Introduction

The profession of occupational therapy has a distinctive yet contested identity, which remains under discussion despite many scholarly attempts to come to an agreement that would satisfy all members of the profession. Nevertheless, as previously suggested, I believe that we share a foundation in belief and purpose, although these are interpreted in many different ways.¹ In this article I suggest that the identity of the profession is constructed daily through all the encounters that therapists have with clients, because while the ‘core’ occupies a central position, and exists as a guide for practice, each therapist’s professional identity is influenced by every encounter with clients, so that an interaction is established which should form and offer focus to the therapeutic process and its outcome.
The identity of occupational therapy will therefore be under constant construction in myriad situations all over the world if service is delivered in appropriate and helpful ways.

It is not possible to think about occupational therapy and identity without referring to professional education. Professionalisation entails habituation to the field of practice, as guided by expert bodies, the most important of which is the World Federation of Occupational Therapists (WFOT), and guarded by disciplinary groups that represent the protection of both the public and the practitioners. However, while adhering to certain guidelines, and remaining aware of the increasing power of globalising trends, each occupational therapy program and every country where the profession is recognised must make adaptations that will satisfy the demands of their local context. This paper suggests that this is a dynamic process through which practice should be constantly confirmed and modified in ways that reinforce the goodness of fit between what the profession can offer and the client’s needs, so that between them they create something meaningful and helpful.
The outcome while different for client and therapist should whenever possible be useful to both of them. In order for this to happen a customised service must be mutually negotiated if it is to achieve an immediate and longer-term impact. Furthermore, the cumulative effect of service that is sensitive to client needs and everything that this entails should lead in time to changes in the way that the profession is practised.

In order to illustrate my thinking for this paper two case studies are presented in summary from, one of a man and the other a women who live in a remote rural area of the Eastern Cape Province of South Africa. They have some things in common as they both hold a specific place in the community and their own households, but do not live in the same village. They are both resource and structurally poor i.e. “they are affected by complex social dynamics and power relations that limit the distribution of resources, and adversely influence the physical and systemic restructuring of society.” They are also disadvantaged by institutional, environmental and attitudinal barriers,  which impact on their capabilities and freedoms as people who have been disabled by society. I hope to show through these examples how the profession’s uniqueness, the therapist’s character and the distinctiveness of each of these two persons creates a particular dynamic which enriches and interprets the profession in a way that leads to an ongoing process of construction of the profession identity. The thesis that I employ assumes that the therapist is able to think laterally, reason intuitively and practice respectfully in situations that are complex, challenging and fulfilling.

The core of occupational therapