and formation is a complex process that involves an interaction between person's characteristics or traits, their context, and their emotions within a socially constructed, figured world. Occupational therapy is a socially constructed world in which "members of the profession, in sharing their beliefs, values and assumptions, adopt a common language through which they agree on norms, boundaries, rewards and penalties, and the distribution of power and status" (Watson, 2006, p. 153). Through participation in the world of occupational therapy, the person acquires the assumptions, beliefs and values (philosophy), and social practices and roles of the profession. As McGarry (1992) said: "occupational therapy is not just a career, it is a way of life" (p. 186). But how does this happen? I propose leveraging

an emerging model in occupational therapy, the Kawa model, to explore the social process of acquiring occupational therapy as a professional identity.

The Kawa model was first published in 2006 by Michael Iwama, a Japanese Canadian who was working with a group of Japanese occupational therapists to develop and articulate a conceptual model that was more consistent with their practice than the predominant (and dominant) occupational therapy models developed and articulated by Western occupational therapists. The self-centric concepts expressed in Western models were problematic and did not fit with the Japanese collectivist beliefs that do not define the self in the same ways. Rather than the Western traditional, linear models of occupation, this group of therapists used a metaphor of the river to represent life. The model uses the metaphor of a river to conceptualize the life path of a client, be it a person, group or organization. The length of the river is conceptualized as the history and life course; cross sections represent moments in time and elements that impact the river and its course (Turpin & Iwama, 2011) (Figure 1). The river and its elements are depicted in Figures 1-3. The elements within the river (concepts/components of the Kawa model) shape the river's path and increase or decrease river flow: water (life flow), the riverbed and sides (the environment or context), driftwood (personal attributes and resources), rocks (discrete life circumstances), and spaces (opportunities to increase flow; a target for occupational therapy).

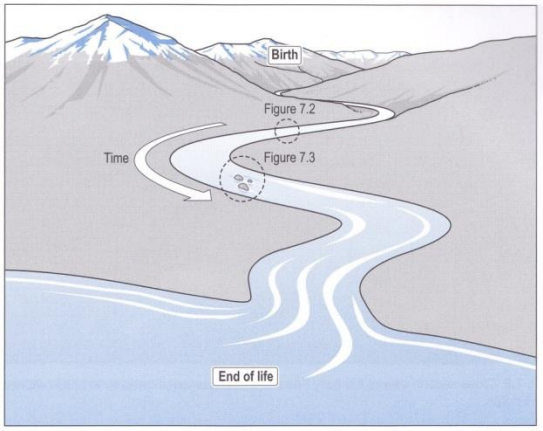

Figure 1. The Kawa as a life course. [Reproduced with permission of Elsevier from Iwama (2006) The Kawa Model: Culturally relevant occupational therapy]

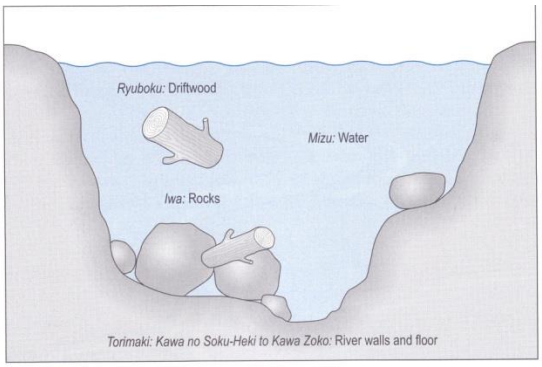

Figure 2. Cross section of a Kawa showing elements. [Reproduced with permission of Elsevier from Iwama (2006) The Kawa Model: Culturally relevant occupational therapy]

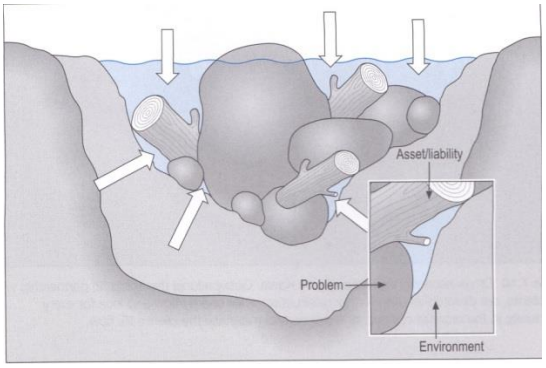

Figure 3. Cross section of a Kawa showing forces and space. [Reproduced with permission of Elsevier from Iwama (2006) The Kawa Model: Culturally relevant occupational therapy]

Each of the elements of the model interact, influencing one another as the river flows across the landscape, shaping and being shaped at the same time

Mizu: Water (Figure 2). Water in the model represents life: life flow, life force. Water moves and flows to take the shape of its container. Each of the elements influences the others and cannot be considered in isolation – they are interconnected and interdependent (Turpin & Iwama, 2011). Well-being is represented by a strong flow. But as it flows it touches the riverbed and sides, rocks, other elements in its path, each of these altering, changing the flow of the river. If the flow of the river is strong, life force or flow is thought to be strong; if the flow is weak, so is the life force. A strong flow can move obstacles in its path; a weak flow cannot.

Torimaki: Kawa no souk-heki (River sidewall) and Kawa no zoko (Riverbottom) (Figure 2). The container for the river is the riverbed/riverbank. The riverbed and sides represent the environment, the physical and social aspects of the world that support or constrain a person. The riverbed and river walls are "perhaps the most important determinants of a person's life flow … because of the primacy afforded to the environmental context in determining the experiences of self and subsequent meanings of personal action" (Iwama, 2006, p. 146). As with any container, water will flow and move to take the form of the container. A riverbed that is deep and wide (with supports and facilitators) allows for strong flow; one that is shallow and narrows (few supports, more constraints) has weak flow and may be at risk of drying up. In the model, the riverbed and sides represent the physical aspects of our environments, the resources at our disposal, the people who influence us. The elements interact continually: if there happen to be obstacles in the river (driftwood or rocks) at a time when the riverbed is thickened, the river shallows and flow is weakened. If these obstacles appear when flow is strong, their influence may not have the same significance.

Relationships between the self and others are emphasized within the Kawa model (Turpin & Iwama, 2011). If relationships are felt to be in harmony, the riverbed is deep, and therefore flow is strong. When there is disharmony, sediment builds on the riverbed, obstructing life flow.

Iwa: Rocks (Figure 2). Inside the river, one may find rocks. In the Kawa model, the rocks represent discrete events or life circumstances that provide a barrier or challenge. They may be present early on, such as with a congenital illness, or can happen suddenly such as an accident or a stroke that occurs later in life. They are conceptualized as rocks as they are relatively permanent, are thought of as difficult to remove and can significantly alter the flow of the water. A single rock may have limited impact, altering the flow in a minor way, but still having an impact. Several large rocks can change the direction of the river or limit the flow; many rocks and the river may cease to exist.

Ryuboku: Driftwood (Figure 2). Also within the river are pieces of driftwood. Driftwood represents personal attributes (skills, abilities, talents) and resources within the environment (equipment, accommodations, finances) that may or may not alter the flow of the river. At times, these are of limited consequence, simply floating along with the current of the water, having no effect. Other times they may become blocked by the rocks, compounding the effects of the event, as when one's liabilities complicate the situation, further damming the flow of water; or the driftwood may be useful in removing the rocks, using the assets to limit the influence of the rock. For example, the attribute of persistence can assist a person to persevere and work to change policies that limit their ability to work [working to change the environment (riverbed)] or to persist with difficult therapies following a stroke (a rock). At still other times, these attributes can limit the flow by becoming trapped against the riverbed or rocks, blocking the flow of water.

The same attribute of persistence could prevent a person from moving past an experience or event that cannot be changed, preventing participation in different activities.

***Sukima: (Spaces between obstructions) where life energy still flows (Figure 3*).** The final aspect of the Kawa model is space. Spaces are the places between the rocks, the driftwood and the riverbed where water still flows. They are found between rocks and driftwood that accumulate along the riverbed and riversides. These spaces represent opportunities – in the model, opportunities for occupational therapy to act to change the flow of the river and alter the course. The client, in partnership with the therapists, works in these spaces to increase the flow of water, by using driftwood to move rocks or dig out the riverbed.

The Kawa model was designed for use by occupational therapists and clients (person, family, organization, etc.) to examine and understand the interconnectivity between the person and their environment/context and to conceptualize barriers to well-being. It has been put forward within the occupational therapy literature as an alternative to other Western models of occupational therapy as a means of understanding the situatedness of a person within their context, rather than as separate from their context. While the Kawa was created as a way of understanding humans and their interconnectedness with each other and their environment, I believe it is also a useful metaphor to describe the process of forming an identity and provides a framework for creating and telling participant stories.

Iwama (2006) indicated that the Kawa model was designed for use by not only individuals, but also groups and organizations. Iwama (2009) further indicated that professions are their own cultures and as such, each possesses their own language, behavioural expectations and practices that distinguish them from other professions and make them recognizable to those within and outside the profession. Occupational therapy as a profession is itself its own culture

(Watson, 2006). It is a figured world. The profession of occupational therapy provides a context for meaning and action: a therapeutic relationship within a system of health. Social positions and relationships are named and constructed: the therapist client relationship and occupational therapy's relationship to others within the health system. It provides a context within which potential and practicing therapists can fashion an occupational therapist professional identity.

The figured world of occupational therapy, as a professional group, can be represented by its own Kawa (note: the Kawa described below relates roughly to that of occupational therapy within a Canadian context; it is not meant to be representative of occupational therapy as it developed in other contexts and cultures). The early river, created through the assistance and leadership of the medical profession, was shallow, flowing quietly in a few areas. The support of medicine in the early years of the profession created the riverbed, offering support allowing the river to begin to flow. There were many rocks in the early days as well: the profession was not well known, the early therapists were young and inexperienced, and there was resistance to their presence in the hospitals, as examples. However, there were a number of pieces of driftwood that assisted with moving the rocks: prominent physicians took a leadership role to move the profession forward and the new therapists were enthusiastic and persistent. The rocks were insufficient to stop the flow of the river and the river deepened. Over time, more rocks appeared (funding challenges, staffing shortages, demands for research) and sediment deposited on the riverbed (relationship with medicine became restrictive and controlling, lack of general awareness of the profession outside of a rehabilitation setting). At the same time, the profession acquired new driftwood (increased education, research skills, use of support personnel). The occupational therapy Kawa continued to develop and grow.

Within an occupational therapy Kawa, the driftwood can be the skills and abilities of the therapists, but they can also be the artefacts of the group. For example, occupational therapy specific language (use of the words occupation, occupational performance) is meaningful to occupational therapists and communicates a focus for occupational therapy practice. At times these can be assets, aiding in the articulation of our scope of practice; at others, these can be liabilities, isolating us from other team members who do not use or understand the meaning of the language. Physical artefacts such as reaching aids, raised toilet seats, and goniometers represent physical tools of practice. Other artefacts such as crafts, woven baskets and stacking cones, represent a history of practice – one that is often shunned by newer practitioners, but that are persistently associated with the profession, both from within and by outsiders.

The riverbed of the occupational therapy Kawa has shifted and changed with time. Relationships with other professions, such as physiotherapy and speech-language pathology, have at times been harmonious and we have worked together to forward the goals of each profession with similar contested histories and relative powerlessness within the medical system. At other times, these relationships are uneasy, with issues of scope of practice and work substitution creating conflict. The power differential between medicine, seen to be in control of systems of health, and occupational therapy limited occupational therapy's growth, therefore limited the depth of the river. Beyond the social relationships, physical environments have altered the appearance of the Kawa. Lack of space and isolated departments in hospitals further limited the flow in some areas. However, the building of new relationships with other groups – clients, families, and industries – allowed for broadening riverbeds and the flow of the river into new areas.

Rocks have, and will continue to appear in the river. Budget challenges, staffing shortages, alterations in educational requirements, new policies and procedures affecting practice, among other things, crop up within practice, altering the flow of the river, either for a period of time, or permanently. To this point, the occupational therapy Kawa has continued to flow, finding spaces between the rocks and the riverbed, using its driftwood to the best advantage when possible, creating new opportunities for the water to push beyond the blocks to the river. The profession's Kawa has altered and expanded its course and continues to do so. The profession continues to grow, change and develop, with the addition of new members, who bring their own stories to the occupational therapy narrative.

The primary use of the Kawa has been to explore and describe the "life journey" of clients within occupational therapy practice. Clients can draw their own Kawa, using longitudinal orientations or cross sections to explore the events and contexts of their lives as well as their personal assets, liabilities and resources. Much the same, each person choosing to enter occupational therapy comes with their own Kawa, their own life history, influenced by their personal context, attributes and circumstances. Just as no two rivers are alike, no two Kawa models for people are alike. Their riverbeds are made up of families and friends, whose relationships enable or constrain their development, shaping the direction of a life course, as well as the environments in which they live, go to school, work, etc. Rocks appear in their rivers (accidents, losses, etc.), difficult circumstances which alter the life flow for moments in time, or for years. Driftwood (personality, emotions, financial resources, intelligence) assists with digging out the river bottom or shifting rocks, or, it interacts with the rocks and riverbed to create larger blocks, limiting and altering the water flow.

Throughout each person's life, they acquire the cultural tools of their figured world(s) (be it a community, cultural group, school, workplace, etc.). At some point, their Kawa enters the path of occupational therapy like a stream joins a river. Perhaps they have experience with occupational therapy themselves or because of a loved one; perhaps they discover occupational therapy in school; perhaps they didn't get into another program and needed to find another career. Whatever the influence (be it a rock, a piece of driftwood or something from the riverbed), they decide to enter the figured world of occupational therapy. The two rivers meet, the personal Kawa of the individual, considering becoming an occupational therapist and the Kawa of the profession, which is continually developing, forming and re-forming as the water flows being shaped and shaping the figured world of occupational therapy.

Meeting of the Kawas

When a person chooses to enter occupational therapy, they are not simply entering a career; they are entering the figured world of occupational therapy. "Occupational therapists work together to construct and sustain their collective identity" (Mackey, 2011, p. 134), to construct and sustain the figured world of occupational therapy. In the process, they acquire the knowledge and beliefs of the profession, using the cultural artefacts within their daily lives. At the same time, they influence occupational therapy, bringing with them their personal histories, skills, abilities, assets and liabilities. The person and the profession become mutually influencing, each altered in some way by the participation. "Figured worlds, like activities, are not so much things or objects, as processes or traditions of apprehension which gather us up and give us form as our lives intersect them" (Holland, et al., 1998, p. 41).

As an individual, my life intersected with the figured world of occupational therapy. I was "gathered up" by the current of occupational therapy; it shaped my life from that point in

many ways, and I, to some degree, am shaping it through my participation in it. I choose to represent this intersection as the meeting of two rivers: the Kawa of the person entering the Kawa of the profession. The riverbed, rocks and driftwood within the river of occupational therapy, become the riverbed, rocks and driftwood for the person, and vice versa. The rivers flow together, the person becoming part of the flow of the profession's river, made up of all the other rivers of others who have entered before and who will enter later; the river of the profession flowing over and through that of the person, becoming a part of that person. The flow of the Kawa for occupational therapy is dependent upon people (other rivers) entering the profession: was no one to enter the profession, the river would dry up and occupational therapy would cease to exist. It is the flow of other rivers into the profession that continues the flow of the occupational therapy Kawa.

As a person enters the figured world of occupational therapy, they are confronted with new and unfamiliar artefacts of the profession. The driftwood of the profession's Kawa model becomes the driftwood for the person. These can be assets for both the practice of occupational therapy as well as life in general, as Korner-Bitensky (2009) discussed in her Muriel Driver Lecture. She described the skills and abilities that occupational therapy provided her beyond her practice as a clinician and educator; she describes its influence on her own perspective on health, disability, parenting, and other relationships. The driftwood can also be liabilities for a time. The meaning of these artefacts must be learned and internalized. "People learn to use these signs [artefacts/driftwood] historically first as part of behavioural routines, then as signs meaningful to others, and finally signs for directing their own actions, managing their own feelings and organizing their own thoughts" (Holland, et al., 1998, p. 287). Lave and Wenger (1991) would describe a person's early participation within the figured world of occupational therapy as

"legitimate peripheral participation"; the novice/student occupational therapist enters practice at the periphery through participation with others (occupational therapists, other novices/students, educators, clients) gains access to the artefacts (driftwood) of the profession. Personal driftwood also becomes driftwood within the river of the occupational therapy and can be used to remove barriers (rocks, sediment) from both the personal river and that of the profession.

Rocks within occupational therapy's river become rocks for the individual. Events and circumstances such as lack of influence, lack of funds, lack of identity, impact the flow of the occupational therapy river and therefore the flow of personal rivers, as the individual internalizes this through their participation within occupational therapy. Through active use of tools (driftwood, water flow) a person responds to the circumstances (rocks) they encounter (Holland et al., 1998). Personal driftwood such as a positive emotional response such as elation following a successful client interaction can wear down a rock representing the lack of professional recognition for occupational therapists, making it smaller. However, a negative emotional response (also driftwood) such as guilt over a mistake or perceived lack of knowledge can strike up against that same rock and become lodged, diminishing the flow for the individual (and potentially the profession, should the person choose to leave the profession). The driftwood can interact with the river bottom: power struggles and poor relationships between professions (river bottom) meeting with a piece of driftwood representing patience and perseverance may result in a deepening river bed as relationships move into harmony. Meeting with a piece of driftwood representing anger and frustration could lead to more disharmony (sediment on the riverbed) and again, someone choosing to leave the profession (exiting the occupational therapy Kawa).

As the novice acquires the driftwood of the profession (through participation in occupational therapy), the novice also acquires the history of the profession. This becomes part

of the narrative of not only the profession, but also the person him or herself. This narrative provides the beliefs, assumptions, values and practices of the profession, and a sense of how to interact with others who become part of the Kawa of occupational therapy. The person is shaped by these influences; their own Kawa is shaped as well. If the social practices of the profession are inconsistent with their own, conflict (a rock) may arise. The person must figure out how to cope with this conflict. This may mean that they may leave the profession or they may abandon or alter personal beliefs to take on those of the profession. It is through the interaction with the profession, and those within it (as represented by a Kawa), that the individual acquires the philosophy of the profession. In assuming this philosophy, it becomes an integral part of the person's identity.

By entering into occupational therapy, the person is entering into a figured world, one inhabited by others, who, through engagement in the practices of occupational therapy, provide the tools of the profession, provide feedback on practices and behaviours, and assist the newcomer with the development of their professional identity over time. The representation of this through the intersection of the personal and professional Kawa models illustrates the mutual nature of this practice. While the Kawa of the profession shapes the individual, the individual, through use of their own resources and assets shapes the practice. With entry of an increasingly diverse group of people, each from their own contexts, the profession itself continues to form and re-form. New practices are improvised (Holland, et al., 1998) as new barriers (rocks or sediment) arise, or new methods of using the tools are realized. In this way, the figured world of occupational therapy is remade, and the Kawa is re-shaped, taken in new directions, or with deepening or broadening flow into and across new landscapes (new areas of practice, new

technologies of practice). The Kawa of the profession is co-constructed by those within it, in turn, (re)constructing the therapists within.

Social Constructionism. Social constructionism is a theory that is found in both sociology and psychology. Difficult to define, no singular description has been articulated that encompasses the entirety of the theory (Burr, 2003). Bryant and Charmaz (2011) describe social constructionism as a theory that:

> assumes that people create social reality(ies) through individual and collective actions. Rather than seeing the world as a given, constructionists ask, how is it accomplished?... social constructionists study what people at a particular time and place take as real, how they construct their views and actions. (p. 610).

This definition of social constructionism recognizes that knowledge is bound by time and culture — what we believe we know is a product of the time and culture in which we live. Burr (2003) identifies four key features of social constructionism: 1) a critical stance toward taken-for-granted knowledge; 2) historical and cultural specificity; 3) a belief that knowledge sustained by social processes; and 4) knowledge and social action go together.

For researchers taking a social constructionist stance, each of these has implications for the data collection and analysis process. A critical stance toward taken-for-granted knowledge (Burr, 2003; p. 2) involves the researcher examining assumptions of reality and challenging the "truth" of our understandings and observations of the world. These observations are believed to be biased by how we have been socialized to understand the world. Challenging these truths is central to social constructionism.

Historical and cultural specificity (Burr, 2003; p.3) recognizes that what we know and how we know it is grounded in the time and context in which we live. If we take the example of

health as a social construction, what was considered health 100 years ago could be thought of as an absence of physical illness; by the 1940s, the concept of health had changed to include mental health and social participation. Mental illness at one point in time in many cultures was considered to be the result of possession by spirits; today, in the West, it is considered to be a result of neurochemical imbalances. What is known and understood about any construct is a result of the time and place within which one lives.

Social constructionists believe that knowledge is maintained in social processes (Burr, 2003; p. 4). People construct knowledge with other people, in their day-to-day interactions with others. What we come to know and understand is the result of this engagement; we develop shared understandings of the world around us and the phenomena within it. Finally, these shared understandings lead to social actions. Each construction lends itself to a specific form of action. If mental illness is caused by a chemical imbalance, the correct action is to treat the imbalance with medications or other treatments designed to correct these imbalances. If it is caused by possession by a spirit, the spirit must be exorcized. Specific constructions of knowledge lead to develop specific courses of action, while others may be discarded.

Social constructionism views the individual as constructed through external forces and in interactions/relationships with the external world (Burr, 2003). The knowledge that is constructed within a specific historical context is maintained in our day-to-day activities and conversations. How we come to understand the constructed world in turn, guides the actions that we take. “Social constructionism is about relationships” (Raskin, 2002, p. 16) and it is in these relationships that knowledge, identity and sense of self develops.

Social constructionism also provides an understanding of research process and practices. Social constructionists acknowledge that the data gathered in the research process “do not speak

for themselves; they are a product of the relationship between the researcher and the participant, and the researcher's interpretation of the data" (Bryant & Charmaz, 2011, p. 38). The results of any analysis are not in the data to be discovered, they are co-constructed during the research process with the researcher. The questions the researcher asks, the information the participant provides, the choice of words and performance of any stories in the data gathering process all influence the construction of any research results.

It is from this starting worldview that this study is grounded. Understanding the influences of the social world, of the relationships that influence the development of an occupational therapy identity are of significant interest within this study. Additionally, it is recognized that the data are not so much being gathered as constructed in the relationship between the researcher and the participants. This position is reflected in the selection of methodologies and methods explained further in this proposal.

Chapter Three: Methods

This chapter provides a summary of the research methodology, research questions, and data collection and analysis techniques that were used throughout the research project. A novel method for participant analysis using the Kawa model is also presented.

Research Methodology

This study uses a hybrid of methodology: two distinct, yet compatible research methodologies have been selected. The study is situated within the qualitative paradigm and uses constructionist grounded theory and narrative inquiry methods. The rationale for the blending of both these methodologies will also be discussed.

Research Questions

There are three main research questions that guide this study and the design decisions:

1. What are the characteristics of an occupational therapist identity?
2. How is an occupational therapist identity formed?
3. What are the stories occupational therapists tell about forming an OT identity?

These three questions focus on the experiences of occupational therapists and their personal understandings of their professional identities. Given the personal nature of the questions and the focus on meaning, experience and process, a qualitative methodology is best suited to this study. Specifically, a blended design using constructivist grounded theory and narrative research was used to explore these questions. These methodologies will be discussed in the next sections.

Constructivist Grounded Theory. Grounded theory as a methodology was initially developed by Glaser and Strauss (1967) who posited that through examination of the views and experiences of a large number of participants one could develop or generate theory. They

developed a structured method for collection and examination of data to produce an explanation of a process rather than a description of the process. Charmaz (2011) indicates that "grounded theory enables researcher to unravel the complexities of doing qualitative analysis and understand the mysteries and moments of human life" (p. 165). It is an appropriate method for studies in which there is little known about the topic of study; where the desired outcome of the study is to generate a theory, and when there is an emphasis on a process (Birks & Mills, 2011). Initially developed within a post-positivist ontological perspective (Mills, Bonner & Francis, 2006), early grounded theory researchers emphasized the need to maintain a distance from the participants and limit the influence of the researcher voice in any grounded theory study, as well as follow a set of prescribed and structured processes to be followed to ensure the validity and scientific integrity of any theory "discovered" in the process. With the increasing influence of postmodernism, feminism and constructionism, many recent researchers have challenged the realist orientation of Glaser's and Strauss's grounded theory and have instead embraced what Charmaz (2005) has called *constructivist grounded theory.*

Constructivist grounded theory challenged earlier conceptions of grounded theory (Charmaz, 2005). Rather than a structured set of guidelines, more flexible ones are emphasized, resulting in a more emergent, evolving process throughout the project (Charmaz, 2011). The distant relationship of the researcher was also challenged, replaced with a growing recognition of the difficulty of remaining detached from participants and from the process (Charmaz, 2005). In contrast, the researcher acknowledges their position, and recognizes the research is being co-created with the participants (Charmaz, 2011).

More in keeping with traditional grounded theory methods, constructivist grounded theory maintains some of the early key features. Data collection and analysis is an iterative

process, with the researcher moving back and forth from data collection to analysis to collection. Coding begins early on and data collection continues until the final theory is presented. In any grounded theory study, there is a move from the data to more abstract theoretical ideas (Charmaz, 2011). This movement to the theoretical is emphasized throughout the data analysis process. Finally, in keeping with the early traditions of grounded theory, the role of literature early in the project is limited (Birks & Mills, 2011; Charmaz 2011; Charmaz, 2005). Preferring to limit preconceptions and theoretical bias in the data, extensive reviews of the literature are avoided until the last stages of the research process to allow the research to entertain all possible explanations for what is found in the data.

The term grounded theory has been misused and misapplied since its inception (Birks & Mills, 2011). Often applied to any qualitative research that uses an inductive process and generates a model, theory or framework, grounded theory has a number of distinguishing characteristics considered essential for a quality grounded theory study. According to Birks and Mills (2011) the following methods are hallmarks of a grounded theory study:

1. A process of initial coding and categorization of the data.
2. Concurrent data collection and analysis.
3. Use of memos.
4. Theoretical Sampling.
5. Constant comparative analysis.
6. Theoretical sensitivity.
7. Intermediate coding.
8. Identifying a core category.
9. Advanced coding and theoretical integration.

As can be seen from Birks and Mills summary, the emphasis in grounded theory methods is on the process of data analysis. Data is generally collected through interviews and observations, but the researcher makes choices as the analysis progresses as to what further data is required and the best method to obtain such data.

Narrative Inquiry. The term narrative becomes confusing within the context of narrative research. Narrative is defined as "the representation in art of an event or a story" (Merriam-Webster.com, 2018). Put simply, a narrative is a story. Narratives may be spoken, performed or written (Wells, 2011). They can be considered co-constructed or shaped based on the storyteller, the audience and the context within which the story is told (Wells, 2011). In narrative research, stories become the key element, as a data source and as a means of analysis. Narrative is considered both a phenomenon and a method (Clandinin & Connelly, 2000; Connelly & Clandinin, 1990). As a phenomenon, narrative refers to the stories that people tell. Stories are part of the human experience; people live and tell stories as individuals and within communities (Connelly & Clandinin, 1990). Stories are how people make sense of their lives and the world around them (Webster & Mertova, 2007). We relive events in our world through storytelling: connecting ourselves to our personal and collective past, making sense of our present and forecasting our future through the stories we tell (Bell, 2002). Stories are not separate from our lives; they allow us to make sense of our experiences (Bell, 2002), our and other's actions (Chase, 2005), and form connections to our lives (Webster & Mertova, 2007).

Relating to narrative as method, researchers are interested in how humans experience their world (Connelly & Clandinin, 1990) and stories provide a means to access this experience. Narrative inquirers use what Creswell (2012) calls an "everyday, normal form of data that is familiar to individuals" (p.512) and write narratives of people's experience (Connelly & Clandinin, 1990). It

is people's experience that interest the narrative researcher. "For us, narrative is the best way of representing and understanding experience. Experience is what we study, and we study it narratively because narrative thinking is a key form of experience and a key way of writing and thinking about it" (Clandinin & Connelly, 2000, p. 18).

Chase (2005) defines narrative inquiry as "an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods – all revolving around an interest in biographical particulars as narrated by the one who lives them" (p. 651). As such, it is not a singular approach but a group of approaches that are used to explore people's lives and experiences through the stories that people tell. It is important to understand that narrative inquiry is more than the use of narrative as a rhetorical structure, as a telling of stories; it is an examination of the assumptions that underlie and shape our stories and that are often unexplored (Bell, 2002). Narrative inquiry involves the collection, analysis, criticism and retelling of stories, told (and untold) to understand experience.

Webster and Mertova (2007) indicate that narrative inquirers operate from the assumption that people come to understand their experiences through the imposition of stories on their lives. As such, there is no presumption of objectivity, but rather it is recognized that what is gained is an understanding of personal perception as well as an examination of both the social and cultural contexts of the phenomena of interest. The purpose of narrative inquiry is not to determine the "objective truth" or to draw definite conclusions about the human condition, but to create understandings of experience that are "well-grounded and supportable" (p. 10). The imperative in narrative research is to elicit the unique perspective of the participant and how their narrative is facilitated or inhibited by the circumstances of each participant.

Why Narrative Inquiry. Narrative inquiry is "set in human stories of experience" (Webster & Mertova, 2007, p. 1) and can be considered "the experiential study of experience" (Xu & Connelly, 2010, p. 354). Stories provide a means of accessing and exploring human experience of individuals or groups (Clandinin & Connelly, 2000; Connelly & Clandinin, 1990; Webster & Mertova, 2007). "Telling stories is a natural part of life, and individuals all have stories about their experiences to tell others" (Creswell, 2012, p. 512). Narrative researchers believe that stories provide a means of access to the experience in a way that other forms of research do not allow. Through narrative, the researcher gains not only an understanding of the experience of an event, but also the impact of that experience (Bell, 2002).

Because narrative research often involves extended time in contact with participants, it allows for in-depth exploration of the "complexities and subtleties of experience" (Webster & Mertova, 2007, p. 1). This interest in complexity differentiates narrative research from other traditional research methods that cannot manage complexity or that seek to limit complexity in studies to understand phenomena without "confounding" variables or issues (Webster & Mertova, 2007). Rather than examining phenomena at a single point in time, narrative researchers seek to understand the whole picture, examining experience within context and through time. This temporal aspect is central to narrative research and is something that is difficult to capture in more traditional methods of research.

Stories can also be used to educate. Narrative inquiry is a methodology that crosses borders and minimizes the boundaries that exist between educational research and practice (Webster & Mertova, 2007). Our stories become powerful teaching tools (Bell, 2002), as well as a readily available data source. As educators, we learn and teach through the telling and re-

telling of our stories of experience. These stories we tell allow researchers to access and analyze experiences that can lead to new learning.

Data gathering. Once the researcher enters the research context, data is gathered. The most discussed method of this data collection is the gathering of people's stories. Stories are often gathered through the use of substantial, lengthy, often repeated interviews that are frequently audio or video recorded (Creswell, 2007; Reissman, 2008; Webster & Mertova, 2008). Chase (2005) encourages the researcher to prepare in advance of the interview to understand the environmental constraints and influences (social, political, institutional, and cultural) and how they may affect the narrative and the types of narratives that may be heard. The story that is told is particular to the storyteller and may differ from the researcher's expectations and from other stories told of the same experience (Chase, 2005). Familiarity with the context of the particular participant will assist the researcher to listen for new and unexpected stories that may emerge.

The process of the interview in a narrative inquiry is often different from that of another form of qualitative research. Narrative researchers often view the interview as a conversation (Reissman, 2008). The interview is conceptualized as a whole, rather than a sequence of questions, and often starts with a broad question about the issue of interest (Chase, 2005). The researcher generally does not follow a structured or semi-structured interview to gather information. Questioning in this way can restrict the participant, interrupt the narrative and result in an incomplete account of the experience (Chase, 2005). What questions are asked and how a question is asked will shape the narrative that is told (Gubrium & Holstein, 2009). Instead of following an interview schedule, the researcher must "follow the participants down *their* trails" (Reissman, 2008, p. 24). The researcher must give control of the interview to the participant and

encourage the participant to explore the experience of the phenomenon. The researcher must be open to hearing narratives that are different from what is expected or that are elicited in unexpected ways. What may appear to be a digression from the topic or the question asked may be the story that needs to be heard (Reissman, 2008). The research must remain flexible and open to the story the participant tells.

Narrative analysis. In doing narrative analysis, the researcher takes data collected and structures the data into a story that "unites and gives meaning to the data as contributors to a goal or purpose" (p. 15). This method of analysis is consistent with Connelly and Clandinin's (1990) or Creswell's (2007) description of narrative inquiry. Narrative analysis refers to the procedures used to find common elements in the data and organize them into a coherent story. Whereas other forms of qualitative analysis involve separating the data into themes, narrative analysis involves a synthesis of the data into a story (Polkinghorne, 1995; 2010).

The data sources for studies using this method are not inconsistent with other forms of qualitative research. Data come from multiple sources, including observations, interviews, letters, diaries, documents, and photographs, but is often obtained through repeated contacts with participants over time rather than in a single interview (Clandinin & Connelly, 2000; Connelly & Clandinin, 1990; Reissman, 2008; Webster & Mertova, 2007). Clandinin and Connelly (1990) suggest that for this type of study, multiple different types of data are needed to construct the final narrative and to establish trustworthiness. Because of this, research involving narrative analysis often requires an extended time in the field collecting data and involves building an ongoing relationship with the participants (Clandinin & Connelly, 2000; Reissman, 2008; Xu & Connelly, 2010).

Combining Constructivist Grounded Theory and Narrative Research. Grounded theory and narrative inquiry have been combined in this study for two main reasons. First, use of narrative analysis following the construction of a theory has been found to be useful in reconstructing the texts, particularly since these texts can be fragmented by the analysis process of grounded theory (Lal, Suto & Ungar, 2012). The re-storying of the data re-presents the data in a cohesive form lost in the process of coding. Second, and related, narrative is being employed as a knowledge translation strategy (Lal et al., 2012). While the theory generated may be of interest to those in the academic sphere, theory is not always considered accessible to the larger audience this dissertation is intended to inform: students, clinicians, and employers. Stories would provide a means to reach the broader audience in a manner more readily useful in their context.

Research Design

In the previous section, I discussed the methodologies and conceptual framework that guide this dissertation. The epistemology underpinning the conceptual framework and the methodological requirements of constructionist grounded theory and narrative inquiry inform each of the decisions made in the research design. This section will describe the methods of participant selection, the position of the researcher, data collection and analysis methods, and ethical considerations of the study.

Participant Selection. A purposive, theory-based approach (Marshall & Rossman, 2011) to sampling was used for this study. As there is limited research into the professional trajectories of occupational therapists, a model proposed within education has been identified to assist with the development of a sampling strategy. Day and Gu (2007) developed a model of the professional life phases of teachers, based on the identity, learning and commitment tensions

over a professional teaching career. Their model proposes a six phase career trajectory (Day & Gu, 2007):

1. Professional life phase 0-3 years: commitment – support and challenge; learning that builds identity and competence
2. Professional life phase 4-7 years: identity and efficacy in the classroom; developing professional identity
3. Professional life phase 8-15 years: managing changes in role and identity – growing tensions and transitions; defining work-life balance
4. Professional life phase 10-23 years: managing work-life tensions – challenges to motivation and commitment
5. Professional life phase 24-30 years: challenges to sustaining motivation; adjusting to change
6. Professional life phase 31+ years: sustaining/declining motivation/commitment, ability to cope with change, looking to retire

Using Day and Gu's (2007) model, participants were selected if they are in professional life phase three or greater. Those at earlier phases were excluded as it can be argued that they are in the process of forming an identity, rather than being seen as possessing or embodying the identity during the period of study. The sample was stratified along the professional phases: 8-15 years, 16-24 years and greater than 24 years of practice. Professional life phases five and six were collapsed for the purposes of this study due to anticipated difficulties in recruiting a sample of occupational therapists in practice for 31 years or greater.

As this study concerns the development of an occupational therapist identity, it is important that the participants have such an identity. As one cannot "see" an identity, therapists were chosen based on external criteria that demonstrate a minimum level of identification with the profession and be considered as practicing occupational therapists. Therapists were considered practicing if they have current registration with a provincial regulatory body. Registration with a regulatory body allows for an occupational therapist to identify themselves to others through use of a protected title. Participants also had current membership in their national occupational therapy professional association (Canadian Association of Occupational Therapists). This membership was considered as a minimum criterion for demonstrating sustained engagement within the profession beyond what is required by law or by an employer. Participants were practicing in any setting in which they identify that they are working as occupational therapists, with the exception of academia. Those therapists who hold their primary employment position within a university environment were excluded from the study as the development of their academic identity may confound the identification of an occupational therapy identity path.

Finally, participants for this study were female occupational therapists. Current membership statistics for the Canadian Association of Occupational Therapists indicate that 92% of members are female. It is anticipated that men and women experience identity formation within the profession differently and as such, these differences could confound any resultant theory developed. Given the sample size, homogeneity of gender allowed for a more focused analysis of the participants' experiences.

Participants for this study were recruited using email advertisements. Names of occupational therapists currently practicing were obtained from the Canadian Association of

Occupational Therapists (CAOT). The CAOT assisted with selecting participants for the email list based on several factors: 1) greater than 6 years of experience, 2) identifying as female, 3) not primarily employed in a post-secondary institution, and 4) English speaking. Additionally, the names on the list represented provinces and territories from across Canada in a basic proportion to the number of occupational therapists practicing in that province or regional area. Smaller provinces and territory were collapsed into groups due to the small number of therapists practicing in those areas. This stratification was done in an attempt to avoid local contextual factors unique to one region of the country that could have limited the robustness of the developed theory. Interested participants were asked to contact the researcher via email. Participants were then approached via email or phone to clarify the inclusion criteria and their role in the study (time, energy).

Participant Characteristics. Because of the small numbers in the profession, and the potential for participants to be identified, the participants will be discussed in general, rather that specific characteristics of each participant.

Following the email recruitment process, six occupational therapists contacted the researcher to indicate interest in the study, five were ultimately selected for participation. One participant was not selected to participate as this imbalanced the numbers of therapists in each experience band. Participants were practicing in the following areas: one in British Columbia, two from Alberta and the Territories, one from the prairie provinces (Manitoba and Saskatchewan), and 1 from the Maritimes. Therapists were educated in five different Universities: Dalhousie, McMaster, University of Manitoba, University of Alberta and University of British Columbia. Three of the five therapists were practicing in provinces or territories other than where they were educated.

Two therapists had 9-15 years of experience, one had 16-24 years of experience and two had greater than 24 years of experience in occupational therapy. Four of the participants had Bachelor level entry to practice degrees and one had a Master's level entry to practice degree. One participant was dual trained in occupational therapy and physiotherapy as part of her degree. One participant had obtained a Master's degree following entry to practice, and one was pursuing a Master's degree at the time of the data collection. All were working in direct clinical roles: one in private practice, two in community-based practice, one in hospital-based practice, and one in a non-traditional social services setting.

Participants were provided with an overview of the study, the required elements, and signed informed consent documents, following the opportunity to ask questions of the researcher via both telephone and email.

In keeping with the need for theoretical selectivity and reflexivity when doing constructivist grounded theory research, prior to entering the data collection, I reflected on my experiences of becoming an occupational therapist, and engaged in critical incident review myself. It is important to understand the positionality of the researcher in order to attend to inherent biases that could present in the data collection and analysis.

Researcher's Position

I am an occupational therapist, practicing in Manitoba, educated and practiced in my early career in Ontario, Canada. I have been socialized as an occupational therapist since the first days of my occupational therapy education. The worldview that I now hold is heavily influenced by this socialization process. I speak the language of occupational therapy; I recognize the

artefacts. I find it difficult to ‘take off’ my occupational therapy glasses, even outside of the work context. It influences me day-to-day in innumerable, invisible ways.

I entered the research context with the history of my own process. This firsthand experience aided and complicated the research process in a number of ways. First, it helped me to generate the guiding questions of the interview. Second, it helped with the language of the interview. I speak ‘occupational therapist’ and as such, have access to insider language used by occupational therapists. Third, it assisted with building relationships with my participants that was necessary for the depth of information required within the study.

However, my insider position did pose challenges to the study as it is material that I am close to. The first step of this study I explored my experience of becoming an occupational therapist, using similar tools and reflections as the participants. I needed to more fully understand my own experience before I could attend to someone else’s. This reflective process assisted me during my data collection and analysis. My own reflection served as a means of separating myself from the experiences of my participants, so that I could better hear their stories. My insider position also challenged me to hear experiences different from my own. I needed to be open to others’ processes. Finally, because of my position, I needed to be conscious of the need to clarify taken-for-granted knowledge and meanings. I did not assume that my understanding was shared by my participants, who may share a similar identity, and who had evolved and developed their identities in different ways and in different environments. The need for reflexivity was paramount throughout the entire research process.

Data Collection

There were three data collection stages, one of which was a combined data collection/member confirmation/data analysis stage.

Stage One: Initial Kawa drawings. Participants were asked to draw an initial Kawa (river) to reflect their process in becoming an occupational therapist. Prior to this, they were provided with a brochure explaining the Kawa model and the key elements of the model to ensure at least a basic level of understanding of the model. The twists and turns of the river represent the shifts and changes within their career or within their identity. Participants could choose to begin their river at any point and were to label significant moments in their river drawings. These drawing served three purposes: 1) they assisted the participants in beginning the reflective process, 2) they provided an interview guide or prime for the initial interview, and 3) they provided initial experience with using the Kawa in preparation for the later stage of the study. This method creating a visual guide was used by Iantaffi (2011) in her study of identity development in women with disabilities in higher education. Drawing from a method from personal construct psychology, she asked her participants to draw "rivers of experience" (p. 275). She, and others (Pope & Denicolo, 2001), identify that this method allows for private reflection prior to interviews and richer detail in stories elicited through use of the river metaphor. For occupational therapists, this method has resonance as several participants had at least glancing familiarity with the model.

The collection of these Kawas is consistent with both grounded theory and narrative inquiry. In both grounded theory and narrative, the researcher is concerned with following the participants' trails, collecting their stories of experience (Charmaz, 2005; Lal, Suto & Ungar, 2012). The process of generating the Kawa to represent their experiences allowed the participants to shape their own stories, and to shape the subsequent interview that were developed based on their rivers, rather than the researcher imposing an interview structure on the participant.

Stage Two: Extended interviews. Consistent with both narrative research and grounded theory, data was collected through an extended, in-depth interview with participants, using the drawings as an interview guide for each participant. Interviews were video and or audio recorded for later review and transcription. For four of the participants, the interviews took place using voice over internet protocols (VOIP), specifically Skype. The Skype interviews were video and audio recorded using Evaer, a VOIP recorder that interacts with Skype. For one participant, the interviews took place in person and were audio-recorded only, as the researcher was present in the room with the participant. Two interview formats were used with each participant, each taking between 90 minutes and 4 hours, taking place in 2-4 sessions. Each interview format had a related yet differing focus.

Interview 1: Career History Interview. Career histories can be viewed as a subset of life history interviews. Marshall and Rossman (2011) identify that this type of interview is useful in "defining socialization and in studying aspects of acculturation and socialization in institutions and professions" (p. 151). This initial interview focused on the participant telling the story of their occupational therapy career. In this interview, demographic and background information were collected as well as the story of their choice of an occupational therapy career and their practice history. Participants described their practice, their thoughts about their practice, the contexts, the actors and other events that occurred over the course of their career. They were asked how their identity as an occupational therapist may have impacted other personal identities or other aspects of their lives. The interviews were open-ended and were guided by the initial Kawa drawings. All interviews began with the same request: "Starting at whichever point in time you choose, tell me the story of you becoming an occupational therapist".

Following completion of the career history interview, audio data was transcribed verbatim, reviewed and sent to each participant for review, confirmation and clarification. These transcripts were used for further reflection for the therapists to complete the next interview process. The participants were asked to identify any gaps or errors in the transcript or any further details they would like to add or correct. All therapists confirmed the content of the interview as reflecting their experiences

Critical Incident Interview. The second interview had a more specific focus on participant identified critical incidents in their career, most having been previously identified in the career history interview. This technique was first used by Flanagan (1954) and has subsequently been applied to other careers and professional groups. Flanagan defines "an incident is critical if it makes a 'significant' contribution, either positively or negatively, to the general aim of the activity." (p. 338). What is significant can be defined by the researcher or the participant.

Participants identified between four and eight critical incidents in their careers that were explored. As with the previous interviews, audio recorded data was transcribed verbatim and provided to the participants for review. These transcripts were provided to the participants for their review and were confirmed and clarified by the participants as needed. These transcripts were then used by participants for the next process.

Stage Three: Reflective Kawa construction. The Kawa Model (Iwama, 2006) was developed to assist occupational therapists in identifying important issues for their clients. Used as both an assessment and an evaluation, a client is asked to use the metaphor of a river to pictorially represent their life course. The use of the Kawa model and its river metaphor enables

the participants to examine and represent the complexity of their lives and professional careers through a common understanding of the elements of the river (Iwama, 2009). The Kawa model recognizes the complexity of the human-environment relationship and the cultural and historical situatedness of both the person and the profession and allows the participants to examine these concepts in a more accessible manner. In drawing the longitudinal and cross-sections of their rivers, the participants essentially 'mapped' their experience, enabling the researcher to better understand how the participants experienced their critical incidents and their career histories (Kara, 2015). MacLeod Schroeder, Enns, Cooper and Atleo (2012) proposed that this process could also be used as a reflective tool by occupational therapists to identify and analyze their professional practice history, allowing them to focus not only on personal characteristics and attributes but also contextual barriers and facilitators to their professional development and growth.

The final stage interview combined data collection and preliminary analysis. During this stage, the participants constructed Kawa representations of their occupational therapy careers. Similar to the initial Kawa drawings, these rivers reflected the data collected throughout the interviews. Participants re-created longitudinal river drawing, reflecting the data collected in the previous interview and, in addition, they created cross-sectional river drawings based on the shifts in the participants' careers as well as the critical incidents identified during the later interviews. The participants were asked to create these Kawas using whatever means they found comfortable. All therapists were able to draw the cross sections and did not require assistance as had been anticipated. One therapist opted to use mixed media to create her longitudinal Kawa, consistent with her interests and preferences. By using a shared, common metaphor, the participants essentially began their analysis with a shared set of codes with which to begin

analyzing their own stories and experiences, and allowing the researcher to have the participants' analysis as central to all further analysis.

Once these Kawa representations were received, the final interview took place and the researcher reviewed the Kawa with the participant. The researcher asked questions related to the process of creation of the Kawa, how they made the decisions in representation, clarified details based on the critical incident interviews, and clarified the relationships between elements of the Kawas.

Co-analysis is commonly used in narrative research to ensure the participant's voice is appropriately represented in the finished narrative. While less common in grounded theory, co-analysis is consistent with the constant comparative methods and the concurrent process of data collection and analysis. Additionally, Charmaz (2011) acknowledges that in grounded theory studies informed by constructionism, the data collected are a product of the co-construction of the researcher and participant.

Data analysis

Data analysis began with the completion of the first interview. Once transcribed, each interview was reviewed by the researcher, attending to the field notes generated during the interview. Preliminary codes, and key ideas of the participant's narrative were identified. These were used as potential probes or concepts to attend to during later interviews with the same participant as well as with other participants. Additionally, each participant reviewed their transcripts prior to the next interview to identify key ideas and reflections for later stages and to ensure accuracy in representation. This process continued throughout the data collection phase.

Following data collection, all transcripts were again reviewed, using the recordings while reading the transcripts. Codes were reviewed and refined. Transcripts were reviewed initially by research stage (i.e. all participant career history interviews, followed by the critical incident interviews), and then all interviews by participant. This allowed for comparison both within and across participants. Transcripts were coded, recoded and categorized throughout this process, using open coding. Second stage coding included attribute coding to identify values and beliefs.

Narrative analysis. Each participant's career history interview was re-storied to tell each of their stories of becoming an occupational therapist. Stories were constructed chronologically, considering time, place and plot. Key elements of the stories identified in the coding process were used to construct the narrative and develop a narrative theme. Preliminary drafts of the constructed stories were sent to each participant for reflection. The participants then provided feedback to the researcher as to the accuracy of the constructed story and any changes to their quotations were made for inclusion in the final draft of the stories. With these corrections all participants indicated the stories were reflective of their experience.

Grounded theory. Flanagan (1954) identified that the final step in analysis of critical incident interviews is the identification of critical behaviours and reporting them in ways that are appropriate to the aims of the study. Following this guidance, and recognizing the participants' ownership of their stories, the preliminary analysis was considered the generation of the Kawa diagrams, as participants were able to identify most relevant, salient ideas and elements information from their stories. This allowed for a fuller understanding of their perspective as they were able to capture and reflect thoughts and emotions that may not have been elicited during the interview.

Once all Kawas were collected, these diagrams were then preliminarily coded using the concepts of the Kawa model itself, as they were represented by each participant. The concepts and ideas reflected in each of these elements were then categorized, maintaining the participants' preliminary analysis (i.e. they remained in the Kawa element category as identified by the participant). Using the preliminary codes generated, as well as the attribute coding, a preliminary Kawa model of the key influences was developed.

Second stage analysis involved reducing the preliminary categories. Related categories were collapsed and named to reflect the new category. This continued until all data were included within the identified categories and categories were reflective of all data. Once this process was complete, categories were reorganised and reduced into themes. During this stage, categories were reorganized into themes reflective of the element of the river that represented the best fit with the definitions from Iwama (2006). Concepts were duplicated across Kawa elements were re-organized to be located in the element that represented the best fit, by the interpretation of the researcher, to reflect the definitions of the Kawa elements, and were felt to be most interpretable and understandable. This analysis was then represented in a draft Kawa model and sent to participants for reflection.

The final stage of analysis involved returning to the literature review to understand the themes identified. At this stage, some themes were renamed, consistent with the literature and understanding of identity formation. A final model was then generated.

Throughout the entire process, memos were generated, documenting the research process, developing understandings of the data, and all research decisions made. Member reflection was included during the final stages of analysis to refine the developed theory.

Data management. NVivo was used to store and manage all data. Kawa diagrams were scanned for inclusion in the data set.

Ethical Considerations

Ethical approval for this study was obtained from the Education and Nursing Research Ethics Board (ENREB) at the University of Manitoba. All participants provided informed consent using the consent form in Appendix 1. Additional consent for use of the created Kawa images was also obtained (Appendix 2). Access to data was limited to my participants, my doctoral advisor and the transcriptionist during transcription. All participants were given pseudonyms that were used in data analysis and representation.

Participants reviewed all generated transcripts, as well as the constructed stories generated. Participants were given the opportunity to correct, change or otherwise edit their stories. These edits were included in the final drafts of their stories.

Chapter Four: Kawas of Identity

This chapter includes a narrative analysis of the participants' career histories. The stories all begin at the point at which each identified their occupational therapy journey began. Direct quotes from the participants are represented in italics. Each therapist had 'acquired' the identity of an occupational therapist, though each had a different level of comfort with this identification, as well as their own expression of this identity. Images of their Kawa trajectories can be found in Appendix 3.

Donna: Finding a Fit

Donna entered occupational therapy school without knowing very much about it, only what she gleaned from the paper course catalogue from a University on the other side of the country. She was intrigued by the holistic nature of the profession, the blend of the mental and physical. She had never heard about this profession, and didn't know anyone who called themselves an occupational therapist. But after applying and being accepted at 2 different programs, she decided to go to occupational therapy school – a different one than first interested her, but still provinces away.

The decision to go to a school away from home was impactful for Donna. The transition to university life, away from home, seemed more influential and significant than the training as an occupational therapist. She was learning to be Donna. School came with lots of theory, but a lack of connection. Professors used the rhetoric of the profession, but a feeling of disconnect prevailed for Donna, save for one professor.

> *I've been able to reflect back on her style and, you know, her message and all that kind of stuff over time and get more out of it. And part of it I think was she spoke the*

> *language so easily. So fluently. She really internalized it and it was really coming from within. And others I think it maybe seemed more academic.*

Her curriculum gave her the basics *"... there were the interviewing courses and all that kind of stuff. ...there's the core content that you have to go through"* but she needed more guidance, mentoring. Another professor pushed Donna and her classmates to be more self-directed, to accept the process and the openness of the profession but this was a struggle for Donna: *"But at the time, I just wanted certainty. I just wanted to tell me, teach me what to do.*" She found herself frustrated with the theoretical nature of the program *"it seemed very theory heavy. And I really just wanted to know what to do*."

Fieldwork helped, being in clinical settings with occupational therapists, seeing what they do. On fieldwork she learned the technical skills of being an occupational therapist, but couldn't connect the ideas to those she heard about in the class.

> *I couldn't quite make a connection between making foot orthotics and some of the theory around coping, holistic and about how people do what they do in living your life in a meaningful way.*

The disconnect between the theory of the profession and the practice continued across placements and school. She continued to search for the connection between theory and practice, for the profession as advertised in the course calendar and spoken of so clearly by her professor. She thought she had internalized what occupational therapy was, but practice often fell short.

> *There was an outpatient kid and I was supposed to do something around upper extremity strengthening. And I remember I kind of had a sense that she wanted me to do some kind of exercise based thing. And I think what I did was some kind of game that involved writing or reaching or, you know, moving things around on a board or something. It was a game.*

> *And afterwards she said, kind of said, oh that was, that was good but I was really looking for something more like an exercise program.*

The result was a somewhat confused identity. There was the label of occupational therapist that was ultimately applied. She was told she was now an occupational therapist. She felt she should know more, know what to do or how to be an occupational therapist. *"I was just suddenly out and supposed to know something and I didn't really know anything."*

Added to the difficulty was the desire to be the type of occupational therapist she wanted to be. This occupational therapist was the theoretical representation, not the component based therapist she saw reflected in practice, the one disconnected from occupation and meaning. She felt that the practice context was shaping her more than what she wanted*, "So part of that I think is in coming out of school, there was still like, the river still trying to find its own course."* She was still trying to understand occupational therapy and what it meant to be an occupational therapist. Her initial understandings partially, but not fully confirmed by her academic experience, and disconnected from what she had seen in clinical practice. She was 'figuring' out who she was in relation to the profession. Her initial accidental entrance and developmental progression in the profession strongly influenced her identity.

> *So the fact that it was kind of an accidental, not necessarily completely intentional or fully formed when you went in, you're still going to figure that piece out at the end of where you're supposed to be and where you want to go.*

The need to connect the work she did with the purpose and meaning for her clients was important yet difficult to find. Ultimately she was able to find a position outside of the traditional health setting, working in community development. She found herself 'figuring' out the profession of occupational therapy, and what it was 'supposed' to be.

> *… then in this community engagement piece was organizing events for elders and bringing people together and kind of incorporating some of my, at least my attempts at, some cultural sensitivity. And a lot of just really exploring and talking to people about what would work here? What are people interested in? What do you think they would like? And what do you think they would enjoy doing? So, in terms of who am I as an OT or what does that mean to be an OT with my identity, that part really fit for me with what I understood of the theory piece.*

She understood the breadth of occupational therapy and, as she had since entering her occupational therapy program, she was challenged by the feeling that despite the philosophy and theory of occupational therapy, there was an expectation that the work was somehow different, more medical, more component based.

> *I had this idea that I wasn't doing what I was supposed to be doing. Like even doing it and feeling good about doing it, I had this feeling like this probably isn't really what I'm supposed to be doing in this role. I should be doing more of the equipment stuff, which I did. You know I did some of that, I did that too. I got to be seen as the person who would get people toilet seats and bath benches. But there was the other stuff I was doing too. But then I was really struggling too with, [pause] not struggling I guess but like reflecting a lot on cultural expectations of people's roles at different stages of life.*

She continued to seek meaning in what she was doing with her clients, but felt out of her comfort zone, not being part of the culture, and not feeling confident in how she was choosing to approach her practice. Reconciling the dissonance challenged her identity.

> *And noticing that what I was coming with was maybe not what people in that place was not really part of their cultural expectations for people of different ages. And then*

> *recognize that the elders would talk about wanting to be able to go out on the land or missing being able to go out on the land or out in the bush or whatever it is. And I was struggling with, well I'm supposed to be an OT, you know, I'm supposed to be able to facilitate people to do the occupations that are meaningful to them but I don't think I can get this person out in the bush. I don't know how to do that. Having this kind of feeling like this is what I'm really supposed to be doing is some kind of medical thing around rehab stuff or whatever. And so, feeling a little bit like an imposter. Like I'm doing the stuff which I think is really consistent with my theory and like kind of let's use that theory and that reasoning. But I feel like it's not really OT. [pause] No. I felt like it really was OT but I felt like it wasn't what the… somehow it wasn't what I was supposed to be doing as an OT.*

The isolated context, being unable to speak the language of her clients, the preconceived ideas of her colleagues and her own clinical inexperience made the experience stressful. One interprofessional colleague in particular had her own conceptualization of what an occupational therapist was, and what they should do. *"She was very medically oriented. And it was much more kind of community level and engagement stuff that I was seeing as things that I could do, I was working on."*

Ultimately, Donna made the choice to leave the setting after about a year. She couldn't find a fit in the context, despite the richness that the opportunity offered. Her social supports were elsewhere and the isolation was a challenge to her own mental health. She returned to the city and found a more traditional occupational therapy position, involving home care and school health interventions. Her feelings of being an imposter, and not part of the culture, persisted, though for different reasons here. Now there were other occupational therapists in similar roles

she could look to for support and guidance, but they had their own culture that Donna was not yet part of. She needed to find her fit in this new context, to fit in with the therapists and the practice, and to fit with the profession – to figure out who she was, or wanted to be as an occupational therapist.

> *You know it was just coming into an established group and trying to find my place in it. And I'm still trying to find my place in the profession too because like, so now I'm doing home care which is a very OT kind of thing. And being in the community part was good. But then I was still, I think it was during that period of time but, I guess it's just still trying to find the right area.*

She continued to struggle with who she was supposed to be and with what she believed others expected her to be. In her school health role, she found similar experiences to her fieldwork, the disconnect between the ideal of occupation-centred practice and the reality of the components she was expected to address.

> *So here I am and I'm doing these assessments. And then I'm supposed to, you know, I report on the results and I'm supposed to say what it means. And I don't really. I can never say that, but in my head I think I don't know what it means. But I'm supposed to say that we'll work on fine motor skills. So, I'll say that we're working on fine motor skills. And, or printing or whatever. So I didn't ever really make a connection.*

The lack of relevancy for her again led her to question her identity as an occupational therapist.

> *I'm bullshitting in giving my feedback and my results. And so that reflects on me as an OT, that I'm not really a good OT or I don't really belong in the profession.*

She had her own ideas but found herself restricted by expectations *"Because I was coming at it with some new ideas and I was just as frustrated. So, anyway, I know I was more frustrated probably because I had new ideas."*

She struggled to find meaning in the assessments and interventions for her clients. She questioned their fit. They didn't seem relevant for most of those she saw. And much of the work was out of context for the clients, taking place outside of their actual environments. She tried to spend more time in classrooms, seeing the child in the environment that mattered, and to look beyond the simple generation of letters, but how the child managed as a student. She struggled with meaning and holism, basic tenets of occupational therapy philosophy, but too often found lacking in her experiences thus far. She struggled to connect what she had been told occupational therapy was and what she was seeing. As a result, she struggled to see how she fit in as an occupational therapist, and if that was who she wanted to be. Her identity at this point was fragile, and dependent on the credential, rather than an internal sense of self. *"I came out of school and I graduated as an OT and I was an OT but I didn't really have a sense of what that meant to me I think. Like I was an OT because I was OT on paper."*

She saw the breadth of occupational therapy, and recognized there was a fit for many different types of occupational therapy, but needed to find her niche, one that connected her need for holism and meaning, and went beyond component body functions and skills. When an opportunity presented itself in a paediatric mental health setting, she moved positions. Here she found a better fit: *"it just felt like I was in the right place."*

The new site had inter and intra professional 'elders' who were not only available to offer support and guidance, but also saw it as part of their work*, "... they really seemed to see it as part of their role to mentor upcoming people, professionals."*

She enjoyed the work and the general support. However, she could see a connection to occupation in others' roles, in addition to hers. While the role of the occupational therapist was clearly defined, she continued to struggle with what the uniqueness of occupational therapy was.

> *And I was still struggling with that thing of, like what is OT. And why is this, why is doing a VMI OT and not psychology. Or why is doing a VMI OT and helping them to learn to sit and raise their hand in class not OT. Or helping them to communicate with their family.*

She also learned that she wasn't the only one with the struggle. Her predecessor also seemed to struggle, but had not yet found a way through the reductionist nature of the assessments and making the role more occupationally based. While she struggled with the standard nature of the work, doing similar things over and over again, she found that she had more opportunity to explore and discuss her thinking than she had experienced previously, with like-minded colleagues.

> *We spent a lot of time reasoning through what is it that works for this kid and why do some, why does it work for some kids and not for other kids. And how do we anticipate which kids it will work well with… So we could really delve into those questions at that time, which I haven't really felt able to do in many other, with many other OT contexts*.

She had found some of the things that had been lacking in her placement and previous work. She could make connections and learn from her non-occupational therapy colleagues, to use with her clients.

> *And I think maybe has helped me get a more holistic, helped to kind of flesh some of those areas that we didn't really learn about in OT very much. Like understanding more of the cognitive piece, or the neuro cognitive piece from the psychology perspective. And*

more of like the family systems and emotional process piece from the social work and counselling side of things.

The setting offered her the opportunity to work with and learn from her inter and intra professional colleagues in a new way. An opportunity to discuss and reason and process what she was seeing, and to actually challenge and question practice, in a safe space. Over time, as with many work contexts, the people and the work changed and she found herself enjoying her work and her co-workers less and less. She had exhausted the learning and the challenge, and the work had become rote and once again procedural. The biomedical and behavioural approach that the team worked from had become too limiting. She was looking for new ideas and new challenges and the practice was less and less of a fit for her. Donna credits her work on her Master's degree with keeping her in the profession. The ideas that she was exploring were what she had been looking for, even if she couldn't see them applied in practice, *"It felt so good to me. Like it really felt like closure, coming home or, you know, I don't know…finishing unfinished business. It was good."*

At the same time, she entered a private practice, with occupational therapy colleagues who shared her sense of occupation, and the need to connect with meaning, once again working in a familiar area.

Donna continually links her learning and need for challenge to her identity as an occupational therapist. She needs the challenge and the questions to keep her moving forward.

I get to a point where I've learned as much as I can learn and integrate it as much as I can integrate from one thing. I need to move on to something else so that I can keep going with the questions. I don't think I get to a point of professional identity being a fixed thing. …So I always have questions about what is OT and who am I in OT. And as

> *long as that there's that kind of dynamic being able to explore that, that probably is what kind of keeps me going with it.*

The Masters was a way to reconnect with the theory of occupation and take on new learning outside of the work context.

> *And I really went into it with, that it was something that I was doing for myself. And I wasn't trying to get anywhere. Like it's not going to advance me in the profession. It doesn't get me any more money. It doesn't really get me anything. I wasn't really thinking I was inclined to academia or anything. It was just something I was doing for myself to explore, to have some freedom to explore.*

Following completion of her Master's degree, and with the lack of interest in her work, Donna was feeling burnt out in her occupational therapy practice. An opportunity to move across the country presented itself and Donna went, not knowing what her future as an occupational therapist would look like.

> *I've kept up my licensing but there certainly have been times where I felt like when I'm done whatever this thing is, maybe I'm just not going to keep it up anymore and go in different directions. But I've kept it. And sometimes, I guess it's kind of like a marriage, right. Sometimes what gets you through is that you're married and that you're stuck with it.*

Part of her identity is tied up in the commitment to the profession she entered more than a decade before. She continued to search for her connection to the profession. She took short term contracts in the community, including roles that involved supporting children with special needs in the community, outside the health context. While not labeled as an occupational therapist in her context, she brought her skills and knowledge to the work.

Through this, she made connections to a children and youth centre who created a position for her that didn't have an established job description. The lack of clarity and their lack of understanding of occupational therapy was not without its challenges, but the freedom of not being constrained by what others think of as occupational therapy is freeing. Her work in the social services setting allows her a broader lens, but she still finds herself in conflict with what she sees as the traditional or medical lens that many occupational therapists take on.

> *And so, the report is commenting on the kid's pencil grasp. She's 13 or 14. And in crisis enough that she needs to be flown far away to stabilize. I don't think how she's holding her pencil is the biggest issue and how in relation to how she's occupying herself there. And so I feel like, in the little bits that I've seen a lot of OTs drop into these other settings and they don't change their lens.*

Donna continues to see the need for occupation, and the disconnect, or lack of connection to occupation and meaning that is often part of the role expectation for occupational therapists.

> *And it feels more comfortable for me as reflecting kind of professional. Although I've struggled with that a lot too because what does it mean to be occupation based? What does it mean to be occupation focused? Or what it means that we haven't had a practice that is based on occupation? And what techniques or approaches or whatever count as occupation based approaches to fill the occupations.*

Donna continues to struggle with these questions. What does it mean to be occupation focused? How do the components we are trained to look at relate to occupation, or how do we see them fit? These questions have often put Donna in the position of outsider on the inside. She is accepted as and expected to be an occupational therapist, yet she continues to challenge what it means to be an occupational therapist in many settings. Her most occupation focused role is one

that doesn't even understand or require the credential. There her credential makes her the outsider.

Rachel: Finding a Niche

Rachel completed a degree in kinesiology after trying out most of the basics sciences during her Bachelor's degree. She had taken longer than was typical to complete her degree, also exploring sport and other extra-curricular activities on her way to discovering what she was going to do. Her first job after graduation was working as a health and fitness co-ordinator for a large industrial company.

She enjoyed her work and working with people; it gave her the opportunity to develop skills in providing education, work with interesting people and support herself. However, she found that during her fitness sessions, people would often talk about their problems, to the point that often she didn't complete fitness testing.

> *And I found they would walk in the door and they would talk about all their problems, addictions, or relationships or home life or children. And I would talk to them and not test them for any type of fitness. And then they would leave. Because, depending where they were at, I felt like why do a sit-up test? It kind of seemed like you're missing the mark somehow. So then I was thinking about something more holistic.*

She had previously considered a career in medicine but ultimately decided it wasn't for her. So, when a friend was applying to occupational therapy, she also applied, even though she didn't have a clear picture of what an occupational therapist was or did. She did some research and felt it was broader than kinesiology. She was also attracted to the status of occupational therapy as a profession, something that kinesiology was struggling with.

"And I felt like occupational therapy was a profession. That you'd be more mobile and employable and it would be dependable and all those kinds of things."

She had completed her previous degree without debt, so leaving a paying job to go into debt for another degree was a bit daunting, but she was single and without children so felt it was worth the risks and expense. She felt that working in something that she found worthwhile, and rewarding was more important, crediting her upbringing for instilling this value.

I was raised to have that outlook, to have something rewarding and something you could live into. And I knew there was a breadth to it. I think I felt like it was open enough that OK, you go and learn more, and then you can choose to work with this population or that population. So I think I had an idea of the breadth of it.

It was the breadth of occupational therapy that appealed to Rachel, as well as the potential to grow into a profession. She recognized that there was more to working with people and wellness than merely physical, that different people had different needs.

Rachel attended an occupational therapy program several provinces away. She found the program a strong foundation for understanding occupational therapy and found there was excitement about the profession of occupational therapy and its potential in the program. The faculty projected a sense of satisfaction with their chosen profession that she found very different from her previous degree.

The curriculum was very alive. And fully interactive and into that self-directed, problem based learning. It's one of the reasons I chose that school. And I did really enjoy that, working with the material. Getting into it. Dialogue and debate and discussion and project.

While the faculty were supportive, some of the students struggled with the self-directed nature of the program and the variation in knowledge and skills with entry into the program, as well as the faculty members' commitment to this model.

> *Some of the students felt because they didn't have a physical undergrad, they said, 'I can't go into the anatomy lab and be self-directed. I need some more kind of direction at least in terms of where do I start, and maybe have somebody come with me the first time or the first three times.'*

She found that at times she was looking for more discrete answers than the curriculum and the theories provided, often feeling as though she was adopting a persona that she didn't completely feel.

> *I remember all these theories of everything. After so many semesters, you figure OK, now I'm going to learn about the parts of a wheelchair. It's like no, you're not going to. That's what you learn on your practicums or maybe you never do. They didn't really get into the specifics of a lot of things. I think a few things maybe were covered in more detail but at the time, I felt like our curriculum was always about the approach.*

The students, even those with experience, felt lost in this model. They created their own structures to work through the difficulties. They challenged the faculty and requested more support that Rachel did not feel was received. Rachel felt that she still needed to see what clinical practice looked like as the problem-based model, and 'figuring it out' for yourself did not always seem adequate for what she felt she would need to be in practice.

> *But some of those clinical skills I think I would have loved a whole classroom observation of some really skilled…I mean they have amazing clinicians there. … And*

just to come in and demonstrate, OK, here's an example of what you might do. Very specific. Because it was never very specific.

But she also realized she was going to need to find her own way into the profession and what would fit for her. She found more traditional acute care and community based placements were the norm, and not necessarily what was interesting to her. She found herself drawn to practice areas such as hand therapy, given her previous experience with anatomy and physics, and she considers herself a detail person, that assisted her in those areas. She also found herself enjoying learning from others beyond faculty. But from her peers she also learned the ambiguity that was part of occupational therapy, and the different ways 'to be' an occupational therapist.

I think the scary part was I learned that it could look like almost anything. No clear sense. I remember sitting around being like, what is this anyways? I mean we're student OTs and we still don't understand what this is like? And is this going to be enough? Are we really going to be employable and all those kind of questions?

Students found that the placements were there to teach the tangible, technical skills that the academic curriculum appeared to be lacking; but they didn't necessarily integrate the holism that Rachel found in the curriculum, leaving a disconnect. She attributed this to the personalities of the therapists and their older training.

A lot of them were more mature OTs of course, had been trained however many years ago. And they spoke nothing about theories or theoretical models or gave anything about how or why they were approaching something a certain way. …It was exposure but I really don't remember applying a lot from school.

Placements were seen as potentially building technical skills, but also a way of exposing the student occupational therapists to different practices, helping the students to choose an area

of potential practice. Beyond the disconnect between school and clinic, placements also caused some emotional distress that wasn't anticipated, leading to further reflection about where to practice.

> *I went home and ran every day because I thought my legs, my legs, I gotta run. You're just so emotionally affected by everything at that stage I think.*

These experiences led to hesitation about the profession. She wasn't seeing what she was being taught, she wasn't certain she was getting the skills she would need, and she didn't see herself represented in the occupational therapists she was working with.

> *I had multiple preceptors that were kind of in that same personality category, kind of scattered, not really planning their day. Didn't really give me a list of anything that I was going to be seeing. It was just kind of like go from one thing to the next and follow them along and see what you see. … But I felt like it'd be neat to actually shadow somebody that had been trained more like I was being trained.*

The supervising therapists weren't able to put the pieces together for Rachel. She couldn't see the entirety of the picture of the client or the context. She was looking for more clarity, in the work and in what was expected of her. She found this on her paediatric placement.

> *I think she broke it down a little bit more in terms of, 'OK, let's work on visual perception and he has a hard time with coordinating hand-eye movements and so you're going to try these types of things.'*

Rachel found that she couldn't reconcile the approach she was being directed to take and meaning or relevance to her client. She was being taught about meaning and relevance to clients and felt she wasn't seeing this in the practice she was observing.

I had to do these cones games, moving the cones from one side of the desk to the other. And there was this guy, I read his file and it was cancer. And I remember thinking, why am I doing cone games with him? And then the guy had actually passed away later that afternoon. And I thought, I just spent his last day with him doing cone games. … But just the disconnect between why in the world would you want to strengthen your shoulder and cross midline when you're just about to pass away. Just seems crazy.

Rachel found placements confusing and inconsistent. They were seen as important to build skills but they were often lacking what she felt she needed. The disconnection between the theory and practice of occupational therapy was one contributing factor, but the characteristics of the supervising therapists also impacted her. Similar to the therapists that couldn't translate practice to her, she found that she was looking for a level of engagement from her supervisors that wasn't there.

In fact, there was a calendar on the wall and she was crossing off the days to her retirement as I was on this placement… I remember going back to school after my placements and hearing about other people's experiences of being, what? How did I get the disinterested almost retired OT again?

Rachel did find success in one of her final placements, one in the field of hand therapy. She attributes her success and enjoyment to the clarity of expectations, and translation of her reasoning, that she had not experienced on early placements, in addition to her growing knowledge.

It was really solid. And I was doing more maybe because I knew more. But maybe just because they knew how to use me more, you know. And she actually set up, OK, for the first couple of weeks, you're going to be doing this. And maybe you'll finish the splints at

> *the end, near the end of the second week…. And I remember there being sort of this trajectory to the point for the last 3 or 4 weeks, you're just going to be basically like seeing clients. ... So there was this real kind of journey.*

The engagement of the supervising therapist in Rachel's learning, and her ability to translate her reasoning and practice to Rachel, enabled success on the placement. For Rachel, this was the sole placement where she felt supported to learn and then, as a result, experienced a sense of competence.

The exposure of the students to skilled clinical practice was dependent entirely on their exposure in placements, and if the supervising therapist was not skilled, or not engaged (as Rachel feels she experienced often), then this exposure was missing and the students were left to develop the competency and determine skilled practice on their own. The result for Rachel was graduating and feeling that while she had a lot of general knowledge, and principles of occupational therapy, she was uncertain what to do in many areas.

> *It was like, OK, I know generally how to approach every single client in this country but not really specifically how to approach anything. So now what? It was kind of a little bit daunting I think graduating and realizing, oh wow, it's the end of the journey. I think I felt emotionally like an OT. I think the weak parts were the actual clinical skills.*

After graduation, Rachel took some time and did some volunteer work. She moved back to her home province and started looking for work. She was not looking for a specific area, just someone hiring an occupational therapist. She ultimately found a position in a small private practice company in a small town. One of the draws for the position was the owners' willingness to offer her mentorship in this new position. The role was broad in nature as the practice did not

specialize in any one area of practice. In the owner, Rachel found the mentor she had been looking for, a therapist unlike most of her preceptors.

> *She was very, very smart. She was very entrepreneurial which is quite unique in the OT land to have that real entrepreneurial mind as well as the OT identity. She was really energetic. Fun. She was confident.*

While she was being offered mentorship, she also found that she was sometimes treated like a student, or directed in ways that she wasn't completely comfortable. When directed to make a splint with what Rachel felt was the incorrect material, she complied. When another professional called about the splint, she felt embarrassed by her work and the fact she was going against the practices she had been trained in. She found the use of evidence in practice (a key tenet of Rachel's training) was lacking. But she also found the experience useful, as she developed an idea of being in practice and learning how to be an occupational therapist. She struggled with the roles between herself and the owner. While Rachel was an independent contractor, the owner had asserted multiple roles that caused some blurring and confusion, (supervisor, mentor, employer) resulting in challenges for Rachel to be autonomous. When she wanted to work with clients in a different way, Rachel found that there were limits and boundaries to what she could do.

> *And sometimes I felt like I couldn't really be autonomous in terms of where I took files because she was overseeing them. That's the relationship which she and I had. I came in kind of as a subordinate almost. But because I didn't have any experience she was always mentoring me. But then the mentoring was blurry. I didn't feel the freedom that I could go that journey. It was just OK, stay within whatever's approved by my supervisor?*

While she struggled with following the direction of the owner, she did find that she learned a lot from the exposure to a wide variety of clients and cases. The owner did ease her into practice, limiting the more complex cases at first as Rachel gained experience.

Rachel did continue to struggle with what she called occupational therapy's ambiguity and openness in approach and the lack of a clear, single correct answer, something Rachel saw as a lack of orientation to detail. Rachel saw that ambiguity as one of the more difficult things she faced in her career – coming to terms with the lack of one discrete answer for many clients.

> *And I think, that bridge for me was really long and under duress. I remember that being the hardest thing to kind of get over. I really want to feel like I'm doing the right thing, that I'm doing well. And how do you measure that? I had no way of feeling good about what I was doing.*

This search for the detail, for the one correct solution, occasionally led to identity questions.

> *Sometimes I wonder 'why am I doing this?' It's a field where it's just creative and there really isn't the one right answer. But there's that constant search I think when you're developing your identity in it to think 'well what would other people do here?' I'd be out breaking down a task for a brain injured client with a memory problem and I'd think, OK, notebooks and alarms and all these strategies. You think, what would somebody else do? Like somebody else is going to walk in there and do something completely different. That didn't sit well with me? It didn't feel settled. I wasn't OK with that.*

Rachel felt as though there was something she was missing, that the correct answer was out there if she looked hard enough or if she were simply more experienced.

> *And I would stay there 10 or 11 at night and be typing and trying to like fix and fiddle and read and learn more and what kind of resource… You're just in this, I think I was in*

this panic for resources and being able to apply. I would want to apply kind of the perfect thing to this. I want to be prepared and I just wanted to be all these things, but I felt like I wasn't.

To augment her hours, Rachel also took a job at the local community hospital, working with clients who were preparing for discharge from hospital. At that point in her career she felt she needed those tangible skills that she might have been missing, or at least, that she needed to maintain, so that she could continue to 'be an occupational therapist'.

And if I don't work in a hospital, I just won't maintain that knowledge of wheelchairs and of transfers and then I just won't be employable anymore. Maybe I won't even be an OT anymore.

Rachel found that while the hours help to support her and maintain her identity as an occupational therapist, she found it more difficult to engage in the more limited role. The two positions were quite a contrast. In the hospital she felt a level of familiarity and comfort with the traditional role of occupational therapy, but also a little bored. At the private practice, there was no consistency in cases and every case was new learning.

I feel comfortable here [the hospital]. I feel like I know what I'm supposed to be doing and I feel like the parameters are kind of more clear. And, you know, on a day-to-day basis, it's more rewarding in some ways because you can say, yes I saw 7 pre-op patients and I told them all what their abilities are going to be after. … And each person is more or less the same. And so that builds some competency. Where I think the private practice, it was just a smattering of this and that. I loved it more. I was more passionate about it but it was also, I think I felt like it was far more challenging and it kind of rocked me a little bit more.

After a few years of working casually at the hospital and the private practice, she added in work at a local paediatric centre, again to add more hours to support herself. While she felt that she had developed competence as a therapist, this change was another challenge, as she hadn't done paediatric practice since she was in school. While she didn't feel that she had the expertise that they were looking for, she drew on the problem-based learning model that she had used in school to market herself to the new employer. She struggled to connect some of what she was doing to the context of the child. *"I remember everything was just a little bit over here and a little bit over there. And I didn't have any kind of complete puzzle as to what I was trying to do."* And similar to her placements, she found the expert there could not translate her practice in a way that Rachel could understand. Rachel found it difficult to figure out which details she should be attending to, and more importantly, how these details integrated into a whole. *"And it was hard to even keep in mind all those kinds of different things that you're supposed to be looking at, let alone try to integrate them together or really interpret anything,"*

The paediatric centre offered her other opportunities beyond learning this new area – it offered her the chance to work in an interprofessional team that Rachel found helpful as she was trying to learn the new area. *"It was very swimmy those first few years. It was positive and supportive enough to kind of keep me going and keep me floating but, in terms of my own, you're in way over your head, you kind of know that, right?"*

She found her sense of competence came on suddenly and caught her unawares.

> *All of a sudden. And I don't know when that exactly happened. It just happened so gradually and so much over time that all of a sudden after how many years. … But sure enough, all of a sudden you're looking at a client and the team's asking you things and*

all of a sudden you're thinking, I don't have enough time to share everything that I know. It's like, how did that happen? It seems like it happens overnight sometimes.

With her sense of competence came an increased comfort with the ambiguity of occupational therapy, and an increased sense of identity.

But I think OT's pretty unique in that even though there can be a lot of shifting between how you're going to approach something or how you're going to assess something or how you're going to look at something or work with something, a soundness in there. I feel good wearing like that pin that says I'm an Occupational Therapist because I know whatever that shifting is, it's going to fit in the boundaries of that profession.

As Rachel developed in her identity, she found herself taking new challenges. She joined her provincial occupational therapy association, and after that, the provincial occupational therapy regulatory college. This opened her eyes to another way of being an occupational therapist.

I think having that experience of the professional association really helped me realize how powerful it could be. How you could be a powerful OT and it's OK. Like it could be client centred and you can still be powerful in some way.

Along the way, she left the private practice and was working solely at the paediatric centre. She had several maternity leaves while she was there, and eventually she and her young family decided to move. She then took a part time position in another paediatric centre, though her caseload had a different focus. In this position she was working with support personnel in a more consultative role. She developed programs that would be delivered by others. The entire context was different, and she found it not only less client-centred, but also less supportive with respect to the interprofessional team*, "There was a kind of jadedness about what those families*

were like and what they could do." She found the attitudes of the others difficult and disempowering. When she challenged the conceptualizations of the clients, it created conflict. The team seemed demoralized and it created a difficult environment. There was no clear leadership that seemed to create an environment where everyone managed themselves.

> *There's no personal practice leader, no kind of therapy head or anything. So I was shocked at that and what that does because it just puts everybody so level which seems like a good idea but then it's really nobody's responsibility to look after the program which is quite apparent that the program isn't really looked after.*

She was only in the position on a term but she often chose to question the others on the team about their approach and what had been tried. She maintained a sense of openness to finding the competencies of the children and their families that much of the team had discarded. When the term completed, she was in some ways relieved that it was not extended.

When that locum ended, Rachel became a private contractor, and eventually decided to open her own private practice. Her first contract was similar to her work at the first paediatric centre, consulting with children with autism and their families. Familiar territory that gave her a sense of competence. However, the consultative nature was more difficult for her. She was limited in the number of hours she could spend with a single client, and she felt constrained by the contract as it limited her ability to interact with the families, something she was always committed to. She also found that she was being called in for specific cases, and always at the direction of another professional, something that was different than the team approach at the centre. She found herself assessing and making recommendations, then passing off files to others, that made her uncomfortable, not knowing the background of the person she was

transitioning clients to, even going as far to call the provincial regulator to make sure this was acceptable.

She often found that unlike her previous positions, many did not understand her role or what an occupational therapist could offer. While this was difficult at first, rather than giving up, she used this as opportunity to educate others about what she could offer.

> *But I still keep putting out the olive branches, like 'hey, I'm willing to present.' And 'here's a two pager on the evidence base of sensory processing and, where does the evidence lie and where does it not lie' that kind of thing.*

She didn't find this a threat, just something that she could slowly work towards changing as she builds her practice. She is slowly building her own private practice, something she didn't necessarily seek out. And learning the processes that go with that, learning how to market herself, reaching out to a community that doesn't necessarily understand occupational therapy and letting them know what she can offer. She is also building a community of other therapists to provide herself some professional support and guidance.

Jessica: Finding a Passion

Jessica first heard about occupational therapy as a high school student. Given an assignment to explore and learn more about a future career, she chose nursing. The resulting research for the paper brought her to the conclusion that nursing was not a career for her, but given her interests, her guidance counsellor suggested occupational therapy. After an opportunity to shadow and spend some time with an occupational therapist in a city about an hour away, Jessica thought she had found what she wanted to do. She was interested in working in health care and also intrigued by the combination of physical and mental health that the career seemed

to offer. So, following high school, she went to university and entered occupational therapy after her first year.

She found an immediate connection with most of her classmates as she felt they shared something in common. And she enjoyed most of her professors. She did struggle with courses in that she could not connect with the material, and with more abstract courses where the professor was not able to translate to the abstract concepts in a way that she could understand.

> *I remember kind of dreading that class and dreading the assignments because I just wasn't really sure what she was getting at, what she was looking for and I didn't know there'd be so much theory.*

Her first fieldwork supervisor was an important influence on her development. Jessica found it wasn't so much her clinical skills that needed work at that time, though she didn't know much about occupational therapy, it was really her confidence that needed development.

> *I needed help with my confidence then. I was 19. Just away from home essentially. I was young. I'm here and seeing people, working with adults who maybe have had certain diagnoses for years and had varying therapists over the years. And here I am coming in very naive. … I remember just feeling that she went out of her way.*

The therapist helped her to understand what the role of the occupational therapist was and to stay focused, that in turn grew her confidence. Her next placement wasn't as successful. She was working in a hospital that employed only one occupational therapist and she found that with the style difference of the therapist created challenges for her.

> *So if it wasn't done his way, I had to redo it a lot. I remember having to redo chart notes because they were written in black pen instead of blue pen. And just being quite nervous around him. So I just felt like I didn't learn a lot at that placement.*

She also believes the gender difference, and the intimacy of some occupational therapy assessments and interventions made her uncomfortable.

> *I was a bit uncomfortable because he was a man I think. So sometimes we were doing an ADL assessment on an elderly woman. And I personally felt that woman would have been more comfortable with just me. But he had to stay there. And I felt there was just lots of weird sort of. Maybe I wasn't comfortable with our relationship obviously.*

The interactions with her supervisor altered her mood and led her to question her fit with the profession. *"I was feeling pretty low. And wondering, if this is how some therapists are, that's not what I want to be like."*

The interaction had a significant effect on Jessica as she holds it with her even now:

> *I think it probably helped me as an educator in the future. Because I knew how he made me feel. And I wanted to make sure that that didn't happen. Students, this is the first time doing this or second time doing this and they need, some of them more than others, might need more encouragement and feedback. And not a critical attitude for their learning.*

The difficulty with the placement led her to question her fit with the profession. Fortunately, other placements were more successful, something that often went with the personality of the supervising therapists and the working relationships, more than the client population or site of the placements.

Beyond identifying the type of environment she wanted to work in and beginning to realize who she wanted to be (or not be) as a therapist, fieldwork also helped Jessica to identify areas of practice that she did and did not like. She spent some time in a developmental centre, working in mental health and older adults which didn't appeal to her. She also spent time in a paediatric hospital setting, where she realized she didn't want to work with children, finding that

the behavioural and developmental differences in children complicated the work and she felt the practice area was not the best fit for her personality.

> *I've always thought that I'm not that creative of a person. And I felt that the therapists I watched at the hospital had to be creative very quickly. That potentially turned me off a little bit. Because I felt, although I could be creative, I had to think about it more. But with the kids, you needed to be creative quickly. You need to change things up quickly if they were getting bored or losing attention.*

For her final placement, Jessica opted to take a placement out of province in a large city. By this point Jessica was certain that she wanted to work in neurology and this placement gave her the opportunity to explore the role and her fit.

The placement confirmed this interest area and Jessica was lucky enough to secure a position in neurology in her home province immediately following placement. She was on a team with two other therapists who were both very confident. She found herself in need of some support in her early days.

> *I went to them a lot. They were good. Was a good team. But I also felt quite unsure what I was doing. …The clients were dealing with traumatic changes. Drastic. From walking to being a quadraplegic. Many of them were very angry. And I certainly remember a lot of my first clients and just 'wow, I hope I did the right thing.' Went to my coworkers a lot.*

She found the population more difficult than she imagined "*It did make me realize that, 'I'm going to try this for a while but there are other opportunities. I'm going to move on from here. Because I just feel like I wasn't making as much of a difference perhaps.'"* She found that the catastrophic nature of the injuries and her location in the hospital often limited what she felt she could do.

Her thoughts of moving were complicated by rising conflict with her occupational therapy colleagues. As the new graduate on the program, she felt that her voice wasn't heard among the more confident voices of the co-workers.

> *I felt like all my decisions had to go with what they were thinking. I would think something was maybe right but it was kind of vetoed down from them. But I do remember ending up in my manager's office talking about this and feeling like, 'am I losing my mind?' And it was really well known that these two people were very strong personalities. So, I'm a new grad but my opinion still matters.*

The result was Jessica second guessing her thinking, and with her novice skill set at the time, she felt that she *"Had to follow the process, their protocol."* While her manager supported her, Jessica ultimately left the service, with conflict with her co-workers ultimately the deciding factor. She took a maternity leave position in the same hospital but on an orthopedic unit, moving away from the neurology department that she had originally sought out.

The orthopaedic unit had clients with less catastrophic injuries but still left Jessica wondering about how much she was able to do in her clients' lives.

> *My interactions with the clients were very repetitive. From client to client my chart notes were pretty much exactly the same. Because I basically did the same thing with everybody. So it wasn't a highly stimulating time for my brain.*

She knew that she didn't want to stay there as the work did not offer her the challenge and problem solving that the neurology unit afforded her. But, at the same time, she was glad for the change *"I was out of that stressful environment."* A few months in, Jessica knew that she wouldn't stay beyond the maternity leave. Aside from the work not being stimulating, she didn't like how the occupational therapist was seen.

And just feeling that the OT role on the team wasn't necessarily that valued or was only valued for a couple of things. Well it was just sort of like we were the equipment people.

When the term position was over, Jessica returned to the neurology program, though this time on a different team. She found that she had more time with her clients and as a result, she got to know them better, something that was important to her. She also found challenges working with differing personalities on the interprofessional team, but unlike earlier in her career, she found that she felt more confident to advocate for her role and her ideas. The physician in particular had strong opinions that often conflicted with Jessica's. Jessica often worked with the other team members to support her ideas and advocate on behalf of the clients.

And she was very black and white. So you're never going to recover. Never going to use that arm again. You're never going to walk. So it took me a while to figure out, OK, she's saying that but look at this person is actually doing this. So probably my first while there I was believing her. And I remember certainly standing up to her many times in rounds or in the hallway. 'Actually, this is what this person's doing in therapy.' I'd ask her to come watch sometimes. She never did. But certainly, I remember it was a good team. Like the physio would often be seeing the same the thing I was. So it wasn't just me. We'd back each other up. And even around discharge planning, she would want someone to be gone while these are the many reasons why OT thinks they can't leave yet. Here's the reasons physio thinks they can't yet."

She felt it was an important part of her role to give her clients hope, which was often made more difficult by the lead physician.

These people needed hope. That was the bottom line. 'You know what, if we're going to do anything in therapy they need some hope. So we need to address that immediately.' So

> *I think that was probably one of the frustrating things is taking her negative they were feeling and turning it into a hopeful situation again.*

Jessica enjoyed working with clients with stroke and brain injuries and found that the potential for the brain to heal intrigued her. In her early days in the roles, she focused mostly on compensation for lost physical or cognitive function as her role. She took additional continuing education to learn more skills but found that while her clients would show some improvements clinically, it didn't necessarily translate into change in occupation.

Jessica enjoyed the team but found she still didn't feel she knew enough to truly help her clients. Her senior therapist, someone who was in a position to assist the more junior therapists wasn't able to assist Jessica in her development. Jessica found this a sharp contrast to her senior therapist from the orthopaedic unit who had taken a more active role in teaching her.

> *She was very involved with making sure all the policies were up to date and that the binders were all organized and if we asked questions, she'd point us to the right binder versus helping us and then maybe giving us some extra supplement reading. So I pretty much avoided her. And she was quite abstract when she spoke so I didn't get that with her. She was talking about theories and stuff. And I just wanted to know what to do with this blessed arm. So it ended up being a make work project when you talked to her.*

Following her own maternity leave, Jessica chose to leave the stroke rehabilitation unit, moving back to acute care, though this time in neurology, which gave her the opportunity to work part time. She entered the position with some trepidation. *"I'd gone into that job with hearing a lot about how I'm not going to like it. There was a very negative perception to that job. There'd been lots of people in and out of that job. It seemed like a really hard job."*

The job was considered fast paced and highly technical, with high expectations of the person taking the role. To Jessica's surprise, she enjoyed much of the position.

> *I really liked it. It wasn't that different from what I was doing. We had a pretty good team there. A clinical nurse specialist was the boss of them and she totally valued OTs opinion which was great.*

Team dynamics and supports were very important to Jessica, and often the main reason she enjoyed a team. The clinical nurse specialist had a clear understanding of what occupational therapy could offer to the team as well the clients. While this nurse was supportive, Jessica did have some challenges. She found that many of the clients were very complex, and as a result, she often had to learn new skills on her own.

> *But it was very challenging. I'd never done stim [sensory stimulation] with people before so. And there was no one to teach me how to do that. So I had to do a lot of research and looking into that and I don't know even know who I would have gone to necessarily. So it's challenging again. I didn't feel so terribly confident. On the other hand, I thought, again it was something nobody else was doing on the team.*

Jessica enjoyed having a clear role on the team, and providing something to the client that others were unable to offer.

After some time on the unit, the part time role ended and Jessica moved to another service, again to find an area that could fit with her home life and she could work part time. This time she moved to an outpatient rheumatology service. Again, Jessica found herself in a program that she couldn't see herself in for the long term, but it fit for her personal life at the time. What did give Jessica satisfaction in this role was her interaction with her clients and learning about their lives – the engagement with the clients.

At about the same time, Jessica added private contract work to her occupational therapy portfolio. This allowed Jessica to add to her work, but in a way that allowed her to still have the work life balance that was important for her. She enjoyed the flexibility, and the familiar practice, as she was doing work that was similar in nature to other positions. She found herself mostly prescribing equipment such as mobility devices, to people living in the community, rather than being in the hospital. This model did have its drawbacks as well.

> *So that was good because it was my first foray into the community and see people in their homes. The one thing I wasn't keen about that is, depending what the request was, why we went in, is often times there wasn't money for follow-up appointment. So you needed to get done in one appointment.*

She was frustrated by not being able to address the clients' needs more fully.

> *I didn't think I had a really good impression after one visit of who they were and what their needs were. And I was just going in for one thing. So if I saw other things, sometimes I had to not talk about that or mention it in my report knowing that it might not be addressed. Because that's not why I was asked to go in. And then I'd never, and the frustrating thing I remember, I never knew what the outcome was there.*

She also found the demands of the charting in private practice somewhat difficult. Reports were extensive and needed to be almost exhaustive, or else risk some necessary equipment or support for a client being turned down by the payer. This was further complicated by the fact that she often had a single visit to ask and see everything that she would need to support her opinions. While the position initially offered Jessica flexibility, over time, as the practice grew, she found herself receiving more referrals than she could manage, especially with the preparation and writings that were required to ensure that she was thorough in a single visit. Following her final

maternity leave, she moved into another position, once again returning to the area that she preferred, neurology, only this time working with outpatients. The move was partially about her desire to continue to work part time, but it also enabled her to work with someone she had admired who was a practice leader in the neurology unit.

> *Just her approach with clients,…mature and client centered and I just felt like she was offering so much to these people. And I wanted to find out more about that. I remember she had a few clients that were sort of further along in their rehab and more back to work kind of clients. And she stuck with them even though the system was telling her, you should be discharging. But she still saw them irregularly, just to make sure that transition was going well for them.*

Jessica saw the opportunity to learn from another occupational therapist who embodied what she respected in practice. Under the mentorship of the service leader, she found herself focusing in a new way of recovery following stroke. She was intrigued by the healing that could happen for clients, and she struggled to understand the approach that traditionally was taken in neurology. Occupational therapy often focused on compensating on the loss of use of a limb by training the client to use their other arm to replace those functions. She felt there was more that could be done for the clients and was searching for new answers for her clients to regain their function, their occupations.

> *I mean it interested me but I just felt there was still more we could do. I still felt like we weren't getting the functional outcomes. The people legs were getting better and why aren't their arms getting better? Are we doing the right thing?*

Her search to help her clients led her to explore new technologies and new approaches to her clients. In contrast to her earlier days where theories were too abstract for her to grasp, she found

herself exploring more specific ones that offered her better explanations for what she was seeing and gave her new options of how to work with her clients. Despite the new learning, she found that many of her clients were too affected by their strokes for the therapy to be appropriate to use with her clients.

> *I was learning about CIMT [constraint induced movement therapy]. I knew there was this huge group of people that weren't qualified for CIMT because they didn't have enough movement. So that's really unfortunate. How do we get these people to participate in these activities that are turning up in the research as really working?*

Her desire to do more with her clients led her to start pursuing more continuing professional development opportunities. She went to an education session in another profession that had promised to be a new approach to managing stroke. She was surprised by what she discovered.

> *I went to a course in Edmonton that we thought, 'OK, this is going to be very revolutionary to your practice' and essentially it was two physiotherapists talking about stuff that we do already as OTs and we're both just like, aaah? Activities and bringing activities into your practice. Instead of just exercise and stretches.*

This revolutionary approach to practice is what occupational therapists had been using as a key method working with clients since the beginning of the profession. She ultimately found courses taught by occupational therapists that resonated more with her, "*I just felt like we were all on the same page."*

This course introduced her to new technologies that she hadn't used before, a type of splinting that helps people use the hand and arm affected by the stroke, rather than compensating for the loss of function. The most important part, this technology was designed to be used in everyday activities – occupations – that were central to occupational therapy practice, and more consistent

with Jessica's way of thinking. She became so excited about this technology, she became a leader in the city, working with the provincial association to bring in more continuing professional development to therapists to learn to use the approach in therapy.

Jessica began doing presentations to other therapists about the approach she was using and became a local leader in occupational therapy treatment of stroke. She was approached by the senior practice leader to work with other therapists to develop guidelines for other occupational therapists to follow when working with clients following stroke.

> *We started looking at the best practice guidelines. Canadian Best Practice Guidelines thinking, OK. These are good but they're not super clear as when you have this client in front of you and they have this arm… Where to start, what assessments to use. So we decided to put together a tool kit.*

This led her to a research project, something that she had never done before and never saw herself doing, but it was also very exciting to be able to communicate the results of what she found to other people. From there, Jessica started to attend stroke conferences more regularly, sharing the work that she and the others on her team had done. After using the Best Practice Guidelines as the starting point for her project, she was approached to become one of the members of the national group updating the guidelines. This invitation caused her to reflect on her career and ultimately pursue a master's degree.

> *I was actually on the rehab sub-committee for developing the guidelines which I felt totally underqualified for. But awesome experience. And so, I think I realized then that I needed, you know everyone sitting around this table, they're doctors, PhDs, one Masters. And I thought, you know if I want to keep up with this, I need to do this. I need to go back to school and do this first.*

Jessica is currently working on her Master's degree and working with the national groups to continue to improve the care that occupational therapists provide to clients with stroke. Someone who struggled to understand the abstract and the theory of what she was doing has become a leader to others, translating the theory into practical terms for others, something others had been unable to do for her early in her career.

Michelle: Finding a Language

Michelle remembers always wanting to work in health and with older people. Raised in a rural community by a mother who was a nurse working with older adults, she was exposed at an early age to caring for others and working on health and wellness. She wasn't really interested in nursing, and being a physician seemed to be something incongruous with having a family as far as she could see, so she set her sights on physiotherapy. However, at the time, she wasn't able to make the grade requirements for entry into physiotherapy school. She took some extra time and upgraded courses, intent on applying for physiotherapy the next year.

A chance encounter with another student on the steps of one of the university buildings led to her pursuing occupational therapy. While Michelle and this student discussed what their plans were, the other student suggested she consider occupational therapy. Michelle had never heard of the profession, but the description she had been provided sounded intriguing and seemed to fit with her love of sciences and her desire to work with older adults.

> *Just sold me totally on this is a perfect fit for who I am. It's in health care. It's a creative flow or work. There's diversity from the physical being to the spiritual being to the cognitive, emotional being. It all kind of fit who I knew I was in myself.*

She found the school work interesting but compartmentalized. Beyond that, she wasn't entirely certain what it meant to be an occupational therapist.

> *I wasn't sure in some ways in the beginning how it would be different than physio except it didn't feel like a whole lot of exercise. But I felt very compartmentalized. And it was very clear, if you're an OT, are you going to be a phys med OT, are you going to be a mental health OT, are you going to be a paediatric OT. But it really wasn't defined who's an OT to start with.*

The compartmentalized program didn't seem to be clearly linked to the people she would be working with, nor did it give her the words to describe who she was becoming. *"...I used to describe it's kind of like physio except you do things a little bit more in people's day-to-day life."* Michelle recalls that when she went to school, the word occupation wasn't used as frequently to describe the profession's domain of interest. *"It turned into the functional activity. It turned into self-care, meal preparation, the what, again at that time, described ADL, IADL. Not called occupation then, but it was a description of productivity, Reed's words of self-care, productivity and leisure."*

While the profession touted holism, Michelle found that in practice, this was not what she always saw.

> *"So it became, well OT will do anything above the waist. So range of motion arcs came out and the cones came out. And you shared exercise group and all sort of things. So there was still an overlap that wasn't clear. And there was somehow this taught exposure that ours is upper body, theirs (physiotherapy) is lower body and the two don't, you know, the wholeness of the person from that perspective wasn't seen."*

Her first placement helped her to develop her skills with interacting with clients and learning how to talk to them, but Michelle did find herself confused, trying to work through all the components she had been learning, and then work to link them to the person's occupations. But

she did like the supervisor's approach with clients and the sense of hope that she was able to provide them.

> *"I was still stressed by the fact that I think I'm supposed to have an array of questions I'm supposed to ask. Because it wasn't kind of that flow of just talk but here's all the assessment components I'm supposed to capture. But I was grateful for her as my first clinician, because she was patient and was a good example of just talking to people and affirming for people that whatever has happened to them, there's hope for further wellness in their life."*

Her next placement wasn't as engaging and she found it difficult to relate to the supervising therapist who did not seem interested in teaching her, and she found herself learning more from the other team members on the unit. The role of the occupational therapist on the forensic mental health team was not distinct to her and she found that she struggled to engage with the experience. Despite this she worked to take what she could from the exposure.

> *"I guess the bottom line for me was, I felt I needed to survive so I had to contribute to it as well as I could. And embrace what was being taught by the other team members. I do appreciate this now, as I look at it, it's an appreciation that it was a gift to actually be in that clinical experience because it taught me about what I see now about marginalized people. You know we had individuals who have had a hard life, however you want to describe it, but they're still people. They still want to be engaged in occupation."*

Michelle found that it was important for her to always maintain that sense of hope, as she had seen in her previous placement. It was something she brought with her into the difficult context in which she found herself – a sense of hope both for her and for the clients.

Each of Michelle's placements added to her skill set and her competence but she still felt that the experience was not completely integrated, and each new site was starting over, even though she was expected to grow in her independence.

> *"The clinicals at that time really felt as you're starting again. Because we're in compartments. This is now stroke therapy. So it's supposed to be somehow different from mental health and orthopaedics and geriatrics and forensics. So it always felt like a new beginning. There wasn't a building yet for me. Well what is the common ground here? Self-care was the same like some of those elements. But I was always struggling feeling like I'm starting new again because it felt so technical, so component driven"*

The compartmentalization affected how she was able to interact with clients as it also delineated roles of the professions and what could be addressed.

> *"So even though it was shared paper, it wasn't a collaborative approach. It wasn't shared reflection on now who is Bob and why he was admitted here. We didn't ask a lot about who are you before this other than what was your premorbid ability. It was pretty general. And it really wasn't about who are you. Who are you in full?"*

The supposed holistic nature of the profession was not reflected in the placements or in the curriculum at the time. The language of occupational therapy was not front and centre and not be seen in what Michelle was doing. As a result, she found it difficult to understand her role and how the compartmentalized nature of both teaching and practice connected with the person. Her faculty were passionate about their profession but somehow unable to translate this passion into an understanding of the person beyond the components and compartments.

> *"She wanted you really to understand the complexities of these individuals. Now at that time, I don't recall anyways her tying all that mental health language, medical language*

of mental health to occupation…, or function well. Other than maybe a bit about community living I guess. But I don't remember that being a clear pathway."

Michelle was excited when school was over and she could begin her own career. But she also felt a little apprehensive, not feeling as though she had the tools that she would need to be an occupational therapist. Her passion had always been older adults but she thought that should be where she settled long term, not for a first job out of school; that job should build more of those technical and diagnosis based skills.

"Part of my thinking was, what am I supposed to do? What is the right steps to build my technical skills further because I should be really honed on those clear diagnostic areas. How do you treat somebody who's had a stroke? How do you treat somebody who's had a heart attack? All of those, again, compartmentalized by diagnosis. And so my thinking was, I should go to acute care because that's where I'm going to get all that stuff. And it was not a passion in my heart. I said, oh my God, I really don't want to work there."

Michelle's sense of herself as an occupational therapist was in title only, she did not connect her work to occupation, or any sense of internalized identity. She struggled with the meaning of occupation and its general association with work.

"So actually, I remember saying that I don't do occupation because I'm not doing vocational rehabilitation. So it was even taken out of that language. So, I felt I had some knowledge of OT. Again, still pretty tight in those pillars of components, technical skills and assessment skills. But not really 'so what does this really mean' in a larger picture."

Michelle's first position ended up being with older adults, back in the role she had as a student. The familiarity gave her confidence and *"an identity to the role based on what it was defined there."* What started as a part time locum, lasted for three years in various positions in the

facility. She found herself taking on additional responsibilities such as committees, as she found herself always wanting to learn more. But she continued to struggle with how to connect her treatments to the lives of the people she was working with.

> *"And it was treatment. And it was something I did to a person. …What I had obviously more pleasure in, is when I could actually tie it to something that was more, at that time, functional."*

Michelle found herself drawing on her personal skills to make the links to occupation. While she was expected to do treatment to her clients, she found herself creating more opportunities to do something more activity based and potentially meaningful.

> *"I was more comfortable with that than the prescribed activities, or the exercise. So you look at that and think, OK, so maybe my academic building was really more about the activity that I didn't see first because that felt natural, comfortable. Or is that because it is an occupation and that's part of life so that is part of my lived experience"*

Her program had taught her about occupation but at the time she had a hard time seeing what it was or to use in therapeutically until she was working with her clients and trying to connect with their lives. She found herself comfortable with things connected to everyday life, but struggled with the seemingly reductionist expectations of the role and delineating each of the components that went into the activity or the occupation. She struggled to integrate the parts to the whole.

> *"I know how to do the crafts I chose. I made sure I knew how to do them. So it really was just kind of everyday living and so that seemed easy because it's that living part, that lived process. What the challenge was is always working the components, OK, so is that a cognitive component? Get to do my activity analysis in my head, right? Is that a physical component?"*

Because of her discomfort with the repetitive components that seemed to be expected, Michelle focused on some of the groups that were run within the occupational therapy department. She integrated these more and more into her practice. She then found ways to expand these experiences to get more to the heart of what she felt should be occupational therapy.

> *"So you did that technical piece of the repetitive exercise, drew it into a little bit of that leisure piece of that group work and then, as I looked at it for myself as I grew, it was also then flowing in more to the baking group type thing. Then let's go grocery shopping. We had a full kitchen, living space set up. [We] did the live in, over the weekend, client experience to see, can they go home overnight. So security would check them and you're on call and I did a few of those kind of independent assessments, it would be called. So those were feeling a little more natural to me because it was starting to make a little more sense."*

Michelle found the organization of the hospital contributed to the compartmentalization of practice, as units and departments were organized along diagnostic lines, something that was not as relevant to occupational therapy practice as is was to medicine. *"Still felt quite compartmentalized though mostly from the diagnostic area. It wasn't Bob Smith, it was Bob with his stroke. But it wasn't about Bob, it was what made him come here."*

Michelle attributes her growth into more holistic practice to her work in the palliative care unit at the hospital. While not originally part of her role, over time she took on this area of practice and found that she enjoyed this work immensely. She found that on this unit she learned a lot from her clients.

> *"One is of a young lady, 25-year-old lady, newly married with a year and a half old young girl. And she was dying from ovarian cancer. I was going in there thinking I'm*

> *supposed to do my assessment. I'm supposed to find out how we're going to maintain her physically as much as possible. But she taught me that she could care less about that. What she needed to do was write letters for her little girl for all the special events that would come up in her life. … And I remember that that was, a clear example for me about meaningfulness, purpose, client goals. All those words weren't there at that time but when I look at it now, she taught me that. Actually, I felt like we didn't complete the assessment. I'm not done. I'm supposed to fill up all this piece of paper. But she really taught me, this is important to me and if you can't do this for me, then just be gone. But of course, I engaged with her. I provided her resources. And more importantly I left her alone to do it with her family. Because who am I to stay there? I need to supply the resources. But I remember just leaving that with her. And the meaningfulness that that was for in her last days."*

On the palliative care unit, Michelle found she didn't need to work on components, she found her role was to enable meaningful experiences for her clients during their last days, helping them to engage in roles that they were losing, and create meaning for the clients and their families. The stories and experiences of her clients shifted her way of practice and her way of being with her clients. *"So very impactful stories that really started me feeling more about who people are and what their spirit is. I wanted to be in spirit with people."*

She attributes this change to something within herself as she didn't see it modeled in the occupational therapists around her. It was her own personal journey to find her identity as a therapist.

> *"So that was really an experience that started my shifting of an identity to that connection to people in their wholeness. …. But it really was starting to feel people at*

> *their spiritual level. And being probably year 6 or 7 post grad from a lot, I would say a lot of confidence in myself and, and not being told yet I'm doing it wrong. And knowing that I have connection to people and I have connection to a team that are always grateful for me to be part of their team. But a lot of formal and subtle validations that I was on the right path."*

She found this 'path' reinforced by what she was seeing from students who were bringing new language to her. She also found new publications also were supporting what she was doing. Even though the newer language and approach was more consistent, she surprisingly still struggled to find the fit with the conceptualization she had of occupational therapy.

> *"The COPM [Canadian Occupational Performance Measure] was something, I still remember that coming out. And I was asked by my manager do we think we should maybe should use this tool here? And I said, oh my God no, it's not about compartments. Where's range of motion? Where's pain, where's sensory? It's not there so what am I filling in? How am I going to measure? It's about the person's self-identified issues, right. Well we really missed the boat. And I would say I was a big part of missing that boat."*

Despite the fact that the new resources were more consistent with her practice, she found this development disorienting. She felt that having followed the established practices, she had been doing something wrong or that she would miss something by letting go of the focus on components. *"I could not see how that would be a way we could measure change. How we could have enough information about a client."*

Michelle continued to work in palliative care and older adult rehabilitation until her first maternity leave. When she returned, the department had lost a position and people had been

shifted into different units and roles, and Michelle learned she would not be coming back to her preferred role and instead was given one in mental health, something that she had learned in placement was not what she wanted. So, when her husband had an opportunity in another city, she opted to leave and look for something else.

She found a role in a community assessment team, completing assessments for clients to enter into other rehabilitation programs. She thought she would be working with older adults, but found herself working with middle aged adults following strokes. It would also be her first experience in a program management structure. She found the manager supportive and allowed her to complete her work as Michelle deemed appropriate, supporting her knowledge as an occupational therapist and a professional.

Michelle discovered early in the position that this was not something that she would be able to stay with for long.

> *"But within 4 months I knew it was a job I couldn't stay with because I couldn't just assess people. And that's what I was called to do. Assess them, write up a report, present them and do your best to advocate for them. And it was pretty disappointing when my clients weren't admitted because they saw them on paper. I saw their face. I was in their home."*

While Michelle felt that she was a strong advocate for her clients, she missed the relationship with clients and the ability to see them grow and achieve things that they wanted. She also found that despite the fact that she was supposed to be limited to assessment only, she couldn't limit herself when she saw immediate opportunities for intervention with the clients. *"I found that I couldn't go in the house and not already be educating them about things. Like if they're sitting there after they had a stroke and their shoulder is pulled out of its joint and it's because*

nobody's told them how to put their arm on a pillow." She wanted to be able to do more, to build relationships and make change in clients, but the role limited that and she knew it was not something she would stay with.

After about a year, Michelle found a position in a geriatric day hospital. While this should have been a dream job because of her opportunities to work with older adults and to build relationships, the position was ultimately difficult because of the team personalities. Once again this was a program management team however she found the manager significantly different than at her previous job. For the first time in her adult life she was being given feedback that she wasn't a team player – not for her OT role however. She discovered that despite being in a professional role and having obligations of assessment, treatment and documentation, she was also expected to do tasks associated with the support staff such as porter clients and do dishes. She found this unfair as she was often bringing work home to complete it and not taking breaks, while support staff did not have this obligation or expectation. She struggled to fit this with her identity as an occupational therapist. Michelle felt that her manager did not understand what much of the work of the occupational therapist was, such as advocating, acquiring equipment and that it looked different than nursing or even physiotherapy.

> *"It's the setting and the management. The management … she had no appreciation for the extra that we do beyond being with the client, the face-to-face with the client. It's always that concept it doesn't look like physio. OT aren't doing anything unless they see you with a client. Yet there's so much we do that's not visible. And especially at that time. And we didn't have assistants that did a lot of work around wheelchairs or, that did phone calls for us, get all the kind of the paperwork and things like that for us. We did it."*

If leaving had been an option, she would have left sooner; however, her home situation with small children and would not allow her to be without the income.

She sought out every opportunity to find something else and eventually found a term position a 45-minute drive from home, but it allowed her to leave. The position was a blended role with some community, some acute care and some long-term care responsibilities. For Michelle, she felt as though she was "back to OT".

> *"I was in the barnyard. I was in schools. I was really where people needed me. I was in their homes and in their context of helping them look at what, why, since the health disruption occurred."*

Michelle continued to work in the community, and switched to another town. In this new site, she and her occupational therapy colleagues developed interest groups to help each other stay current with new research and approaches in occupational therapy. Five topics were chosen and five of the therapists took a lead facilitating one of the topics for the other 25 therapists. Despite the moving focus to more meaningful occupation in practice, the topics chosen were component-based for the most part.

The shift she had seen earlier with the COPM continued and she found that while occupational therapy was still assessing components to complete databases, there was an increasing focus on meaning and what the clients needed or wanted to do. Now more than a decade out of school, she found that she was looking to stay current and developed an interest in evidence-based practice, as this was the emerging language at the time. Students were coming with a language of occupation that she hadn't learned, though seemed to intuitively understand early on. Her team took this new language and used it to reorganize those component databases working to integrate it more noticeably into practice.

> *"But it is beginning to be our language that's being defined as something that we should be paying attention to. So we took our databases and then we grouped them so we had the PEO [Person-Environment-Occupation model] embedded in it. The components fit underneath each piece of that model. And the client goal, instead of being on page 4, it was on page 1. And on the other swap we did was so page 1 was the client goal, the client profile, who was the client and their story. And on part 2 we still had problem with treatment plan. We're getting warmer to recognizing it's about the client."*

There was an increasing focus on the client story, not simply the client illness or impairment. The therapists were working to integrate best practices associated with medicine and the 'new' or more prominent language of occupation appearing in the literature. There was also a shift from occupational therapy doing upper extremity, and more about changing ability to do what a client wanted to do. Michelle found that the word occupation was still not central to practice but the concept was becoming more recognizable. She actually found that there was a difference between what was being done in the Eastern part of Canada and her practice in the west. Many earlier publications on occupational therapy models and practice came out of Ontario, and despite their being accepted and promoted by the national professional body, Michelle found it wasn't until more local writers and academics were part of the author groups of these documents that the material became more accepted and integrated into practice.

The therapists continued to work together to support each other in their evolving practice. More emphasis was being placed on research evidence, but Michelle and her colleagues often found the research journals difficult to understand as she felt she didn't understand research. The professional practice journal that was more clinician focused was found to be more useful in

translating concepts into practice, mostly because it connected to client stories, something that Michelle had always valued. She found these easier to interpret.

As the language of occupation began to pervade the practice literature, and students came with the language, she was starting to figure out what had been missing for all the years she had been practice. Despite this, it was still a difficult transition.

> *"Well there's something missing. I couldn't quite figure it out what it was. I just felt there's still something missing in my career. Although individually I was comfortable because I know I'm comfortable looking at people, supporting and helping people, whatever they're doing, you show me what you need to do and together we will find solutions - was natural for me. But I still didn't have a language to put to it. And say that this is occupation."*

Michelle recognized that she had spent her career not being able to, with any confidence, define or describe what she did or who she was, or what was unique about her work with clients. The new practice guidelines published were pushing her to not only look at her practice, but to examine who she was as an occupational therapist. A new director in the picture asked her to explain what Michelle and her profession brought to the team that was unique.

> *"So that was a really significant challenge to me. And I took it seriously. Because I couldn't do it. Here I am working 20 years and I still couldn't say what does an OT do in 5 words or less. Or 10 words or less. So I knew I had to be closer to what that identity is. And With Enabling II, I'd read it all to end and I went, oh my God, I have no idea what I do now."*

Initially, Michelle could not understand how to fit the abstract concepts of the guidelines into her daily practice of occupational therapy in a medically oriented health system. She felt at a loss, for what she was supposed to do, so she sought out everyone she could think of. She contacted the editor of the guidelines for guidance who shared some notes and insights. That nod being enough for her to move forward, she went to her provincial professional association. Staff there were not able to answer Michelle's questions. She contacted the university to find they were working to integrate the new guidelines into the curriculum, but this was in its early stages. From there, she discovered that a national 'book club' for practice leaders had been established to discuss the guidelines. Michelle reached out to the editor again and became the only clinician in the book club.

She found she had a unique voice at the table – she was the only clinician among the authors, editor and practice leaders. She could bring the client stories that they didn't have access to.

> *"And it was fantastic work. And fantastic insights for me. I could contribute the client's story because nobody else had a client story. I did. So I'd bring a client story and say, so here's my client story, so, so how does the chart work on this? And Liz [the author] would analyze it, go through it. And it started to become clearer. And the identity as client-centred occupation based therapist. I could say that now. And I know what that means. And I know what that means for clients."*

Her approach to practice changed significantly from this engagement. The guidelines and the subsequent discussion gave her permission to let go of the compartments and components and the medical focus that had constricted and confused her identity for so long.

> *"I now do nothing but the COPM, having the client's occupational story first. That's is my first engagement with clients for the last five years. And it is their story. I don't want to just want to write their issue, I want to write their successes. …But it was a way to enrich and to really just talk. And it moved from being an interview to being really; it's a conversation. I now have the questions to open things up to clients. And mostly it's triggered by them. And I can write their story down in occupation."*

Michelle has become a model for others in her practice setting, though not without challenges. In a medical world often criticized for its use of jargon that others don't understand, some colleagues have suggested that this is just introducing something that practice did not need.

> *So there's certainly a renewed richness with that language now being our language. And now kind of defending it and people say we shouldn't write jargon. Like why do you write occupation? I say, well we wrote our ROMs for years. Nurses would say, they haven't got a clue what an ROM is. You know we've used jargon our whole life in our careers. It just hasn't been our jargon. So I said, you know, really, for me it's now I'm at the place where I'm not willing to give up my newly found identity by softening, by changing the words. However, I do take the opportunity to now describe and educate others about who occupational therapists are and what we do in and through occupation.*

Old habits were difficult to break and Michelle had to continue to work to let go of role overlaps and her defense of shared competencies. She recognized that by engaging in territory battles over who had jurisdiction over which technology or technique or body part, *"I was contributing to the identity crisis".*

Michelle's entire practice has changed, from the way she engages with clients to how she documents to reflect the core of her profession: *"so we don't use the word treatment, or we don't*

use problem list any more. It's either the OPIs or an occupation update. We don't use treatment plan in our plans anymore. It's enablement. Our enablement strategies." The result for her is a renewed (or new) passion for her profession after more than 25 years.

> *I'm excited to get up for work. I'm good to go to work every day. Because the energy's there, just purely by the passion of knowing how I contribute to clients living. . And it's always been there I think I didn't always have the clear language, models and tools to guide me. Clients and their stories energize, excite me. I have always loved being an occupational therapist and now that I have and understand how to describe our uniqueness it's even more fun. There is nothing else I would rather be or do. I don't want to do anything else.*

Harriet: Finding Fortification

Harriet was taking time to decide what she was going to do. She had taken a year off University after her first year to work and travel, and when she returned she thought of becoming a teacher. After volunteering in a classroom for a few months, and looking at the job market, she decided that a career as a teacher was not what she wanted. While planning another trip abroad she ran into a childhood friend who was finishing her second year of occupational therapy school. The friend encouraged Harriet to enter occupational therapy school. "*She said, you and I are alike. You enjoy the science but you also enjoy the creativity. But I was still thinking physio at the time. But she said, this, this is where I think you should land."*

Harriet then went on another trip abroad and there met up with two other women, a recently graduated speech-language pathologist and a student occupational therapist. After travelling together for a while, Harriet became more interested in occupational therapy. She considered applying to the occupational therapy school abroad, but found that the term had

already started and it was too late for acceptance. The director of the school encouraged her to apply to the university in her home province. When Harriet returned to Canada, she applied and was accepted into the program.

Harriet believes that her life experience and her maturity helped her getting into the program, but she found that her lack of consistency with the early years of university put her at a disadvantage in the course work.

> *"I struggled because a lot of the people that were my classmates had been studying. I'd had a year off and I had been goofing around. So when it came to midterms I just about failed my anatomy midterm. And then I went, oh shit."*

Harriet found she had to learn new ways to prepare and the junior students used the senior students as resources. She also found it challenging being in a profession made up of mostly women.

> *I also struggled with the fact that we had two men in our class but the rest were women. Of 42 in the class I think. And it drove me crazy because it was a little bit like elementary school. Everybody following the cheerleading girls in the school yard. You know like the most beautiful and attractive one, everybody wanted to be like them.*

This added to the stress of a demanding course load to create a stressful school environment.

> *I mean there were the first Christmas we had what, 14 exams because you had your writtens and then you had your practicals, right. And it was like, how the hell am I, this marathon of, will I survive it. So it was everybody just getting so into it and then what bothered me was I was, um, I thought I was more independent and more autonomous."*

In some ways Harriet felt that the demands of the program were preventing her from learning what she felt she needed to know.

> *And sometimes I felt like you're not really testing my knowledge here. You're testing my regurgitation. I knew that I'd have to have this stuff as a working knowledge as a practicing therapist. So I struggled with, OK, I can just study the night before and just ace the exam if my memory's good. But that doesn't mean that I keep that as a working knowledge."*

Harriet considered herself an assertive and engaged student who tried to get the most from her class experiences and as a result sometimes found herself at odds with her classmates and her professors.

> *So this one day, I thought it was my shtick to stand up, because I thought I would have support and tell the professor that, 'listen, I just want to let you know that, is there any way we could sort of change the format here.' I don't think I was really obnoxious in the way I presented this. But I said 'I think we could have some really rich discussion because we all have previous life experiences rather than just being an OT, physio professional and open up the discussion a little bit more.' Well she didn't like that. And I stuck my neck out and guess what, nobody supported me. And I went, oh my God, so now I was the bad guy.*

Harriet struggled with the inconsistencies in a professional program in which she felt she was expected to be a professional but not enabled to enact more critical behaviours or engage in more critical discussions within the classroom with professors.

> *I just didn't feel like we were also being treated as adults. And we were at fourth year and we were about to graduate. You know like 'come on, I think we've earned our stripes here a little bit.'*

At the time Harriet was in occupational therapy school, the occupational therapy and physiotherapy programs were combined and the graduates came out with a combined diploma and could choose which profession they would practice after graduation. Harriet noted differences in the personalities of the faculty and supervisors.

> *What was really interesting was, as a student, you really saw the personalities of physios versus the personalities of OTs. And as a student, the OT preceptors were far more approachable, far more human, far more warm, far more understanding. And less willing to throw you to the wolves.*

While she found she could do the work of physio, it was in occupational therapy that Harriet found her fit. She found her physiotherapy placements interesting, but challenging in terms of connecting with clients, except for with one internationally trained physiotherapist. This therapist did a massage of a client being seen for cardio-respiratory illness, something that was not typical practice in a Canadian context. Harriet found the moment profound and compassionate, but the fact that it was an exception to practice reinforced her connection to occupational therapy.

> *In OT, you're always able to meld that art and science together. So in that moment, as a physio, I enjoyed myself. I could do the physio stuff but my heart wasn't in it. I did OK, I learned to auscultate. I learned to suction. But in all that stuff, but you weren't allowed to bring the human element into it.*

Harriet developed very clear ideas about what a person needed to be to fit well within occupational therapy.

> *You are warm. You have an enthusiasm. You like to meet people. You want to hear their story. You're inquisitive. Those are the hallmarks of a good OT. But you also have other life experiences that you bring to this, whether it's music, whether it's this. And you share*

that. And with those experiences, you can bring out those aspects of your patients or your clients and use that as therapeutic tools.

These traits were what she saw of the occupational therapy preceptors during her training, and she felt were in contrast to her physiotherapy preceptors. She found the expectations and approach of the occupational therapists significantly different on placement as well. When working with a client with hemiplegia one day, Harriet needed to do a transfer. With her preceptor away, Harriet was frightened that she would drop the client during the transfer and sought out the occupational therapy department manager for assistance.

And so she came, and she made me feel so comfortable and so supported and we talked afterwards and she said, 'I would rather you have come to me telling me that you were unsure and be safe than to go ahead and try it and something happened to this man. So you used good judgment.' Whereas I thought, having had some physio situations, I thought that I should have to perform, perform, perform. But she was so warm and so gracious and so fortifying of me that I just will never forget her for that. And that was an OT. I'd have physio preceptors that would bicker to me about 5 degrees on a goniometer this sort of thing.

While Harriet found this distinction in personalities between professions, she did also experience challenges with her occupational therapy colleagues. Following graduation from occupational therapy school, Harriet was hired by the local children's hospital where she had her last clinical placement. She had been very successful on this placement and was excited as she considered this her dream job. Adding to the excitement, the supervisor had been one of her professors at the university with whom she had found a significant connection on both a personal

and professional level. She found, however, that the position was challenging to her on a level that she did not expect.

> *And so this [occupational therapy professor] was now my boss. And thought, oh this was going to be even more awesome because of our relationship at the university. So I started in November and by the April I was, I don't know how I lost, how many pounds weight. I was neurotic. I was looking to jumping off the bridge to be honest with you. I felt that I had failed at the profession and I had fooled myself and all others for the 4 years I'd been studying as a therapist. And what happened was that she kept criticizing me. We'd have weekly meetings, and she continued to criticize me more and more and more about what I wasn't doing appropriately.*

This criticism was counter to most of her experiences as a student of both herself and her profession. The experience had an impact on her identity as an occupational therapist as well as her mental health.

> *I was up at 5 in the morning. I was drinking to get sleep. I was up doing my reports hoping that they'd be fine. I just was getting to the point where I was on a breaking point. And this was also the first few months of practice.*

The experience had a significant impact on Harriet's identity. She had graduated from the occupational therapy program and had thought herself competent. She was willing to learn and engage, but her strategies were not working and she could not figure out what she was missing, or how to please her supervisor, someone whom she had thought would be a support and a resource for her.

She sought out another occupational therapist to teach her what she might be missing, and found support from her boyfriend and her family. She struggled with what to do, feeling as

though she couldn't quit, both from her own sense of herself who sees things through and from a point of commitment to the children and families she was seeing. But ultimately, the stress of the position was too much for Harriet.

> *I thought, OK, I'm not a quitter. I was brought up not to quit. You face adversity and you figure out ways to make it work or whatever. And I just thought, maybe this is the best way. I'd been meeting with her regularly and trying to strategize and she still was criticizing. Still I wasn't making the grade. It just wasn't working. So I thought, OK, on Monday morning I'll just go through things and if she's still critical I had in my back pocket my letter of resignation. And so I did. I went to the meeting. And she continued to criticize. And I realized I wasn't going to get anywhere here. This just wasn't working. So I just flipped down my back pocket, I said, well then here you go. And she read it and she goes, oh, well what will you do? And I said, well right now jumping off [name of] bridge looks pretty damn good. And she said, oh really? And, you know, then she backed off. And I said, no. I said, I have tried, I've done all these things. This is week after week after week. I said, I'm not sleeping. I'm drinking to try and put myself to sleep, right. But I said, I've lost 30 pounds or something like that. The stress. I said I'm sorry, I guess this is not for me. And I was so relieved.*

The experience was so profound, Harriet questioned whether she would fit with occupational therapy and whether she could continue to be an occupational therapist. Quitting was not what Harriet had wanted to do, but ultimately, the fact that she was leaving the stress and the criticism came as a relief to her that she would not have to endure anymore. However, the experience had left her identity in question.

> *There were times when I really felt like 'Jeez, did I fool everybody for the 3 years intense study once I got into the [occupational therapy school]. Did I fool everybody?' because you were just feeling so low. Your own self esteem was so poor. And of course, definitely it was the job. I can't remember how long it took for me to start pounding the pavement again after that…. You were just so battered by the experience. By one of your own. And, I think what even hurt more, was that this person was one of the stellar professors at the university and she was a Jekyll and Hyde.*

The fact that this criticism was coming from someone she respected and from someone who was part of her own profession had a more significant impact on her. She doubted herself as she did not receive not only the positive feedback she had from her colleagues in past, but she was receiving the message that she could not do the things that were expected of her as an occupational therapist from someone from her own profession.

Surprisingly for Harriet, when her colleagues found out about her leaving, she found that they had not experienced Harriet in the same way.

> *But the interesting thing was people then came up to me from the other departments and said, you've been one of the most approachable people, you did this when we couldn't get the other therapist to do that. Or you were such a team player. Or we really enjoyed what you did.*

This feedback was not enough to make Harriet stay. The feedback from her supervisor, and previously trusted professor, had negatively impacted Harriet's identity. She had left her dream job and found herself looking for work. Despite the challenge to her identity, Harriet found she continued to look for work as an occupational therapist, despite her option to apply for physiotherapy positions: *"it was only OT I was applying for when I was going back. I knew I was*

an OT. I knew I wasn't a physio." Despite this knowledge of who she was, Harriet struggled with interviewing. She felt vulnerable and was sensitive to the dynamics of the work context, based on the experience at the hospital. She turned down a job offer based on the impression she got during the interview.

> *I'm feeling vulnerable and extremely sensitive. But I'm at the interview and there are three people interviewing me and they're all sitting across the desk from me. And their body language is gross. There's no affect. They're not warm. They're not gesturing. And so I do the interview. And I left feeling just horrible because I just thought, these people weren't even treating me like a person. I was offered the job. And I said, no thank you. And they said, well why? And I said, well I felt in that interview, I said it's a two-way street here. And I said, I didn't feel comfortable at all. You people didn't even respond to any of my answers or, I don't know. And I think I was also hypersensitive anyway because of the way I was feeling. I was feeling really horrible.*

Harriet continued to interview, conscious of the fact that she needed the work to pay off debts from school, but wounded from her first work experience. After several interviews, she met with the director of an occupational therapy department in another hospital. Unlike the previous interview that had felt like an interrogation, the director set a different tone, which had a positive effect on Harriet.

> *I went for the interview there and [the director] was the type of person I'll never forget it. She was totally opposite to this other group. We sat down. She poured a pot of tea. She had lovely china cups. I was feeling a little bit stronger so I did go a little more prepared with some of my writing. Things that I'd done. Covering letters, this and that. And she said, I just want to have a conversation with you. I just want you to feel comfortable. I*

want you to put your best foot forward and just tell me about yourself. And I left that, I thought, you know, if I don't get the job, I'm OK with this. I just felt so fortified by another colleague in the profession that maybe I'm OK, you know. And I'll never forget her kindness and just that whole warm approach. And I don't know whether she would have seen my application so she would have known maybe I was vulnerable. But she was just wonderful.

The validation and supportive context from an occupational therapy colleague was a welcome relief to Harriet. The director's approach was more consistent with what Harriet had identified as characteristics of an occupational therapist. Harriet was offered a casual position in the department which she took. There she began to develop a sense of herself again. She also got confirmation from other professional colleagues that she was in the right place.

I get a little bit of confidence back. I'm working with really great people to work with. Getting some more OT autonomy. Yes, I think I'm in the right place and all that sort of thing. Getting some fortification. … This is where you fortify your profession because I had done an assessment on a gentleman who had Parkinson's like symptoms. And we were looking at could he safely go back home. And I did my assessment and wrote it all up. And she wrote the most lovely note underneath my note saying, thank you, this is extremely helpful for me to look at the future for this man. …. And so that was a way that I was fortified and, again, bolstered. You know those, at least there were things along the way that helped bolster you, your confidence back again to say, hey, wait a minute. No, no, I just had this one-off really rotten experience. I'm still to be an OT.

The respect of her inter and intraprofessional colleagues helped to bolster her identity and Harriet was able to move beyond her early experience. However, there were no permanent jobs

available at the hospital and Harriet wanted to find something more secure. She continued to look for other opportunities, including contacting a previous supervisor from one of her placements across the country. The site offered her a position right away and Harriet moved provinces.

Her position was in a general hospital that offered a variety of occupational therapy services. Over the course of her seven years there, she worked in almost all of them, developing her skills in a variety of areas. She found that no matter what area she was practicing in, she was always an occupational therapist and always approaching people holistically. She even gave a presentation to other occupational therapists at a local conference about bringing traditionally physical medicine skills into mental health practice.

> *I remember even at our OT Conferences, my presentation was as much as you might be working in psychiatry, you're still using all of your OT skills. You know I remember one situation where it was actually a psychiatrist who had become quite ill with dementia. But his wife was struggling at keeping him at home just even bathing and that sort of thing. So as much as I was the OT during the psychiatric components, I still did a home visit. And recommended grab bars, this and that. And mentally that helped her so much. So my presentation was, I can't remember the title, but it was we take our satchel with us wherever we go - of our skills. And so it doesn't matter whether its phys med or acute care or psychiatry, you are an OT and you look at the whole person.*

She enjoyed her work at the hospital, but after seven years found herself looking for something else. Minor irritations with her colleagues had her questioning a change, and an opportunity for a management came with a competition with a co-worker that she wasn't sure she wanted; she wasn't sure about leaving, but she was looking for something new.

But I remember feeling I'm 7 years in this job, I'm feeling very cushy, everything's good, don't rattle any cages, just carry on. And I thought, but I'm not happy. I was feeling like I needed more challenges. So I thought, you know what, I'm just going to see, oh try, open a door and see or knock on a door and see if it opens.

Harriet left for another position, working in two different part time positions, moving between home care and older adult care. She found that she enjoyed the difference in approach from the acute care units to working in the client's home.

You saw them in their own environment. And that was so critical because I remember different times, a client was coming back to us on rehab but they'd been [to another city]. And the OT there said, oh well, bathroom should be this, this, and this. Well they didn't really check it out but they actually had an outhouse in the back yard. They didn't have plumbing inside or something like that. I was thinking, wait a minute, that doesn't work. They'd completely missed somehow what that environment would be. And when you have the luxury of dealing with that person in their own home, that's where the real therapy happens. And the thing is, you can gain so much of understanding that person by seeing where they live and who they are.

Harriet liked the connection with the clients that the home care position offered her, however she found that the distance driving an hour from home was draining. She was starting a family and wanted the option of something closer to home. So, when the older adult centre offered her the option to work fulltime, she took the opportunity and left home care. While she had worked there one day a week for some time, she found it difficult to connect with her co-workers and to build relationships there. As a result, she wasn't certain about how she was fitting in with the team. That changed during occupational therapy week.

I've never been in a job where it takes a long time to really connect. And then it was an OT month or week then. And I walked into the department. There were two OT assistants working with me and they were wonderful people and we were shoulder to shoulder. There wasn't any hierarchy there. And there was this beautiful bouquet of balloons, happy OT month. You're doing a fine job. And I just about fell over because there was one of the people on the team was an elderly spinster nurse. Hair done up in a bun. Very religious. And so I thought, oh well, she sets the tone for things around here. She's the matriarch, right, and God help you. Well it came from her, this bouquet came from all of the management team. So I thought, OK, I guess I'm doing something right. But it was one of those situations where I don't know where I'm going here. I just do what I think is right. And I move along. But I wasn't getting decent feedback to know where I stood. Anyway, so this OT week came along and we got this beautiful gift and we were all quite chuffed and very pleased and thankful. So we knew were doing an OK job.

The feedback from the team was important to Harriet. She needed to know that her work was valued and that it offered something to the team and her clients. While she was at the older adult program site, she was also asked to develop an occupational therapy department for another long term care facility. In doing this she would be at the management table, giving a voice to occupational therapy where there had previously been none. She was now dividing her time between the two facilities, totaling 200 beds. With her success there, she was asked to take on another 90-bed long term care facility, but felt she was stretched too thin.

And I said, no, I can't do it. I said, this is not going to give that institution a fair shake about what OT can do. I said, look, you've got me at [location] home half time for 132 residents. And you want me half a day every two weeks at this other place with 90? Are

you crazy? You create another position. Well they never did. And then we amalgamated there so guess what, I got it anyway.

Ultimately all three programs amalgamated, that resulted in restructuring of the staff and management team. Harriet became the manager of the adult day program, which including licensed practical nursing (LPN) staff and occupational therapy assistants with herself as the sole occupational therapist, functioning as both a clinician and a manager. There was no longer an occupational therapy department and Harriet soon became overwhelmed by the responsibilities. The restructuring led to many repeated changes in management, and responsibilities and supports varied with the administration of the time. Harriet found that there was a loss of a central philosophy of the facilities and of management.

After several proposals to upper management for increased occupational therapy staffing, Harriet ultimately told her supervisors she could no longer carry the management role.

"*So I said, I'll just be a straight clinician, just like the physio is. And in some respects, I felt I did the profession a disservice but I had to look after myself. And that would be one of those critical moments in your profession where you said, I have to keep my own sanity. I was really over, overwhelmed by all the duties. And so I just had to finally just say, can't do it all."*

Harriet struggled with her decision, as it had wide ranging effects on both residents of the facilities and for her, the profession. Her move took occupational therapy away from the management table and without a voice in decision making. Occupational therapy also lost oversight of several programs that she felt benefitted from the lens that occupational therapy offered, that were now being administered by non-professional staff without the same training. Even with the loss of the management role, Harriet found that she couldn't keep up clinically,

now covering 260 beds as the lone occupational therapist across multiple sites. Harriet continued to advocate for her profession, seeing occupational therapy as a service that was of great benefit to the clients, even when others lost sight. She continued to propose ways to increase occupational therapy staffing across the facilities to allow for better service to clients as well as make the role more manageable. Management eventually agreed to split the occupational therapy position in two, allowing for one therapist at each site, albeit part time.

Eventually Harriet found that the constant advocacy with minimal change was tiring. When the opportunity to take a secondment to a veterans program, she jumped at the chance. She had a new team with a physician and a nurse and she felt more supported in her role. Unlike other positions where she had found she tired of petty squabbles and challenging personalities, she found this office refreshing. The team members were dedicated to their clients and also managed to create a sense of fun in their environment.

> *These people were all extremely dedicated to the veteran. They all were a lot of fun. And there was very little backbiting. They were always keen to have me come on the Monday or the Wednesday., I guess I was also the one that would, for morale boosting because at times recently we needed that, I'd go to my superior and say, can we do something a little silly at Thanksgiving. And he said, sure, let's do it. Let's do it. So I brought in pumpkins and we made turkeys for Thanksgiving. … And the year before we had a draw. And then they were always great to support me if I made muffins to sell for the month of October for the [occupational therapy organization]. They always bought, you know. …, they were just always very thoughtful and kind. And just a wonderful group to work with. And they were very, very dedicated to their clients, you know, in amidst a lot of head office*

change in policy that just really didn't make sense. And made the bureaucratic process so cumbersome. Still would troop along and say, but we're here for the veteran, you know.

Harriet's role was a different one. She wasn't working directly with clients as often. Instead, she frequently found herself reviewing the work of other therapists who were seeing veterans and making recommendations. She found the bureaucracy of reviewing the recommendations frustrating. There was a general sense in the organization that the occupational therapists were wasting money on unnecessary equipment, and Harriet would be asked to review their files. Often by the time a therapist's report would get to her it would have gone through multiple levels of review without a decision. Harriet's approach seemed novel to her supervisors – she would pick up the phone and call them. She found herself coaching the therapists to clarify their reasoning that had not been communicated to someone who may not have their perspective.

And I said to her, you've got to go through your critical thinking. You've got to go through why you chose this at the beginning. I wanted to try this chair because of x, y, and z. I tried it for x number of days. It did not work and this is why I didn't work. And so I went to Plan B. And then I went to Plan C so that it's not a flash in the pan. So you have to appeal to the sense of this other therapist who's got the purse strings to say, I have gone through a critical assessment here and this is why I've done what I've done. And this is why. …. And that's often what I would do as the OT consultant. The information would come in. I'd have to read between the lines because they didn't articulate well. But fortify their critical thinking and explain the process of their critical thinking in a more, not necessarily in a lay way because I didn't think that that was. What I wanted to do it was a great way to promote the profession.

Harriet found herself surprised by what she considered arrogance of the therapists. They saw her questions as challenges to their professional opinion and knowledge, whereas she saw it as a chance for them to showcase the knowledge of their profession.

> *And so some of the therapists would say, it's my professional opinion just take it. Some of those attitudes. And instead of turning it around to say, 'oh God you're right. If I explained that a little bit more'. I give PR to the world to know what OTs can do. And doesn't that also help our whole image as what an OT is and what an OT does which we're still struggling with how many years later. So that's what I would try to do. So in a phone conversation I said, listen, I want to make life easy for you. Don't worry. I don't need more documentation. Just this phone call. I will write up my notes from the phone call but please tell me why you did what you did. I said, your critical thinking and your whole process is very important to justify why this equipment should be bought. And then typically they would settle down. And they would give me the information that I would need. But the OTs, I was really disheartened to see that arrogance. Disheartened to see that arrogance in our profession because I prided OT, as I mentioned earlier and in my teaching or as my tutelage that the OT versus the PT preceptors were the ones with kindness and warmth and the compassion and commitment.*

While Harriet enjoyed the work and what she could offer to clients, seeing colleagues in the profession acting in a manner that she found inconsistent with her view of occupational therapists was disappointing. Rather than using opportunities to champion the value that occupational therapy could add, the therapists often retreated to a position of defensiveness. But Harriet continued to press, both for the veterans, and for the occupational therapists who she felt had much to offer, but who needed guidance.

The secondment ultimately lasted only two years, but Harriet managed to continue to work for both the long-term care facilities and the veterans' organization for a number of years, ultimately acting as a private consultant when she could no longer extend the secondment. Work at the long-term care facility hadn't changed much and they remained under-resourced in occupational therapy. She realized that things were not going to change, and she started looking for other opportunities.

In her search for other opportunities, a colleague connected her with someone in the provincial government who agreed to meet with her to explore what might be available. She found the conversation affirming in an unexpected way.

> *He kept saying, well tell me what else you can do? Tell me what? I know you're an OT but tell me what else you can do? And I couldn't. I was such an OT, I couldn't see the world in any other way but through OT eyes. Because he was thinking, OK, well why don't you apply for this in government or that in government. And I couldn't see much beyond what I was, or I guess it affirmed what I was doing again. But I couldn't see that I really wanted to be a manager of this department that was education or whatever. And, I think it was probably a good exercise for me to sort of consolidate where I was coming from, you know. And I think I've always been proud of the fact. … And to me I'm very proud to be an occupational therapist. I can't think of myself as anything else but. …But I think having this guy interview me was sort of like, oh my gosh, he's all over the map. And even if I try to think the way he's thinking, I can't see myself doing anything else but OT. I'd like to be able to manage OT. I'd like to be able to take the OT perspective to a higher level.*

Harriet's connection to occupational therapy continued to remain as strong as it had been in her student days, wanting to strengthen the position of occupational therapy. Recognizing it might not come in her role, Harriet sought out other opportunities to push the profession forward. She took leadership positions in occupational therapy organizations. She teamed up with colleagues to present on the innovations she developed in her clinical practice. She continues to promote the profession she is so proud of, even going as far as trying to convert students from other professions.

> *I said, you don't want to go into social work, you gotta go into OT. And I try to convert even the nursing students when I speak to them. I said, well, you know what, you do your degree first in Nursing, that would be a wonderful blend. And then we'll take you over into OT to do your Masters. And I look right at the instructors when I say that. I say, I'm indoctrinating your gang here today. We need wonderful OTs that have a nursing background because we blend so well together.*

Identity Course

Despite the differences in demographics, years in practice and qualifications, commonalities could be seen across participants. The proposed course or path for the professional identification process with characteristics of each step is outlined here.

Identity Rills: Identification (prior to entering school). Rivers form from smaller water formations, such as creeks, streams or rills. These smaller formations come together to eventually form rivers. In this sense, they are the predecessor of the river.

Participants had varying levels of awareness of the profession of occupational therapy before applying: Jessica actively pursued the career from high school, Donna and Rachel had some awareness, though mostly from reading, and Michelle and Harriet attribute a significant

element of serendipity to their entry to school. Yet, despite this, each related a connection with the profession that led them to entry. The worldview of the profession and the blend of art and science that is central to the practice of the profession connected with pre-existing characteristics of each participant. Each reported a desire to work with people in a meaningful way - a desire to help others. This characteristic is not inconsistent with the entry to most of the health and social professions and is to be expected. Most found the holism of the profession appealing, citing an interest to work with more than just physical health, but also mental health, wellbeing and spirituality. And for Michelle and Harriet, the creativity and art of occupational therapy connected with their own passions and interests.

All had connected themselves with the idea of joining a helping profession, often nursing or physiotherapy, prior to their pursuing occupational therapy school. However, for each participant some sense of disconnect was present in the possibility of their fit within these professions that resulted in them looking for other options, leading them to occupational therapy.

Identity Headwaters: Socialization (schooling). Headwaters are made of larger streams or tributaries that form the beginning of a river. Here the river is generally named and recognized as a river, rather than a smaller body of water.

Once the participants entered school, the formal process of socialization into the profession of occupational therapy began. Participants were exposed to the theoretical and technical aspects of occupational therapy. Schooling for all included both classroom and practical experiences. It was here they learned about the profession and practice of occupational therapy. Key tasks during this stage were to understand the professional philosophy of occupational therapy (know), and to acquire the technical skills that would be expected in practice (do).

Professors and clinicians were key influences at this time. Professors provided the first understandings of the concepts of occupation, the teaching of the technical skills and acted as role models. Some could deliver the content with ease and assist the students with integrating the concepts; others struggled to make the connection of their content to the general philosophy of occupational therapy. A disconnect between the technical skills taught and occupation was often cited by participants.

This disconnect continued for many into placements. Participants reported that placements were expected to be a place for students to put the pieces together, or, in more recent years, build on technical skills that weren't taught, only referenced. The result was the perception that each student could end up with a different set of skills and competencies at the end of the program that caused a sense of unease.

Beyond the disconnect, placements provided a greater opportunity for participants to develop visions of their future practice. This was done not only through exposure to different sites and methods of practice, but also through the identification (or dissociation) with practice styles and personalities of supervising therapists. Participants could identify therapists that they aspired to resemble, and also those who they felt taught them 'how not to be'. Those who had these negative experiences carried them into their practice both with their clients as well as with future students, promising to be better role models for future generations of therapists.

Participants also expressed challenges understanding the concept of occupation. Much of the course work, particularly for those educated earlier, was taught as technical skills or 'components', while also integrating an occupation lens. While they were to be thinking holistically, the challenges of teaching a complex profession meant educators "compartmentalized" concepts to relay to the students. Participants all expressed some

frustration with trying to understand what occupational therapy was throughout their education. And when they felt they had grasped the theory, clinical placements could further confuse their understandings when the practice context did not match. This lack of connection between theory and practice would persist into early years of their practice.

Young Identity River: Agentic Identity Formation. Young rivers are fast moving, often turbulent and deep. They can be characterized by having large rock formations on the river bottom, adding to the turbulence in the river flow. This formation is similar to the early path of identity formation.

Most participants did not have a fully actualized identity when at the end of the previous stage (at graduation). Entering independent practice, participants identified that they were occupational therapists, as they had the credential to call themselves by this title, and that others recognized them as such. However, at this stage many did not 'feel' like occupational therapists. They connected mostly to technical skills and what they 'should' do in situations, but they lacked flexibility and responsiveness in practice. They worked to demonstrate roles as others did around them. This was a vulnerable stage for the participants, particularly early on, as the actions and words of intra and inter-professional colleagues were felt significantly and could readily unsettle their self-image.

Participants described the early part of this stage as acquiring and refining technical skills from their university period. While they referred to starting in the areas that held the most interest during school, they also looked for positions that would further skills they felt needed development or that they didn't feel they had exposure to during fieldwork. Many of the

technical skills such as transfers and equipment prescription were desired in order to maintain both their personal identity and others' perceptions of them as occupational therapists.

Identity was threatened by errors and challenges to knowledge and skills by colleagues. Most therapists used reflection to understand what might have gone wrong or what they might have missed. In the case of an error, participants sought out resources to improve knowledge and skills such as books or knowledgeable colleagues. They often sought further feedback to clarify their understanding of the issue. They verified and checked their approaches with others. They attempted to figure out how to fit with the perceived expectations. Where issues persisted, and participants were faced with continued criticism despite their attempts at change, two different responses were seen. Participants such as Michelle integrated the criticism from an interprofessional colleague on her skills as a professional difference in scope and competency. She 'let it go' and she made the choice that her skill in that area did not need to change for her to be an occupational therapist. Instead she identified a different means of interacting with the colleague who provided the criticism. She made the choice not to change who she was, but accept her competencies as equally valuable and different.

Other participants, such as Jessica and Harriet, in the face of ongoing conflict with others around perceived skills and competencies eventually made the choice to leave their work environments. For a time, in severe instances, they questioned their fit with the profession, and what they might have missed in their education that brought them to this point. However, all participants recall eventually making a choice to stay occupational therapists, but to seek out another opportunity to practice.

In exercising these choices, the participants demonstrated their own agency. They took initiative to make changes when they themselves found them necessary and valid. Where they

did not see further change necessary, they made choices on how to work with the circumstances and maintain their sense of identity, or to leave these circumstances altogether for one that was more consistent with either who they were or who they sought to be.

As time progressed in this phase, their concept of themselves as occupational therapists developed and evolved. Errors caused less threat to identity. Subsequent roles and positions were taken to further increase and develop skills. Learning of new skills and how to be an occupational therapist was ultimately the main task of this stage; but this was not as simple as learning to do the tasks and skills. This was about how to be an occupational therapist with the skills and techniques required, in a way that fit with who they felt they were as individuals.

Mature Identity River: Embodied Identity. Mature rivers are marked by a slower, steadier course. While rocks may be present, they are generally smaller and create less turbulence. Riverbanks are generally wide.

Somewhere between five and eight years of practice, was when participants reported they truly felt like occupational therapists. At this stage participants demonstrated resiliency and fluidity in their identity. They could express their identity with their own style in any setting without a loss or threat to how they saw themselves as occupational therapists. Role blurring due to institutional structures was still present but with less impact and while participants could identify that it could be seen in practice, they were clear on who they were in the team and with clients. Because of this, there was flexibility in their approaches to difficulties. For example, Jessica, when faced with a lack of consistency in approach that frustrated her, was able to pull a group of interprofessional colleagues to work to consensus to create guidelines that worked across site and professional boundaries. Earlier frustrations were met with a sense that she was missing something, or that she might choose to simply disregard differences in practice; in later

stages, she was able to more clearly articulate her point of view and work to build agreement with others as to the best approach.

At this stage, therapists often sought out new challenges such as management responsibilities, return to school, and new career areas. They took on mentorship roles, either formally or informally. They engaged in the profession related activities. In general, the participants found that they had something to contribute further to the profession. The desire to master the technical skills was forefront in the previous stage; here the press was to further them, challenge their skills and their knowledge, and to advance their profession. Performing tasks and technical skills was not enough for most, they sought challenge, engagement, and expansion.

Chapter Five: Kawa of Identity Formation

A Kawa model was created using the themes from the participants' Kawa models. The chapter reviews the concepts and their representation to provide a preliminary theory of the key influences on and barriers to occupational therapist professional identity, as well as the traits found in an occupational therapist identity. Each element will be described in turn, recognizing that the model and its elements must be considered as a whole due to the transactional nature of the relationships within the model. Figure 4 provides an overview of the elements of the Kawa created.

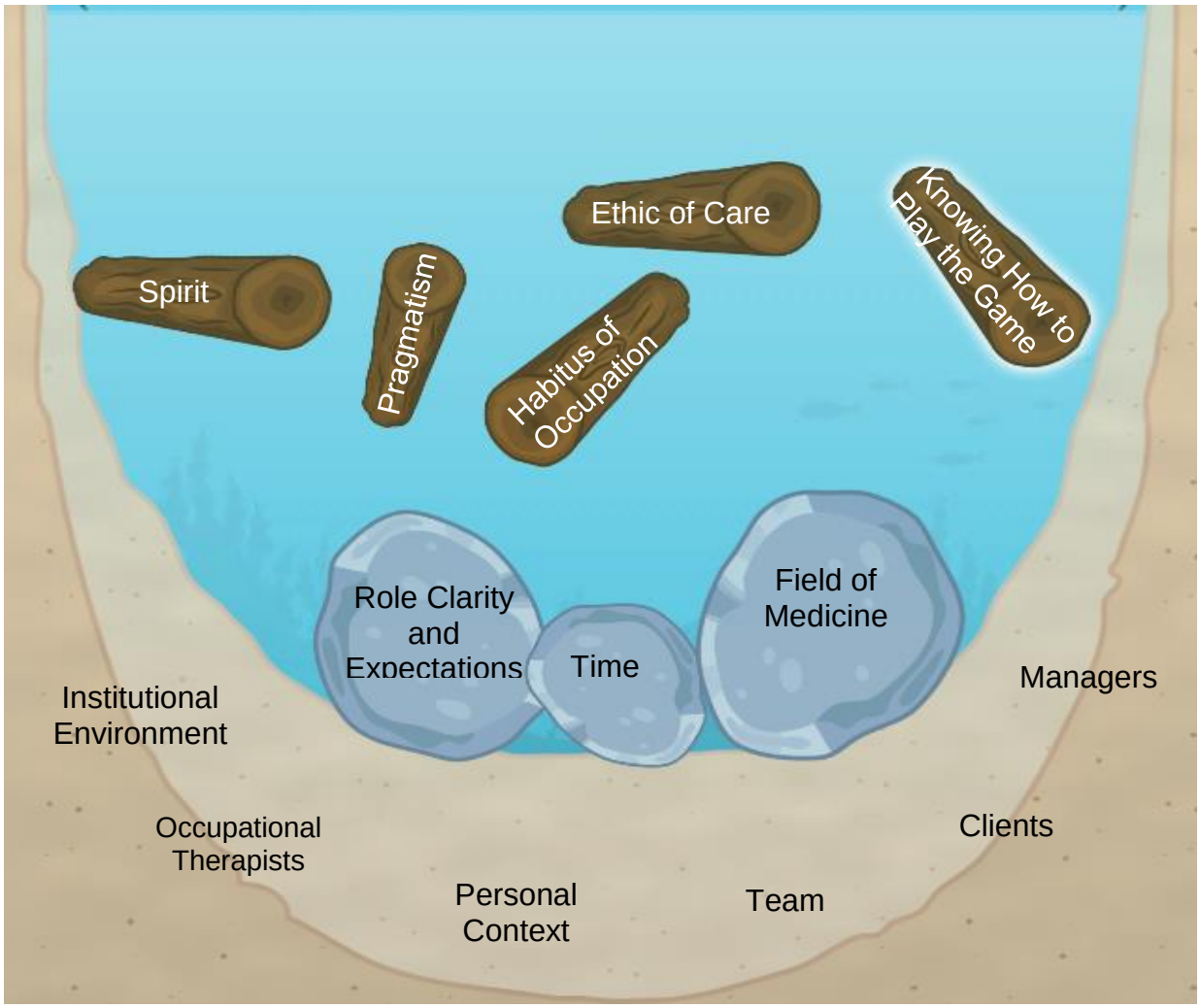

Figure 4. Graphic representation of the Kawa model of occupational therapist identity

Riverbed: The context of practice

The riverbed represents the environment of practice, and of the participants. It is made up of the relationships with others as well as the resources and limitations of the context. The riverbed shapes the flow and direction of the water it contains. When in harmony, the riverbed supports a strong flow and allows for a full enactment of professional identity. When relationships are not in harmony, sediment develops, slowing river flow and energy, therefore stalling or threatening identity. Six major components of the riverbed were identified by the participants: *personal context, institutional environment, relationships with occupational therapists, relationships with team, relationships with clients, and relationships with management.*

Personal context. All participants related the importance of their social supports and resources. These included partners, parents, children and friends. These supports enabled therapists to persevere with work and professional challenges. Parents and partners (dependent on life stage) were seen as a source of stability, emotional support, and even a resource to assist with practice if required. Harriet reported using her partner's skills to help solve a clinical problem. For Michelle, her faith and relationship with God was essential to her resilience throughout her career. Harriet describes seeking assistance from family during a difficult time with her first position "*I talked to my parents and I talked to my boyfriend. And both of them helped me, you know, formulate these letters and correspondence and take tactics. OK, now if this week this doesn't work, then try this."* This assistance and support ultimately allowed Harriet to make a difficult decision to leave what had become a hostile work environment, knowing she had support from her family and boyfriend. While many of the examples of social supports were

positive and helpful, at times they limited participation in work related activities or increased stress to the participant. As examples, having young children often resulted in participants making choices about their careers that reduced demands on time. They chose positions that were less than full time, chose practice areas that were less challenging or interesting, in order to be more available for their families. Financial demands and obligations restricted perceptions of being able to leave unwanted positions. For Donna, working a first position away from friends and family in a new environment, the lack of supports led to detrimental effects on her mental health and her ability to practice:

> *Like feeling very isolated. And I really didn't feel like there was anywhere I could go or anybody I could turn to because anybody I would turn to was a colleague and I didn't feel like it was, I didn't feel like I could reveal that part of myself.*

Institutional environment. In occupational therapy, the institutional environment is often used to refer to policies, procedures, practices and regulations that are found within the context. For the participants, the institutional environment related to both implicit and explicit policies and regulations that affected their ability to practice. Policies included those that indicated which clients could be seen, where participants could see clients, and funding available for services and equipment. Resources available to clients within the facility or the community often could assist a therapist to meet a client's needs, or pose a seemingly impermeable barrier to doing the best for the client. Harriet described the challenges of following policies and process when trying to get equipment for a client: "*What was also frustrating at times was the policy guide would change from Monday morning to Monday morning because he wasn't always there. And it seemed like the interpretation of the policies were different."* The impact on Harriet was

significant. Her desire to do what was best for the clients of her program was being thwarted by seemingly ineffective processes and policies, of which she was at least partially responsible for implementing:

> *… what was also disheartening and really, it would be a real moral issue because it would be one of those situations where you'd walk out of there, people hadn't made a decision. There was a nurse around the table. There was myself. There was a policy guy. There was a doc. There was maybe the coordinator of the head of the health care team. And nobody made a decision that morning after weeks and weeks it finally came to the head office table. And I would come out of there almost physically sick. You know when you know that something's wrong, you can feel a tension in your chest.*

Historical customs that were not explicitly written in policy were often seen as most restrictive to practice and identity. The most impactful of these were institutionalized definitions of the role and practices of occupational therapy. These customs often restricted practice to a medical model, or a prescribed limit on what occupational therapy could or would do, rather than a specific need of the client. In Michelle's early work contexts, she found that what she was expected to do was guided by the institutional expectations of what was expected of an occupational therapist, rather than a holistic focus:

> *We were very detailed in the way that we addressed cognitive evaluation. The way that we addressed, in home visits and documentation flow. So I was very familiar, this is from the 80's, on a system that had policy and procedure pretty grounded.*

Systems often prescribed roles based solely on credentials, which could be frustrating to therapists and not necessarily in the best interest of clients. Funding programs often have gate keepers to programs that require or allow certain professionals to authorize access. Michelle describes her frustration with this structure

> *And again there's things within [province] because of that [equipment funding] program, and again I've learned some of the things come our way only because we are authorizers. Not because we're the best people. Like lower extremity assessment. It's not, OT's not necessarily the best person to be looking at that unless you've got all the special training. You know it only comes up our way sometimes because we can authorize. So it becomes a system rather than a definition or competency or expectation versus a true professional identity.*

Relationships with occupational therapist colleagues. The relationships that participants had with other occupational therapists factored heavily into both the development as an occupational therapist, and their ability to practice. The presence or absence of an occupational therapy mentor enabled several participants to define themselves against a professional example. Mentors served as a support, a role model and knowledgeable colleague who could help them navigate their careers. Conversely, the lack of a mentor, or worse, harsh criticism by a mentor, was seen to negatively affect identity. The lack of a mentor left the participant on their own to develop a sense of who they were or are as an occupational therapist. Betrayal, such as when Harriet's mentor criticized her excessively, and broke her spirit, resulted

in the destruction of identity and ultimately self-harming behaviours such as substance use and suicidal ideation.

> *I was thrilled to be working with this most wonderful professor, ex-professor and, because she left the university and took on this manager at [name of] hospital. And so I thought I had my dream job right off the bat because I loved peds and all that stuff. And then from the November to the April, it slowly went sour. She was meeting with me weekly. I didn't seem to be improving to her standards. And I was driving myself to drink, like literally, and, I was taking stuff home. I was trying to do it. I really didn't feel I had a lot of support.*

And as she sought help from her mentor and colleagues:

> *She would intimidate me quickly I guess, and I'd say, well could we meet regularly and I can work on this and try to improve. And so we did. And I would try my best and I'd be up at 5:30 in the morning working on reports or late at night or whatever. And nothing seemed to be enough. And so that's when I said, OK, well if I'm not getting it, I don't quite understand how but maybe I can work with this other seasoned colleague, who was her roommate and stuff like that. But, again, weekly it was again, just cut you to the quick. Cut me to the quick.*

While mentors had a prominent place in the development of participants' occupational therapist identities, other occupational therapy colleagues also had similar impacts. Support or criticism was often cited by participants as impactful to their identity. Occupational therapy peers were important for a feeling of belonging in the profession, were a knowledge resource and could offer general support. Interactions didn't need to be ongoing to have an impact. Harriet

described a follow up incident during an interview that gave her strength and validation to continue in the profession:

> *And, and then I went to [name of] Hospital and I had an interview with Barb [last name]. She is a gem. She made a pot of tea. She brought out a couple of mugs. We sat down. And I had brought a briefcase and I brought, some samples of my work and my correspondence and communication and just things like that. But she had such an easy way to pull that all out of you that I thought, you know what, if I don't get the job, I've been fortified and mentored in this interview. I think I can go on.*

However, conflict with occupational therapy colleagues could have a significant negative impact on participants. When Michelle's knowledge and reasoning was challenged by her occupational therapist peers, she felt unsupported and alone on the unit and the conflict ultimately resulted in her leaving that area of practice. Peers could restrict or challenge identity. Jessica discussed the conflict that arose with more senior therapists challenged her reasoning:

> *And to me, it just felt so obvious OK, well if he can't get into a certain part of his home or he's going to hate his wheelchair then we have to look at being a little bit flexible here. And this was just one of a few instances where I felt like these other therapists and me, as a brand new therapist, were just being very tough with me. Like Jessica, you don't have a choice here. This client, in order to order this chair properly for him as an occupational therapist, you need to order the right width for him [despite what the client wanted]. …. But there were a couple of other examples too where over time, I'd say a period of maybe 9 months, 6 to 9 months, I don't know, where there were other instances of this to the point where I ended*

> *up getting very frustrated, went to my manager who was an OT then and just explained, you know I know I'm new here. I don't really know totally how things work but I'm feeling like, um, I'm not working to my potential because I'm not allowed to make some decisions that I think I should be able to make and that type of thing.*

When participants saw peers work in a manner that was inconsistent with their view of occupational therapy, such as Donna seeing the reports for her client that focused on what she saw as irrelevant components, they questioned their fit with the professional. Additionally, when peers criticized participants' approaches to practice, such as when Michelle wanted to prescribe equipment consistent with the client's wishes rather than their 'expert' opinion, the result was a conflict that ultimately led to Donna leaving the practice area.

Relationships with team. Interprofessional team members were an important part of the work context for all participants. Frequently other professions offered support and recognition for the unique viewpoint and identity of occupational therapy, and this was found to be reinforcing (or fortifying as per Harriet). Roles were defined in teams and strong team work reinforced the values and beliefs of the participants. Being seen by others outside the profession as providing a valued service or perspective reinforced an occupational therapy identity.

> *They were so appreciative of what I was doing. They said, well if we don't know about this, we'll ask Harriet. So they really understood the role of OT and fortified me. You know they'd always come in for tea down in their little kitchen which was right next door to my office. And they gave me beautiful bouquets of flowers if I helped them out. You know just appreciation so you really felt like, I got to help these guys. … But the fact that they fortified me, in a time when I was*

needing, you know, some verification of being, somebody who was an OT with creativity and valuable services to offer.

However, when a team was in conflict, or when other team members imposed or limited a role, identity was restricted. Team conflict made for uncomfortable work environments that could push the participant to consider another role, or close the therapist down to further development in order to avoid or limit the conflict. Some would make attempts to address the team context and facilitate a more cohesive team. However, when the conflict was pervasive and ingrained, participants often chose to leave the environment. Donna describes a team member that was not collaborative:

I think she wanted to be in charge. And in some ways, that was kind of fair because she'd been there as the only rehabish (sic) kind of person for some time before I got there. And I didn't really feel like she was open to working, to collaborating, to working together. Kind of her way and I was supposed to be a pawn on her.

Relationships with clients. In general, relationships with clients were protective of therapist identity. Being able to work collaboratively toward client needs and goals was important to all participants and contributed strongly to their identity evolution. Participants achieved a sense of pride and fulfillment by being able to offer something of value to clients, even when these were perceived as small or irrelevant by others. Successful relationships were always central for the participants:

And he just said, this [equipment] has changed my life, I now have a quality of life because I don't have the [negative symptoms] and I'm not so tired and fatigued. After the dialysis, I can go home. I can undress myself. I don't have to ask my

> *father. I can transfer myself into the car. And just one of those, because he had been difficult and he certainly was fastidious and, but, you know, he realized also too the reflection of being respectful and responding to his critique that you gained that relationship and he was very complementary of the work that I had done and I was floored. But I realized I just about was in tears because I realized, it's all worthwhile. All the other stuff you have to take the crap. You have to take your whatever. And this one was just one of those wonderful moments.* (Harriet)

Participants reported acting against institutional policy to meet client needs or expectations, such as offering a service that was not generally covered, or arranging celebrations that were felt to be outside the role of a health team:

> *Everybody got into it, but it came from the fact of being client-centered. It came from the fact of going to residents' council saying, would you like this? What would you like? How will it look? And then we would report in and say, here's some ideas. And made sure that they were all part of the process as we carried on. And it was a wonderful. It was elegant and respectful of the residents and respectful of the history that had been in that building too. And, like I say, very client centered, so there's your OT there.* (Harriet)

Seeing clients in their own homes was prized in most circumstances as it allowed a more personal relationship with the clients and a unique perspective into their lives. This could be in conflict with the institutional policies when this context was limited by funding policies or regulations that allowed only a certain number of visits to address specific issues. When this contact was limited, participants found themselves frustrated by the lack of understanding of how their intervention may have helped the client, or if further services were needed.

Maintaining successful relationships with clients is central to working with clients. When this was difficult, or they missed pieces, participants felt they weren't successful. Jessica, described challenges with a client from the military, in which she struggled to make a connection:

> *He was very frustrated. I can totally see where he was coming from. He didn't, he's never listened to women before. Especially younger women. He didn't like being told what to do and how to do things. It's up to him. He was used to being in charge of everything. So here I am teaching him how to get into a bath tub. And he is like very humiliated by that fact. Angry to even be talking about this. And angry even about the extent of his accident because he was wearing a seat belt. He was in the back seat. But just the way the seat belt injured him in the accident, he was left a paraplegic. So by doing the right thing, right. So I never remember having a good rapport with him.*

On another occasion, later in her career, Jessica describes a moment where she realized that it required constant effort and attention to maintain relationships with clients:

> *It's important because here I am, for some of them, giving them home programs that they want to work on that they're probably not even, might not even be invested in. Fully invested. And maybe, um, make whole therapy programs, right, that I might be prescribing for people that might not really be what... I think I could be a better collaborative goal setter but it's even sort of the smaller stuff where people are at that I just feel like, just don't talk so much Jessica, and let them talk and maybe try to figure things out for themselves more instead of me always putting my opinion in there how they can figure things out for themselves.*

Relationships with managers. Similar to the importance of mentors, managers played a key role in the development of occupational therapist identity. Managers were often responsible for enforcing institutional policies and could restrict or enable identity. Both occupational therapist managers and interprofessional managers could have a positive or negative impact on the participants. Participants were noted to give more leeway to non-occupational therapist managers in the participants' stories. Occupational therapist managers were expected to be supportive and reinforcing of the participants, as they understood the profession and its challenges. Non-occupational therapist managers did not have the same expectation, but when they were found to be supportive, this was highly valued by the participants.

Jessica describes how important it was that a manager believed in her during a conflict with co-workers:

> *One thing that really sticks in my mind is one day I came to work and there was a flower on my desk with a little card from our assistant manager commenting how, it's so nice having me in the department and she knows I was working very hard despite the difficult circumstances and thanks for being here essentially.*

Michelle found that an occupational therapist manager was re-affirming as it was someone who understood practice and could give specific guidance.

> *But I also had a manager who was an OT who I could bounce off this idea of a duty. This is what I want to do. Well OK Michelle. So that's important too. Somebody, you know I had somebody to hear my clinical reasoning, hear Michelle's story who said that's occupations. That's what we do.*

In contrast, Michelle's first experience with a non-occupational therapist, who didn't understand the scope, nor in Michelle's estimation, respect the work of an occupational therapist was far more challenging and led to her leaving:

> *I had a manager who didn't really know. She was an RN, you know, she's a good person but she really did not know what my work was. So performance evaluation, the critique was, you don't do enough dishes. You don't do enough floating. So it became a choice (to leave), and that's probably the most unsettling job I ever had. Not because of the work I was doing as an OT. But because of the identity and because of the assumption made that my contribution to the team was around portering and dishes.*

The themes identified as riverbed represent the personal and professional contexts of the participants. The physical and social resources that the riverbed afforded participants shaped identity development by enabling or restricting their flow and energy. Their clients and their stories, inter and intra-professional colleagues and managers, institutional policies and culture as well as their own personal colleagues all had significant influence on how the participants were able to develop and enact their identities throughout the rivers of their careers. The characteristics of these occupational therapist identities, described through the themes identified in the driftwood, were highly dependent on what the riverbed would allow.

Driftwood: Characteristics of occupational therapy identity

Driftwood in the Kawa model represent the assets and liabilities of the person, including personality characteristics, skills and personal resources. They could be considered the key traits or features of occupational therapist identity. Analysis of the participants' Kawa diagrams yielded five traits. These traits were labelled: *spirit, pragmatism, habitus of occupation, ethic of care, and 'knowing how to play the game'.*

Spirit. Spirit was associated with concepts of resilience, perseverance, and drive. Therapists frequently discussed an attitude of positivity and possibility for both themselves and clients. The term spirit comes from Donna who spoke of a client who told her that she had "spirit". While this was a concept that was not easily translated to words, it was the essence of her character and who she represented to her clients and others around her. Spirit in occupational therapy is considered to be the core of the person, the essence of their being.

Therapists describe enthusiasm for and commitment to practice and their clients, and a maintenance of hope, despite others perceptions:

> *I mean these people needed hope. That was the bottom line. You know what, if we're going to do anything in therapy they need some hope. So we need to address that immediately. And if they're being told by the doctor, blah, blah, blah. Well our job in therapy is to still see what you want to get better at and instill some hope in you because if there's no hope, there's no point in working on anything*. (Jessica)

Participants' Kawa diagrams included references to "hope", "positive attitude", "inner strength to persevere", "energy", and "enthusiasm". Rachel describes that she brought this attribute to both her personal and professional experiences:

> *I think personally I just felt, I always have this, you know, hopeful attitude towards people, right. And this belief that you can get through it. That you can do more than, you know, what you think you can do and, and I think that that shines through.*

Harriet reported that she had struggled trying to identify what traits were truly needed for occupational therapy when preparing for the interviews. However, when

describing knowing which students would be successful in the profession, who would find a fit, she included the concepts consistent with spirit:

> *But they have to have a passion. They have to be able to, to want to connect with people, you know, find out more about them. And have that drive and that enthusiasm.*

Pragmatism. Pragmatism is a philosophical perspective that relates to concepts of learning, problem-solving and experimentation and use of theory as a tool (Aldrich & Crutchin, 2013; Ikiugu & Schultz, 2006). A basic premise of pragmatism is that as we learn and develop experience, we apply this in new and novel ways as problems present. This theme was labeled as such reflecting the problem-solving nature of the profession. This theme was linked with the need and desire for challenge, with the use of evidence, creativity and experience to solve client problems. Clients come to occupational therapy practice with issues resulting from personal and contextual factors resulting in a complexity that requires 'thinking outside the box'. 'Cookie cutter' solutions were often inadequate and less desirable as they often failed to consider the multifaceted nature of the client and their context. Rachel describes her dislike of standard approaches that did not reflect the complexity of the client:

> *I just know that I would have been a bit lost with the whole thing if I had not been an OT, you know, I could just imagine, you know, trying to go in to do hand exercises or do, you know, because what I had been before was a kinesiologist, right. So just to look at that physical side, you know, and I think you would say, hey look, your range of motion is that and that and this. You can totally do X, Y, Z, you know, but that really wasn't the case. Like the, the A plus B was not equaling C, you know. How you would normally see it. And I think as an OT, I felt*

it was a great opportunity to enact that thinking outside the box and, and kind of creating something, right. Like no cookie cutter type thing.

The use of experimentation in problem-solving was seen in practice, and determination to meet the needs of the client *"And you know us [occupational therapists], if A doesn't work, we go to B.: we go to C, we go to D. And we find the solution some way or another."* (Harriet). This approach to problem-solving was felt to be central to who occupational therapists are a group. In their own analyses of their stories during the Kawa stage, participants identified concepts such as "confidence in my ability to solve problems", "creativity", "curiosity/intelligence", "lifelong learner" and "experiment" as central to their success and who they were as occupational therapists.

The theme of pragmatism also held in how participants felt theory played into their practice. While participants often struggled with theory in university and in early practice, theory was considered a useful tool to solve problems. Michelle, in her Kawa, identified "power of knowledge based in OT foundation", explaining that the theoretical foundation of occupational therapy based knowledge allowed her to work through solutions to her clients' challenges. Others identified concepts that reflected their tacit use of theory: "think and decide", "see need to change lens" and "seeing the layers of the onion". Participants used their knowledge base to analyze situations and solve problems as they presented.

Habitus of Occupation. Bourdieu proposed habitus as a concept that has been related to an embodied identity (Costello, 2005). Habitus is not something that we are born with, but is something that is acquired over time, through repetition and practice until it becomes something that "we know in our bodies and not in our minds" (Calhoun, 2011, p. 362). Key to habitus is the internalization of a worldview or perspective and ways of being in the world (Costello, 2005).

Occupation was identified by all therapists as a necessary tool for practice. Acquired in school, the importance of occupation and its focus as central to practice differentiated them from their colleagues. Michelle described how empowering it was to embrace occupation after searching for the language in her career:

> *I must say it was so much of the unknowing. But there was so much in the embrace of the word occupation. Because now I could understand what OT, like in my title, occupation is in that title. I'm now beginning to enrich my understanding of that title because it's being defined for me here.*

When enabled by the context to act in ways consistent with their occupational focus, therapist felt empowered, useful and a valued part of a team. Occupation was more than a goal for clients, it was also about a process, the use of occupation as a tool, a means for engaging clients and bringing about meaningful change and meaningful connection. Donna described using a simple game to connect with a client:

> *Well, in the context of playing ping pong we had some good conversations. He established a relationship, a sense of connection or being that seemed to be comfortable for him. And allowed him to ask for help in other situations, with other struggles in other areas. And to experience, and have a positive experience of himself in relationship to somebody else.*

Therapists identified a desire to focus on meaningful activities and goals that were valued by clients and to move away from illness or disability based components that are frequently associated with the health system. It was confusing and frustrating for participants when other occupational therapists did not practice with this lens. Donna described a situation that left her

questioning her fit in the profession when a client was sent to see another occupational therapist and returned with a plan that was limited to components and lacking in relevance for her client:

> *Just because she holds her pencil, that's the biggest thing in her life? But it's completely meaningless to look at in the context of what's going on. The important thing for me is the big picture. But like we're not sensory motor therapists, we're occupational therapists. And occupation includes, includes socio-cultural determinants, environmental, psycho-emotional. And, developmental. All those other things. It's not just about sensory motor. And so, if we're having a broad occupational lens, we need to look at all of those factors that are going into shaping what they are, what they are able to do and what they aren't able to do and what the barriers are to having them be at a broader range of choices.*

Occupation-based practice required participants to work against the dominance of the medical world, or to couch their practice so that others could see the fit. While not all participants used the term occupation to describe their practice, all indicated that they felt like occupational therapists when able to act in ways consistent with this philosophy. Donna describes her role in enabling occupation in a group of her clients that didn't completely fit with the health system in which she worked, but she felt was what her clients were asking for:

> *I would organize an elders' tea or feast or whatever. And there would be food and bingo, and I would try to include elders from the community as well. So we'd arrange transportation to bring all the elders from the community. And I think at the time I didn't realize that there was cultural significance to that too. Like having a feast is something that people do up here. … But I always felt I wasn't*

> *doing anything because I didn't cook. I couldn't really talk to anybody because I didn't speak the language. I didn't organize bingo. I didn't. And then things just happened. Like somebody would bring a goose. And I never knew where it'd come from. But then the next thing I know the kitchen would say they had a goose for this thing and they were going to make this and that and whatever. And somebody would say, oh so-and-so plays the fiddle or whatever. And then suddenly you would just be there. And I would go and buy bingo prizes and I think that was probably like really all I did. But I felt good about that as an OT thing because I think there was a cultural development to it that I wasn't fully aware at the time. It got the elders out doing something. It was something that was, you know, meant something to them in their context. One of the other things that I kind of feel good about was partly the fact that I wasn't really doing it. Like I kind of catalyzed it. And then it just happened.*

The seeming simplicity of occupation, and its perceived common sense-like approach sometimes led participants to underestimate its impact, as when Jessica went to the course with her colleagues and felt she learned nothing new as the concepts discussed were already central to her practice, despite being novel to her physiotherapy colleagues, and to underestimate their importance as with Donna acting as a 'catalyst' with a community to meet the needs of her clients. Occupation was so integrated with their being that it seemed self-evident and common-place, despite its uniqueness.

Ethic of care. Occupational therapists believe that practice should be client-centred, involving the clients in all aspects of the process and decision making, as demonstrating respect for their autonomy. While client-centred practice is central to the occupational therapy, this

theme was labelled an ethic of care reflecting the internalization of this practice into personal attribute and belief. Noddings (2005) and Held (2006) discuss an ethic of care related to relationships between a 'carer' and those being 'cared for'. Tronto (2006) believes that an ethic of care involves a number of concepts, including attending to needs of the cared for, a willingness to meet needs, and competence on the part of the carer to meet the needs of the care for. Participants demonstrated these characteristics throughout their practice and in the retelling of their stories. Jessica describes working to meet the needs of a client, but in doing so she needs to go against practice expectations of the site.

> *To me there should have been a choice that can we just make an exception here. Like sure it's going to be a little snug on him but he's willing to take that risk and he feels it's going to be a better chair for his environment.*

Michelle had a similar experience:

> *He's got ALS and I'm not sure, where he's at within that. But he's been seen by a couple of other therapists, physios and OTs who have really strongly recommended that he have this specific type of seating system because it's particularly focused for him and he doesn't want it because it doesn't allow him to easily move himself in his environment. Well when I see [client name], I'm OK with that now. I'm OK with saying, [client name] what works for you? It doesn't have to be the best seating system I can give you. It doesn't have to be the best posture I can give you if that is not what you need.*

Truly attending to the client's needs often meant going against established practices or policies. Participants demonstrated respect for their clients' knowledge of themselves and integrated this knowledge into their care.

Participants valued the stories of their clients and worked to place clients at the center of their practice, often despite the context of their work. Respect, care, and compassion for the circumstances of the client and their needs were frequently at the center of the stories of the participants. Participants worked to build collaborative relationships through listening and focusing on meaning for clients. Participants exhibited a focus on identifying the needs of their clients, meeting their needs and a desire to develop skills to meet the needs of current and future clients.

Sometimes demonstrating care meant pushing their clients beyond their expectations, such as when Rachel saw more in her client than she felt in herself. It was the relationship build that allowed Rachel to push her to achieve more:

> *But I think we spent a lot of time I think, developing that therapeutic relationship. Where she really trusted me and she really, you know, I knew, I really had this idea that she could be more capable than what she felt like she could. And so how to convey that to her, you know, without going in and sort of saying, well you can do that. You can wash yourself. Watch me, I can wash myself with one arm, you know. How come you can't? But really having that understanding of her emotional being.*

Clients taught the therapists as much as the therapists taught the clients. Keeping the clients' stories close enabled the therapists to remember why they were there and what was important. This work took constant reflection on their skills. Jessica tells of an 'aha' moment after years in practice:

> *It's important because here I am, for some of them, giving them home programs that they want to work on that they're probably not even, might not even be*

invested in. Fully invested. Like I think I could be a better collaborative goal setter but it's even sort of the smaller stuff where people are at that I just feel like, just don't talk so much Jessica, and let them talk and maybe try to figure things out for themselves more instead of me always putting my opinion in there how they can figure things out for themselves.

'Knowing how to play the game'. Knowing how to play the game came from the work of Bourdieu (Calhoun, 2011). Clouder (2001) applied the concept of 'playing the game' to occupational therapy students developing their identities within fieldwork placements. Knowing how to play the game for the participants in this study involved not only knowing a role, but also how to play as a team. Team work involves being able to work in collaboration, working within and at the edges of the rules of the game, and thinking and responding in the moment. Playing in a team was necessary for all participants in their daily work. Participants valued their ability to work with other professionals on the team towards client goals and to support each other in the work context. Participants' Kawas included "communication skills", "collaboration", "honesty" and "openness".

Michelle described the building trust within her team when giving up certain tasks previously associated with occupational therapy and trusting the team to make sure that occupational therapy would be involved if needed:

It took a few years to actually have the comfort level that it was OK that OT wasn't seeing these individuals. It had to be a proven experience that, um, we weren't having remissions. We weren't having people fall through the cracks. So it's not that we're not seeing anybody with a total replacement. It's just we are respecting the resources on a closed unit of hearing other team members telling

us about the client with a specific need. So, we got around once a day. We have charge nurses. We see them as we're walking down the hall. There's a lot of safety nets that will trigger us.

Playing as a team and knowing how to play the game involved looking at the entire playing field when making decisions, knowing where everyone is. Playing the game involves having a "sense of the game" (Calhoun, 2011). Rachel discussed needing to take a step back in the moment to consider all factors to determine the correct 'play' in a specific circumstance:

I think it's that larger context, right, that it stands out in my mind, and like take a bigger picture view of this, right. Like what's really happening? And how can you make all these therapies most effective, given all these pieces that you have, right.

Understanding the rules of the game (for example, institutional policies) was important for this element, but also important was knowing how to work with relationships with team members to work at the edges of these policies to 'advance the game' or meet the needs of the client. Harriet describes working with her client in a way that was not necessarily typical for a community therapist, but was best for the client.

But I did have an example where I was working with this lady in her home. And I went to visit her and her husband was very attentive. And she had a lot of contractures in her hands and I thought it wasn't easy for her to get to the hospital to be splinted. And what was acute care, this is the [name of] hospital, and I'd been travelling all over. And I'd pop in to the OT department, start chatting with them. Ask them questions or whatever. And the OT was off on maternity leave and there was nobody covering for her. I said, OK, so I can't

> *make the referral. I said, well can I snitch your, electric frying pan. And they said, sure. Can I snitch anything else out of here? Oh yea sure. Because I said, I've got a lady at home here and she needs some help. And I didn't know whether it would work or not. But I started doing, and she was quite contracted in her hand, and I started to do serial splinting with her.*

Harriet's ability to play the game, and to work with the team in a different way, enabled her to meet the needs of the client and provided a better outcome for her client. For all participants, being part of a team, and knowing how to work in the team, and perhaps make the team better by their presence, was highly valued. Rachel describes this feeling when working with a complex family situation:

> *Well it's true multidisciplinary involvement too, right, which I really love. I never feel as an OT that I should be working on an island. I mean I love working with other disciplines and putting our heads together. I do think with OT you sometimes have a better time seeing the forest for the trees, you know.*

The themes identified in the driftwood reflect the characteristics of an occupational therapist identity. The characteristic of spirit and ethic of care captures some of the pre-existing personality traits of the participants, reinforced and challenged to develop further throughout their careers. The driftwood of habitus of occupation, pragmatism, and knowing how to play the game are developed and honed through socialization into the profession and refined and solidified in practice. While these characteristics are internalized, they are highly influenced by the previously identified riverbed characteristics and often challenged by the barriers represented by rocks in the river as clarified in the next section.

Rocks: Barriers to Identity Formation and Enactment

Rocks represent discrete barriers in the flow of the river. They are considered difficult to move and change. When rocks exist, flow of the river is limited. However, the impact of the rocks can be minimized where there is a deep riverbed, or strong driftwood to move the rock. In the occupational therapist identity Kawa, three rocks or barriers to professional identity were identified. Barrier themes included *role clarity and expectations, field of medicine,* and *time.*

Role clarity and expectations. Participants frequently reported significant difficulties with their identity when roles were not clear. Blurring among health professionals, limits and boundaries on practice that were seen to be restrictive or inconsistent with occupational therapy, and expectations that were unclear were experienced by all participants at various points in their careers. Participants reported incidents of expectations to porter patients and wash dishes, roles limited to attention to components rather than occupations, a lack of a unique role for occupational therapy and even questioning if there was a role for occupational therapy in the assigned caseload. Participants found themselves questioning the profession and the position in these circumstances. At times, these obstacles were significant enough to push the participant to a change in job if the ambiguity and uncertainty could not be resolved.

Donna describes trying to understand and rationalize the fit with the expected performance of ankle dopplers and provision of orthotics as the predominant tasks of occupational therapy in her health region.

> *It's still really strong and very strongly held position, I guess, throughout the territory that orthotics are an essential thing for OTs to do. And wasn't a lot of openness to consideration about other ways of doing that or how to work with the physio or how to kind of change how they were addressing that kind of thing. So*

> *partly it's the idea that orthotics is like the biggest OT thing and part, really, it's the rigidity around being open to other, different viewpoints and different considerations around it. They also, I'm not sure if it's changed now, but were expecting [the OT] to do a set of Dopplers, a kind of blood flow measure thing in the feet or ankles or legs or something. Can't remember which you call it. And it also was considered like a core OT to do. I know, it's bizarre. And to me both of those things,… Orthotics I could probably reason my way for making a case for it. But I still don't see it as defining OT role.*

Prescriptive and limited roles, while offering an opportunity to develop technical proficiency were ultimately seen as limiting occupational therapy practice.

> *I knew I didn't want to stay there forever. I did some splinting, that kind of thing. And, ortho rounds was interesting because it, I always felt ortho, well OT had a very distinct role and physio had a very distinct role and OTs role was equipment and splinting. Which was good for me on the short term but I didn't want to be there forever. Didn't feel like I, again, I was making much of an impact. Maybe a short-term impact but I was always kind of wondering if people used the equipment when they got home.* (Jessica)

And on another unit, Jessica experienced a similar limit

> *And just sort of feeling that the OT role on the team wasn't necessarily that valued or was only valued for a couple of things. …Well it was just sort of like we were the equipment people. You do the equipment. OK. Good, then they can go home.*

Positions with limited scope and prescriptive occupational therapy practices were seen to be less desirable, and often associated with a new graduate experience to develop technical skills. Participants left these roles as other more challenging and interesting opportunities arose, often those that offered them more autonomy of practice.

Field of medicine. Bourdieu described the concept of a field of practice, one in which a dominant group exerts power and influence on subordinate groups (Calhoun, 2011). Medicine is the dominant and powerful group in the health system that remains the predominant practice area for most occupational therapists. Participants discussed the barriers to enacting an occupational therapist identity that they experienced working in a medical model. In Kawa diagrams, the medical model was cited by Michelle frequently as a barrier to her enacting her full identity. *"Always been in that medical model system. So it's been, you know, it's kind of that monster that really defines or tends to define. And I didn't know how to get out of that."*

In this medical model, the units and departments are organized around disease type, or medicine specialty. Professionals (particularly medicine) are considered the experts, and clients are passive recipients of care. Goals are articulated related to survival, body system function and discharge from services, rather than expectations and wants of the clients (or patients as the medical model considers them).

While occupational therapy has been working within this system since its early days, the profession is not concerned so much with disease as with the impact on occupation. As such, the limitations placed on practice by addressing solely the disease state were felt to be restrictive. Participants reported being unable to see certain clients as they did not qualify for occupational therapy based on their condition or unit, expectations to be working towards treating disease, being limited in what can be addressed based on the expectations of the medical team.

Jessica described the impact that the physician on her team had on her ability to build a relationship with her clients:

> *I mean the physician typically is the head of the team so what she says often goes. So I was just concerned that sometimes she'd be saying things to clients that weren't truly representative of what the team thought. … And she was very black and white. [to clients] So you're never going to recover. Never going to use that arm again. You're never going to walk. This still happens to this day by the way. So that's then hard as a therapist to say, OK, we're going to work on this. You have a doctor that's told me.*

Rachel experienced frustration that she needed to be focused on getting her client home as quickly as possible, rather than on what the client wanted or needed to accomplish:

> *And then where does the OT fit in terms of being able to accomplish those criteria, right. And I think those are the places that I, I tend to have felt less than like an OT because, you know, if I could just go in and, you know, there's this 80-year-old person and she needs to be able to dress herself before she goes home. Like how much therapeutic process is there? So I guess basically it's all spelled out. I mean it's a great first job I guess, right. Because pretty much the team will tell you, you know, they need to be able to work on dressing. And you go in and work on dressing. It's just to me it doesn't seem as creative. Like I can't be an active agent.*

Even when therapists moved out of the health system, this model pervaded participants' experience. Therapists internalized it. Donna found it difficult to move into the social system,

despite the fact that she felt it was a where she fit. She wasn't certain how to adjust her way of being to the system and felt herself waiting for others to challenge her role

> *I anticipated having to have a conversation with somebody at some point about what I was doing and what I was doing there. And, you know, which never happened. So I mean partly it was because I was so new in the place and I wanted to be able to, I guess, justify if there was a conversation about it. But, um, but it was largely I think for my own safety zone. Because I was kind of in the midst of trying to figure out what an OT role would look like in a social services setting as opposed to a health care.*

Time. Time was represented throughout the participants in a number of ways and had a significant impact on professional identity at any given point. In the simplest and most direct way, time related to pressures associated with practice, to accomplish tasks within time frames felt to be difficult or unreasonable. Limited time meant limited access to clients and their contexts, and limited ability to bring about change. Harriet discusses increasing caseload demands and pressures without additional hours or supports limited her ability to enact her role and responsibilities that resulted in her ultimately leaving the facility within which she worked. Michelle had a similar experience:

> *So we went from 15 clients to 20 to 25 and then all of a sudden we're at 50. And so there's 50 people I have to assess. It's a day hospital program so it's about assessment and rehabilitation. So it's a lot to do when you have two groups of clients. So you have those that come Monday, Wednesday, Friday. And those that come Tuesday, Thursday. So now you're talking 100 clients. So it just got to be overwhelming.*

Time was also in short supply for activities outside direct care, such as keeping up with practices or learning new skills:

> *I found in neuro though there wasn't a lot of time to sort of spend doing that. Our waiting list is, was long, it's always been long. And there wasn't a lot of time. To sort of keep up to date with things. You kind of had to fit it in. And I often took reading home which was frustrating but there was no other time to do it.* (Jessica)

In a longer term sense, time was a barrier in that it was needed for the development of both confidence and experience. This included time in a specific role or work context, and time over years to develop experience acting as an occupational therapist. Participants reported that one of their barriers throughout their careers was their lack of confidence and experience. Both were seen to be linked to each other, as in early practice, it was both were often cited together by participants. When therapists felt that they did not have the experience to meet the demands of their circumstances, this challenged their sense of confidence. Additionally, when participants felt the needs of their clients were possibly beyond their skills, their confidence was undermined. Experience continued to be cited by participants even beyond early years of practice when participants were moving to new areas of practice or taking on new challenges for them.

Donna describes feeling a lack of confidence in her skills and knowledge about her job early in her career:

> *I mean what was significant about it was, I didn't really, at the time, I didn't really feel like that was a job that I was supposed to be doing. And I, so I felt like, I guess I felt like I was kind of doing it on the sly or I was waiting for somebody to call me on it.*

For Jessica in handling conflict with her colleagues, her lack of confidence and experience limited her ability to challenge the more experienced therapists and do what she thought was best, "*Because I think at that point he was one of my first clients, I just didn't have the confidence to sort of stand up for it and there was conflict on the team already."*

Most broadly, time related to development and life stage of the participants. Participants' maturity, life demands and adult developmental stages related to their choices about their careers as well as their ability to cope with and respond to identity threats.

The themes identified as rocks posed the most significant barriers to the participants in the development and enactment of occupational therapist identity. Role clarity and expectations were often determined by the context and highly influenced by the field of medicine on both a meso (practice setting) and macro (field of medicine within society) level. Time had both contextual and longitudinal elements, both serving as barriers to the participants.

The elements of the Kawa of occupational therapist identity development all interact in countless ways, shifting and changing both the shaping of identity and enactment in context. Earlier in the career path, when the driftwood may not be as fully honed, large rocks and narrow riverbeds were more likely to prevent and even block flow. With the maturing of the river, and the strengthening of the driftwood, participants were more able to alter the shape of the riverbed, and were less threatened or more able to respond to the challenges and barriers posed by the rocks. While the shape and size of the

river elements change and reorganize across an occupational therapy career, the key themes identified by the participants were always present in some form.

Chapter Six: Discussion and Conclusions

The findings of this qualitative study are consistent with the existing knowledge and literature related to professional identity in general and occupation therapist identity specifically. Themes consistent with Lave and Wenger's (1991) legitimate peripheral participation in a community of practice, with Bourdieu's (1993) concepts of habitus and fields in professions and the overall social construction of identity were found in the participants' stories of becoming occupational therapists.

While the findings are consistent with earlier studies, this study does contribute to the field in several ways. It is the first study to put forward a proposed path or flow of identity formation from prior to entry to professional programs, through late career practice. Most studies have focused on identity development within occupational therapy programs, and some to early years of practice. This study is also the first to identify the key concepts of an occupational therapist identity. This study articulates five key features associated with enactment of a professional identity, beyond the concepts of helper and expert in occupation. With this understanding of the lived experience of identity, a model of identity formation is also proposed, identified the major social influences on the development of professional identity as well as key barriers to identity formation and enactment. Finally, this study provides five distinct stories of occupational therapist identity development, across careers. Stories serve as tools for teaching and understanding experience, for those seeking entry into the profession, for those socializing newcomers, and for those seeking to understand their own experiences. Stories create community.

Course of Identity Formation

This study, while retrospective in nature, traced the entrance of the participants from non-member to newcomer through old-timer/master in a diverse community of practice within Canada. The participants in this study entered their academic programs with a pre-existing, though limited, occupational therapist identity. They had characteristics of the professional habitus that enabled them to connect with the world view of the profession. Initial socialization took place in university programs, and while limited in their ability to control their socialization process, the participants were far from passive recipients of translated knowledge. Their participation on the peripheries of practice in fieldwork settings allowed them to see and question how they fit. They made choices related to who and how they would be within the profession once they were granted full access and participation in the community of practice.

Upon full access to the profession of occupational therapy, participants were seen to experience a level of dissonance between the identity they had acquired and the practice of occupational therapy within the field of medicine. Despite ongoing participation in their community of practice, participants spent significantly more time with interprofessional colleagues and clients who also participated in shaping the identities of the participants. They demonstrated agency in their choices of who to be and how to proceed within their profession, by changing roles and positions. Despite this agency, many clung to the known or expected ‘competencies’ or components of practice, despite the dissonance as a way of fitting in and feeling valued by the team.

With time, came the development of competence and confidence. Participants learned ‘how to play the game’, knowing how to support team members, play as a team, yet exercise and engage in their unique role. Some became masters, valuing sharing their craft with others, further developing the community of practice through professional participation, supervision of

newcomer students, and furthering of their own skills and knowledge. They became less challenged by identity threats and embodied their occupational therapist identity.

Clarifying Occupational Therapist Identity

Unlike previous studies, a model describing the characteristics of professional identity is proposed. This model of occupational therapist identity reflects not only the key values and knowledge base of the profession, but also constitutional factors of the therapists themselves. While some are acquired during educational programs and with experience, others are more likely present in some form prior to entry to the profession. Participants selected occupational therapy as a profession because of a connection with its values, but also because they believed they could bring their own skills and personal attributes to the profession to be used as therapeutic tools within the profession. The concept of a therapeutic use of self, central to many health and helping professions, factored beyond the creation of relationships with clients, but also into the problem solving, creativity and engagement in the enabling of occupation with clients.

These entrance characteristics were further shaped and developed through participation in educational programs, where the paradigm of occupation was introduced, as well as the competencies to enable both occupation and care ethics in practice. The occupational paradigm was not introduced without difficulties for most; the relation of parts to the whole, of components to occupation was challenging in both school and practice. Student occupational therapists are dependent on their professors and preceptors to be able to translate the abstract into praxis in context. Early on, the habitus of occupation is an uneasy fit. There is a desire to integrate the theory into practice, and students and early career therapists work hard to improve both the fit of occupation, and their fit in the profession.

It is not surprising that occupation is central to occupational therapist identity, given that it forms the domain of concern for the profession. Yet, despite this, it is not something that is easily acquired, and is embodied to different degrees based on the contexts within which the participants had practiced, and their time within the profession. This habitus put participants at odds with others from both within and outside the profession, leading to feelings of isolation. The dissonance (Costello, 2006) was present even though they had acquired the desired habitus, when the enacted roles of other occupational therapists went against the centrality of occupation. The habitus of occupation was seen throughout the careers of the occupational therapists, from its early stages, where it is tried on like a set of clothes in academic settings and fieldwork, to where it is embodied and enacted without conscious thought by masters every day in practice.

This finding is consistent with the existing literature related to occupational therapy identity, though in studies of students. Understanding and applying occupational therapy models and practicing in ways consistent with occupational therapy philosophy were found to increase students' professional identities and enhanced their connection with the profession (Hanson, 2009; Ikiugu & Rosso, 2003; Jebril, 2008). However, many practicing therapists may not be familiar with the current occupation-based models or understand how to apply them in their practice contexts (Hanson, 2009; Whitcombe, 2013). The ability for a therapist to not only understand the conceptual models guiding practice, but to apply them within their context is essential for the development of professional identity and the internalization and enacting of occupational therapist identity.

While client-centered practice is emphasized throughout the Canadian context as central to practice, the theme of ethic of care includes characteristics beyond what would typically be considered in client centred occupational therapy. Client-centered practice often focuses on

practices of the therapists and the orientation to the relationship with a client. The results of this study indicate that while client-centred practice was demonstrated by all participants, they demonstrated not just the competencies associated with this model of practice, but also the attitudes and behaviours associated with an ethic of care: attentiveness, responsibility, competence and responsiveness (Tronto, 2006) in the caring relationship with clients as well as others. The ethic of care went beyond clients, to students, colleagues, and others within participants' worlds. The sense of compassion, and attentiveness in relationships, combined with the sense of obligation and competence to help were expressed by all participants and in all relationships. This ethic was central to how the participants saw themselves, even when challenged by circumstances. Client-centered practice merely reflects a set of practices, while participants in this study embodied an ethic of care.

Pragmatism is considered to be one of the foundational philosophies of the profession by its theorists (Aldrich & Cutchin, 2013; Hooper & Wood, 2002; Ikiugu & Schultz, 2006). These authors focus on the roots of the profession, and how pragmatism and the work of philosophers such as Dewey influenced our profession's understandings of human beings and of occupation. However, in this study, the participants demonstrated these characteristics within their enablement practices. Use of creativity, experimentation, and learning in practice was not only exhibited by participants but valued to such an extent that the ability (or inability) to engage in such practices led to changes in practice setting. As students, the participants struggled to put what they learned in to practice. The seemingly abstract nature of the profession posed a challenge that they sought to understand and figure out in clinical settings, to understand how what they had learned applied beyond the artificial nature of the classroom. They used multiple theories and techniques to solve the problems that presented themselves with both clients and

colleagues, experimenting to find the best solutions, to enable occupation, and to demonstrate care.

All three of these characteristics, habitus of occupation, ethic of care and pragmatism, come into play with knowing how to play the game. Occupational therapists drew on their life and work experiences, their skills in collaboration and building authentic relationships, and their understanding of the systems within which they worked, to accomplish what they needed to do for both their clients and themselves. Therapists recognized that they needed their teams and colleagues and they learned how to work within systems, and interact with different colleagues to make a difference. This required awareness of their place within a system, as well as that of their co-workers and each of their relative places within systems. Learning to play the game began in school as therapists (Clouder, 2001) and developed throughout their career as therapists recognized key relationships and as they encountered barriers in practice.

Underpinning all these competencies and traits, spirit is a central personality trait that allowed the therapists to persevere throughout the challenges of their career and to bring that determination to their clients. Hope, positivity and resilience enabled therapists to be engaged in challenging circumstances, and to then engage clients experiencing challenging circumstances, and to see a way forward, and a path for change. Since the beginning of the profession, occupational therapists were selected based on having the "right spirit" (Pringle, 1922, p. 48); this elusive construct is a challenge to define or describe, but is heard in the emotion and the energy expressed by therapists in the telling and re-telling of their stories. Therapists bringing spirit to their practice enabled them to develop authentic relationships in their work and made continuation in their careers possible even when circumstances became challenging.

This representation of the characteristics of occupational therapist professional identity, while consistent with the existing knowledge within the profession, represents the first to identify the key characteristics of this identity. Professional identity is often talked about in a singular way as present or absent, or as if it is a known entity that can be fully understood and quantified. The results of this study support a professional identity with several attributes that while they become more stable, remain fluid and flexible to adjust to the context of the identity.

Barriers and Facilitators of Professional Identity. The personal and professional contexts of the occupational therapists in this study created both barriers and facilitators to identity development. Dependent on the time and the context, each factor could have a positive, neutral or negative impact on the therapist, shaping how their identity developed or could be enacted.

The impact of the context on identity has been discussed at length in the literature on the topic (Hanson, 2009; Ibarra, 1999; Jung, 2010; Tryssenaar, 1999). Students and early career therapists often use colleagues as models of 'how to be' occupational therapists (Ibarra, 1999; Tryssenaar, 1999) which is consistent with the stories of the therapists in this study. Participants found they identified with certain ways of being an occupational therapist and strove to enact these characteristics. Additionally, therapists identified other ways of being that did not resonate and rejected those characteristics for themselves.

Relationships with both inter and intra professional colleagues offered both support and challenge. Both provided opportunities for validation of skills and knowledge, and the confirmation of the professional identity by others. At the same time, when relationships were less harmonious, identity questioned or restricted and could negatively impact the therapists. Mentors in the environment provided needed fortification and endorsement allowing identity to

flourish. Without access to mentors, therapists found themselves struggling to recognize their own competencies and sought environments that could offer them these opportunities. Baptiste (2001) recognized the need to develop mentors in the profession of occupational therapy, as a means of continuing professional development for therapists in order to improve and further their skills in practice.

This study also identified the impact of institutional culture and policies on the ability for therapists to enact their identities. Therapists' practices are often restricted by institutional and system policies that dictate the limits to the client-therapist relationship, or limit the services that a therapist can provide (Hammell, 2006; Ringaert, 1997). These policies and practices can negatively impact the therapist, who may experience conflict when they are unable to provide services that they believe are required, or the policies can even negatively impact the client-therapist relationship, when the client requests something that is not supported by the policies.

The importance of relationships with clients was echoed by all participants. Building relationships with clients, and the ability to meet client needs was consistently reinforcing of therapists' professional identities. Given that enabling occupation of clients is the reason for occupational therapist practice, this is not surprising. Therapists drew on all resources, skills, and relationships to meet client needs and enable their participation in occupation, and this reinforced their identities.

The largest barriers to identity were highly related to context. Role clarity has been identified by many as the largest obstacle to professional identity (Edwards & Dirette, 2010; Hanson, 2009; Whitcombe, 2013). Some argue that the lack of clarity in the profession itself is a large contributor to the problem of role blurring, as it is then difficult for therapists to articulate their unique contribution to the team (Jebril, 2008; Whitcombe, 2013). Certainly, the blurring of

the profession with physiotherapy through joint training further hindered the articulation of a unique identity within health contexts. However, therapists in this study were often very clear in their role and what they brought to the client and team, however the environment created blurred roles that were difficult to overcome.

Therapists in this study encountered barriers associated with working within the field of medicine. Occupational therapists are socialized and frequently work in health systems that are controlled and organized by medicine. Physicians hold the power within these systems either explicitly or implicitly and therefore control the 'play' of others in their field (Bourdieu, 1993). Health teams and units are organized by medical specialty, or even body structure, something that is counter to the holistic participatory focus of occupational therapists. Medicine within hospitals and clinics frequently controls referrals to occupational therapy and can limit the role and scope of the occupational therapist. Even when working outside health, the association with medicine often continues with insurers of service requiring physician authorization for services and scopes of practice are strongly controlled.

The final barrier of time in its simplest form is often a result of the interaction of the field of medicine and institutional practices and policies that create demands on therapists that can be seen to be unrealistic. Therapists feel they do not have time to develop the relationships with clients they would like, to deliver the services they feel are needed, or to maintain or further develop their own competencies. More complicated is the relationship between time, experience and feelings of confidence. Development of confidence in practice takes time – more time than is available in educational settings. Early career therapists often found that their lack of experience and the related lack of confidence in their competence negatively impacted their relationships

with clients, their ability to assert their knowledge and even how they were perceived by other professionals, further undermining their identity.

The professional identity characteristics of an occupational therapist are developed throughout a professional career. They are influenced strongly by the contexts within which they are educated and then practice. The restrictions and affordances shape how an occupational therapist's identity forms and is then enacted, and the barriers that therapists encounter challenge these identities, resulting in career course changes, as seen in the participants in this study, or potentially a career change altogether if the barrier is to great or the support from the environment inadequate.

Recommendations

The results of this study, while preliminary, can inform educational programs, contexts of occupational therapy practice, present and future occupational therapists.

A model of both professional identity and the key factors that influence its development and enactment assist those involved with the profession. By recognizing which pre-existing personality traits therapists possessed prior to entering educational programs, recruitment programs can better target those who may be most likely to be successful in entering the profession. Recruitment materials can be created to attract those who self-identify with the concepts associated with spirit, pragmatism, ethic of care and knowing how to play the game. Interviews can be designed to draw out these characteristics from potential candidates. To some extent this is done currently – health professions tend to draw in people interested in helping. Increased emphasis on building a sense of team and community, maintaining a sense of hope and positivity, and demonstration of creativity in problem-solving could also better assist in selecting appropriate candidates who would most likely be successful and further develop the profession.

Educational programs need to attend to the teaching and integration of occupational therapy philosophy and theory. This study, as others, demonstrates the importance of linking theory and practice to support the profession's core concepts in developing occupational therapists (Ashby, Ryan, Gray & James, 2013; Hanson, 2009; Ikiugu & Rosso, 2003). With this, it is important that clinical preceptors are able to clarify the use of occupational therapy models and practices in the clinical context, so that students can see theory in practice (Ikiugu & Rosso, 2003; Whitcombe, 2013). All involved in the education of students and developing occupational therapists must be able to translate these concepts and make them accessible to students so that they can be internalized, rather than seen as disconnected concepts and ideals separate from practice.

In selecting practice sites for clinical education, the competencies and the skills of the educator should receive further attention. In a profession that often struggles with securing enough teaching sites, the availability of a clinical placement is often the prime consideration, rather than the quality of the experience. Potentially practice sites should be evaluated by both students and universities to determine their suitability for clinical education at various stages of student development. Mentorship and continuing professional development opportunities for clinicians to further develop skills in provision of occupational therapy practice education may also be useful to ensure educational experiences meet the expectations of the students and the universities.

Mentorship opportunities within practice sites for new therapists, or even therapist changing work contexts, could assist therapists with the transitions. These relationships offer not only development for the newcomer but allow the masters to share their knowledge and develop other skills.

Occupational therapy practice contexts should be as closely linked with the clients' contexts as possible. All therapists valued the ability to see and interact with their clients within the clients' own setting, rather than that controlled by medicine. Home-based practiced allowed the therapists a richer understanding of the client and created a power shift from the therapist to the client that the therapists valued.

Occupational therapy roles need to be based on occupational therapy competencies and holism. Gap filling, which often occurs when the role of occupational therapy is not understood, should only be done if the gap is directly linked to occupation, and the full scope of occupational therapy is enabled. Practice contexts, policies and processes should reflect the values and beliefs of occupational therapy and the occupation-based models and theories should be central to this practice. Practice protocols and documentation should use occupation-base language and models as guiding frameworks to enable occupational therapists and other professionals to see this used in practice.

Limitations

While this study is one of the first to examine occupational therapist identity across a career, it is not without limits. First, as with any qualitative study, generalization is not the goal. The experiences related by the participants are not generalizable to the population of occupational therapists. The findings of this study can inform only and may provide some insight into the experiences of occupational therapists developing their identities. This study included only cis-gendered female occupational therapists. Additionally, while not the intended through sampling process, all participants were white and from middle class home environments. The findings of this study may not be consistent with the experiences of men, trans or ipso gendered persons, Indigenous persons, persons of colour, those from differing classes, or other potentially marginalized groups.

Second, as the data collected are retrospective recounts of experiences as interpreted and re-interpreted by the storyteller, the 'truth' of the story cannot be established. However, stories are not collected for their veracity; the goal of narrative inquiry is to gather the subjective experiences of the participants, not to accurately recount the objective truth of an event or experience.

Finally, this study included only participants who were actively engaged in the profession. It did not include therapists whose engagement was more limited, or those who had left the profession. These perspectives could assist in providing alternate stories of engagement or ways of being an occupational therapist.

Future Research

Several recommendations for future research are suggested. First, further investigation to explore the consistency of the model with other therapists should be conducted to see if the model reflects their experience. The model presented here is preliminary and based on the experiences of five therapists. Further validation of this model is needed.

Research that includes a broader group of occupational therapists, including men, non-binary identifying therapists, those who are not actively engaged in professional groups and those who have left, or are considering leaving, is needed. Inclusion of these groups would create a more robust model, or could create a different model for different enacted identities.

Finally, further use of the Kawa model as both a data collection and data analysis tool should be conducted. The Kawa model allowed for the direct participation of participants in the analysis process in a way that was relevant and connected to their profession. Its potential to be used as a research tool for both therapists and clients should be further explored.

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Appendix 1

UNIVERSITY OF MANITOBA

Faculty of Education

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RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: "Doing Being Becoming Belonging: Exploring occupational therapist professional identity".

Principal Investigator: *Natalie MacLeod Schroeder, r137, 771 McDermot Avenue, Winnipeg, MB, 204-789-3554, macleods@med.umanitoba.ca*

Research Supervisor: *Dr. Charlotte Enns, (204) 474-9017, charlotte.enns@ad.umanitoba.ca*

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information and ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study

The purpose of this project is to examine what it means to have an occupational therapist identity and the process by which one identifies as an occupational therapist.

A maximum of 10 participants will be enrolled in this study.

Study procedures

If you take part in this study, you will have the following procedures:

You will participate in a series of three interviews. Each interview is anticipated to take up to 2 hours. The first interview will focus on your career history as an occupational therapist. The second interview will examine critical moments in your career that contributed to who you are as an occupational therapist. The final interview will involve you creating a visual representation of your career (through drawing or other medium) as a river and identify key parts of the river. This is similar to using the Kawa model (of occupational therapy) with clients. Prior to this third interview, you will be provided with transcripts of your previous interviews for review and reflection.

During the interviews, the Principal Researcher will be taking fieldnotes which will be part of the analysis of the study.

Interviews will take place either in person, or via internet using technology such as Skype. The interviews will be video and audio recorded for data transcription and analysis purposes using computer software and/or a digital recorder. Both video and audio data will be analyzed.

Interviews will be transcribed by a transcriptionist (who will have signed a pledge of confidentiality). The transcriptionist will not have access to any information that would identify you.

Only the Principal Researcher will view the video recordings, and will have access to your name, and contact information. The Principal Researcher's Advisor and committee members may access paper copies of the interview transcripts without identifying information.

Following completion of all interviews with participants, you will be provided with a copy of the preliminary analysis for reflection.

Participation in the study will be for up to one year depending on completion of all interviews with all participants.

You can stop participating at any time. Should you wish to withdraw, please inform the researcher by contacting macleods@med.umanitoba.ca.

Risks and Discomforts

There are no known risks associated with participation in this study. Participation may cause mild emotional discomfort association with in-depth self-reflection. You may choose to not answer any question, and may choose how much you choose to share with the researcher.

Benefits

There are no direct benefits to you by participating in this study. We hope the information learned from this study will benefit our selection, education and retention of occupational therapists in the profession in the future.

Costs

All the procedures, which will be required as part of this study, are provided at no cost to you.

Payment for participation

In recognition of your participation in this study, you will be provided with your choice of a $50.00 gift card from a Canadian retailer. This gift card will be mailed to you upon completion of or withdrawal from the study.

Confidentiality

Information gathered in this research study may be published or presented in public forums; however your name and other identifying information will not be used or revealed. All documents related to the study will use a pseudonym. The matched names will be stored in encrypted files accessible only to the Principal Researcher. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The nature of narrative research does carry with it some risk to anonymity. Every effort will be made to remove identifying details (city, workplace, etc.). Your identity will only be disclosed with your permission.

Video recording and audio of interviews allows for identification. Video and audio recordings of the interviews will be reviewed only by the Principal Researcher. Only pseudonyms will be used in the audio recordings to limit identification. Recorded data will be stored on encrypted drives accessible only to the Principal Researcher.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area accessible only to Principal Researcher. If any of your research records need to be copied to the University of Manitoba Health Research Ethics Board, your name and all identifying information will be removed.

Electronic records (audio and video recordings; notes; electronic transcripts) will be

stored in encrypted files. Only the Principal Researcher will know the encryption to access to these files. The Principal Researcher will provide access to the audio transcript for the transcriptionist. Paper copies of the transcripts may be provided to the Research Supervisor and committee members as part of the research process.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. You will still receive your gift card should you withdraw from the study.

Should you wish to withdraw from the study, please inform the Principal Researcher by contacting macleods@med.umanitoba.ca.

Questions

You are free to ask any questions that you may have about this study and your rights as a research participant. If any questions come up during or after the study or if you have a research-related injury, contact the Natalie MacLeod Schroeder at 204-789-3554 or macleods@med.umanitoba.ca.

For questions about your rights as a research participant, you may contact The University of Manitoba, Research Ethics Board Office at (204) 474-7122 or Margaret_Bowman@umanitoba.ca.

Do not provide consent to this study unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at (204)474-7122, Margaret_Bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Participant signature_____Date _____(day/month/year)

Participant printed name: _____

Researcher signature_____Date _____ (day/month/year)

Researcher printed name: _____

Appendix 2

Consent for Use of Visual Images

Title of Study: "Doing Being Becoming Belonging: Exploring occupational therapist professional identity".

Principal Investigator: *Natalie MacLeod Schroeder, r137, 771 McDermot Avenue, Winnipeg, MB, 204-789-3554*

Research Supervisor: *Dr. Charlotte Enns, (204) 474-9017*

My permission is granted to include the images created during participation in the study Doing Being Becoming Belonging: Exploring occupational therapist professional identity in the dissemination of the research findings.

I understand that images of work I create may be used in research forums (conferences, journals) or educational settings.

I have been assured that such artwork or reproductions will be presented in a respectful and professional manner for educational purposes, research, publication, or presentation.

Confidentiality of my name will be maintained unless otherwise agreed upon.

I am also aware that I can revoke this consent at any time through communication with the researcher.

Participant signature_____Date _____(day/month/year)

Participant printed name: _____

Researcher signature_____Date _____ (day/month/year)

Researcher printed name: _____

Appendix 3

Participants' Kawas

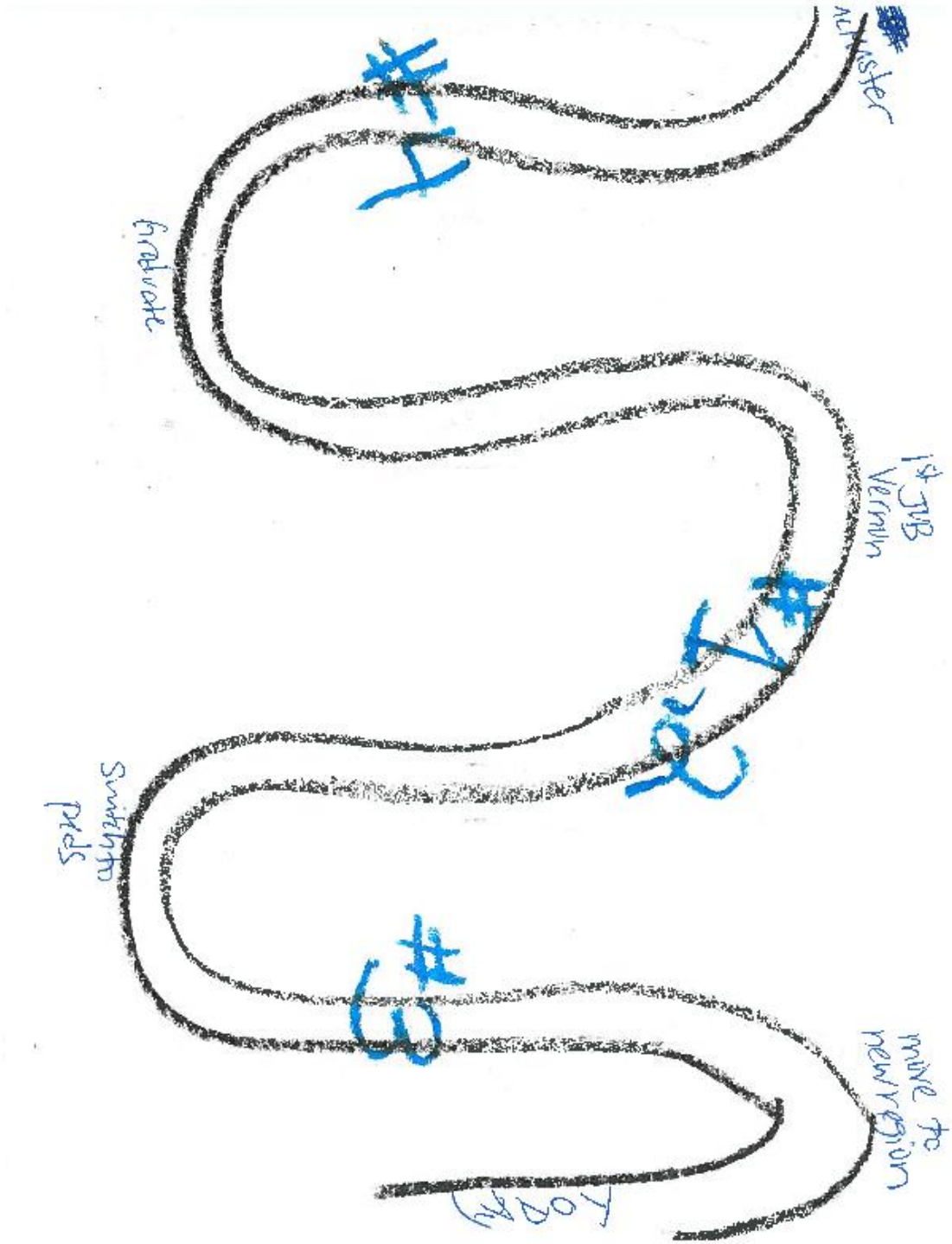

Figure 5. Longitudinal Kawa created by Rachel.

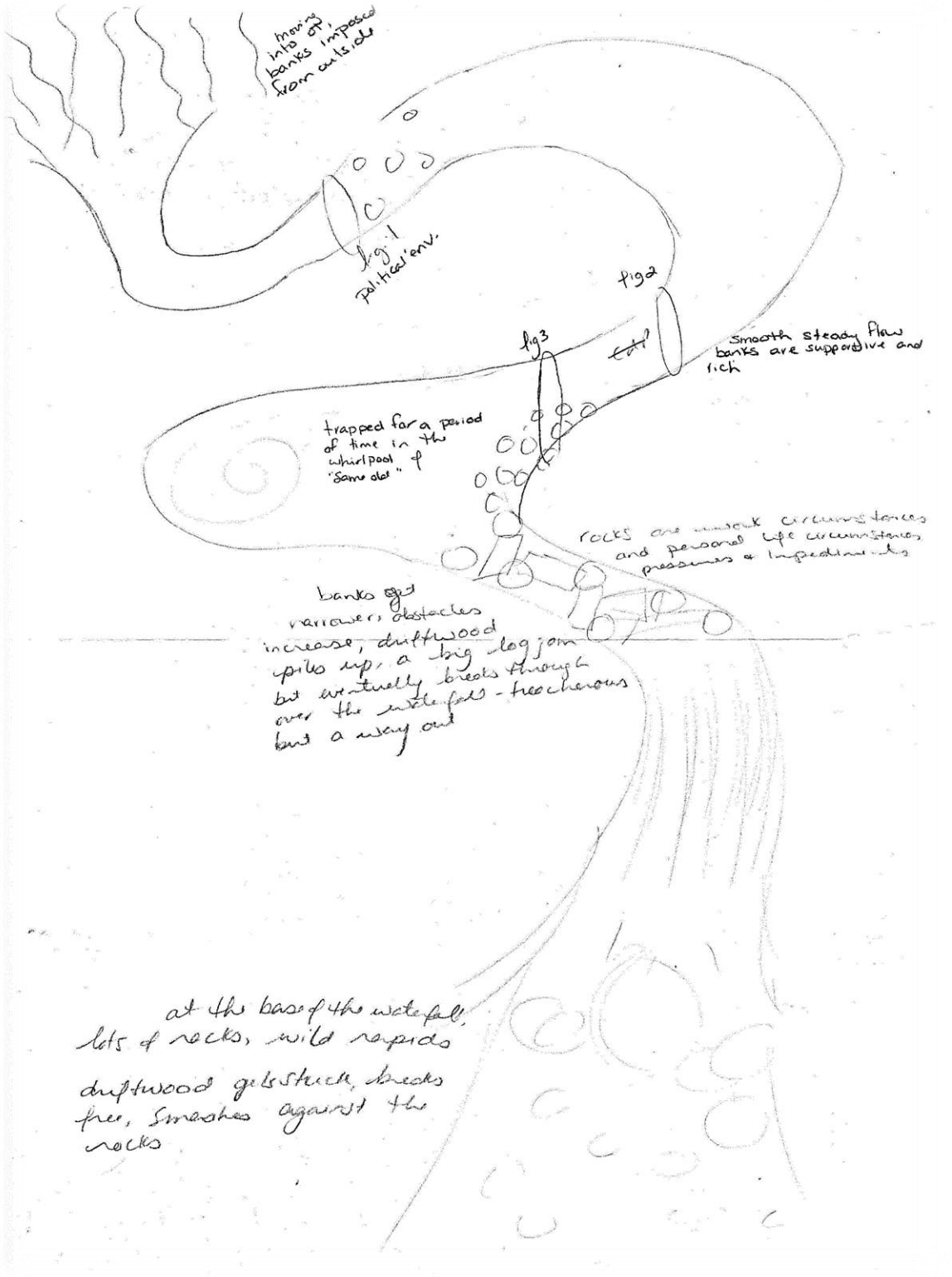

Figure 6. Longitudinal Kawa created by Donna (part 1).

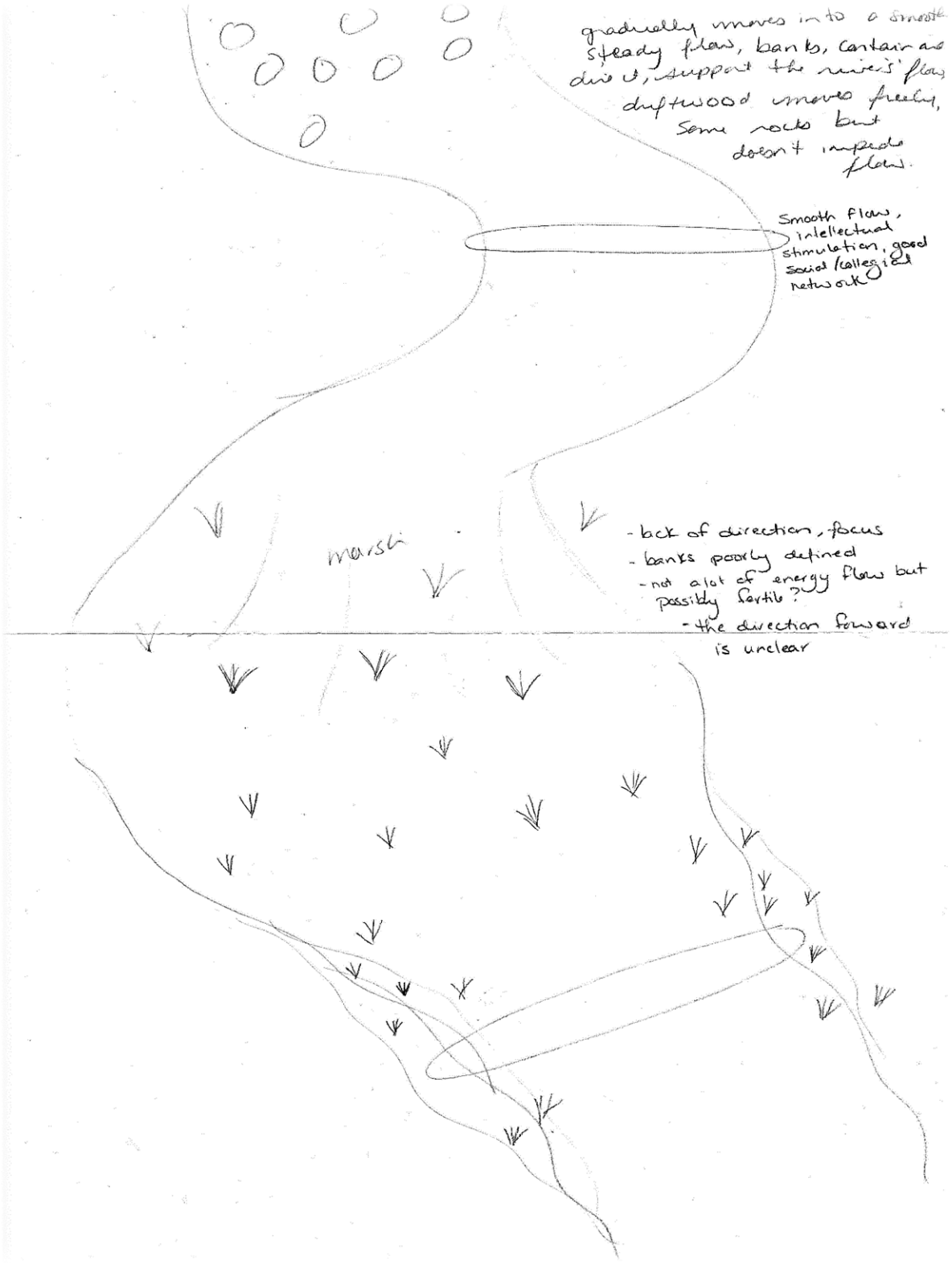

Figure 7. Longitudinal Kawa created by Donna (part 2).

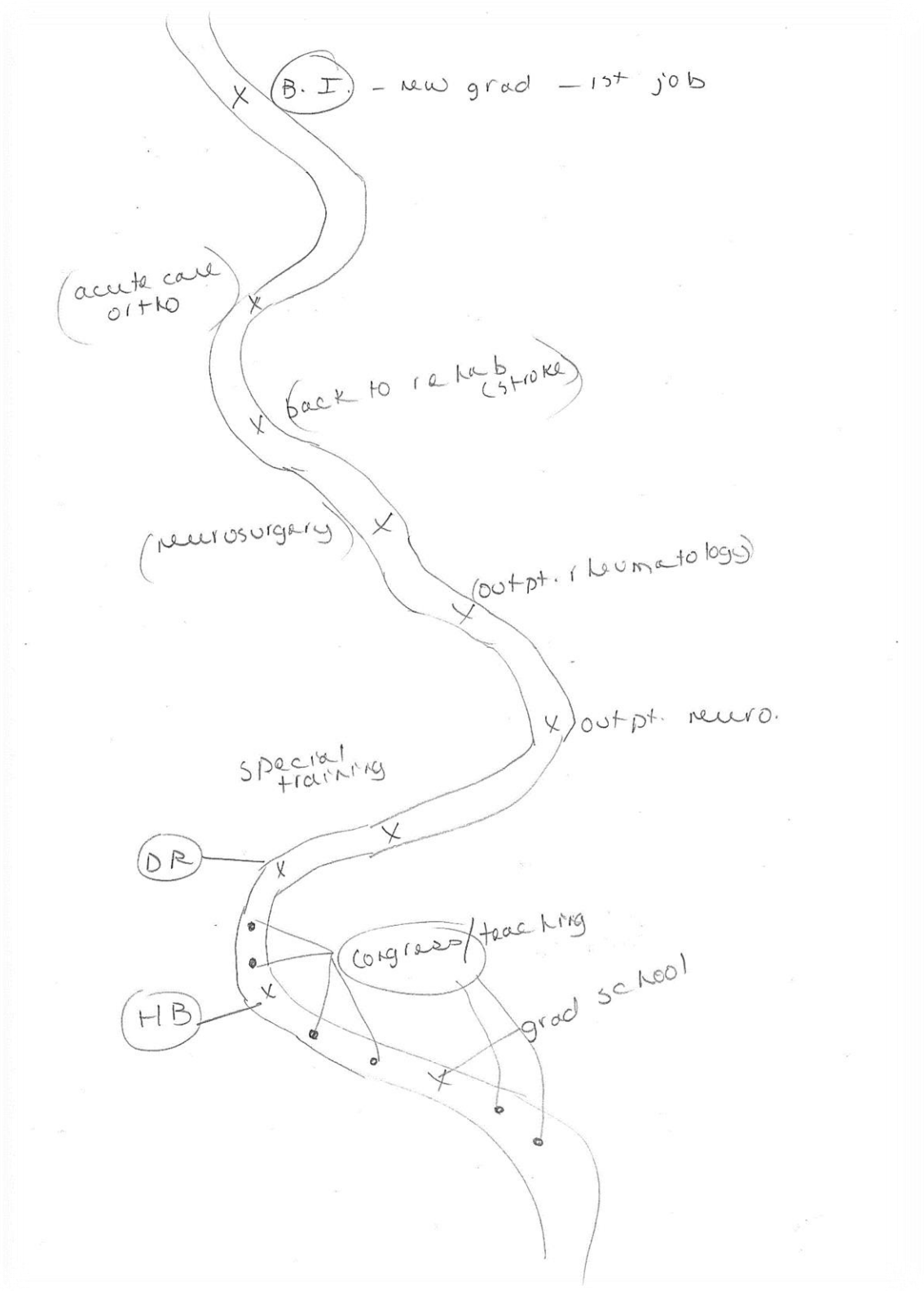

Figure 8. Longitudinal Kawa created by Jessica.

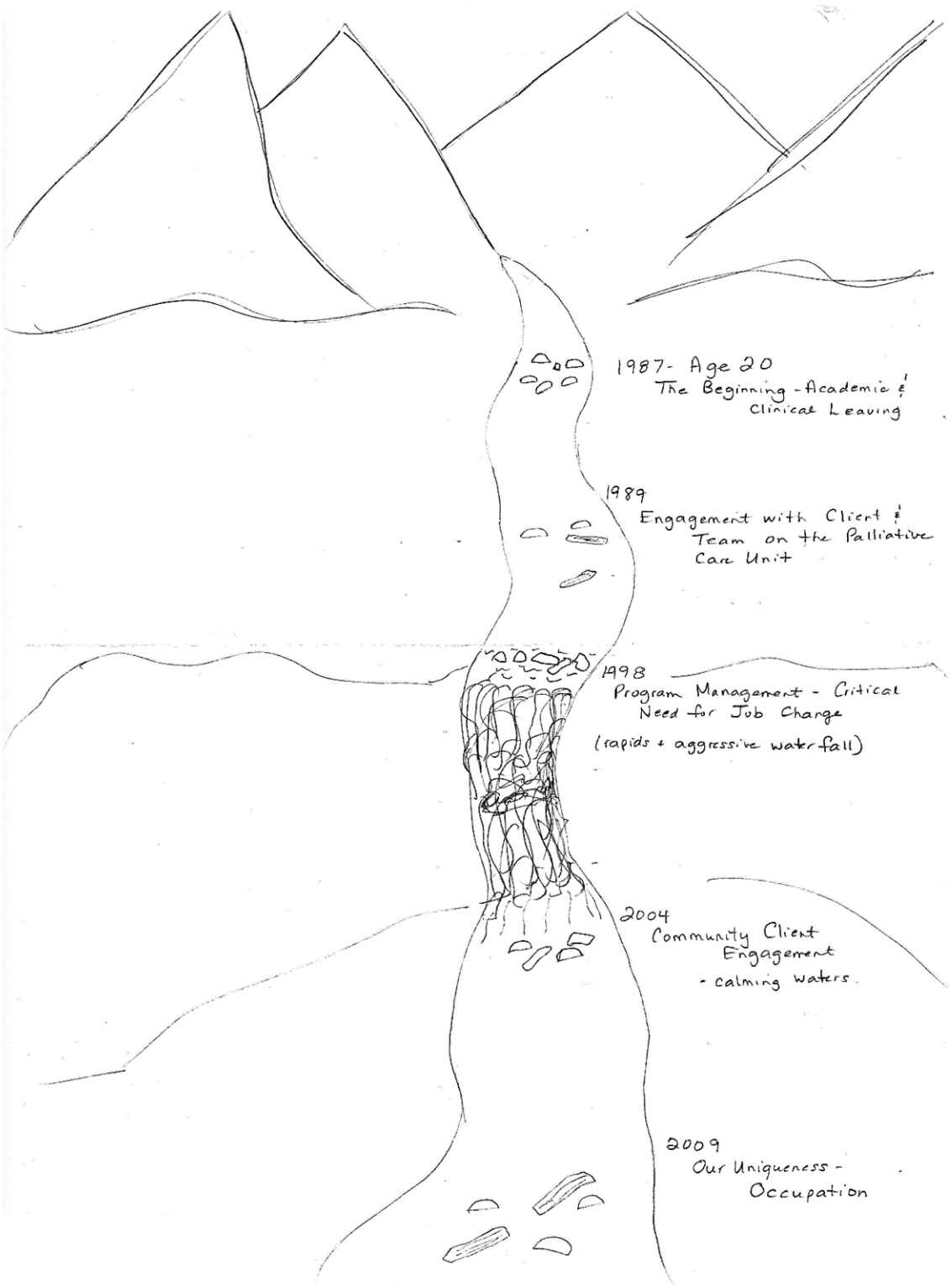

Figure 9. Longitudinal Kawa created by Michelle.

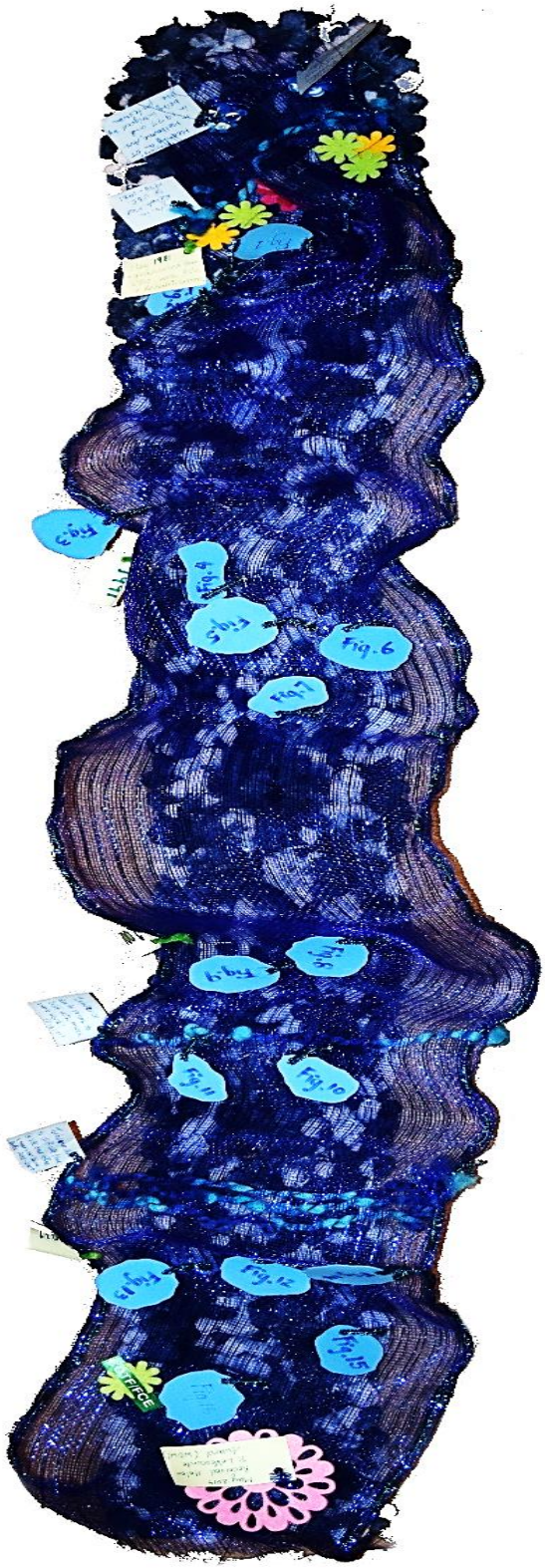

Figure 10. Longitudinal Kawa created by Harriet (in mixed media; photo).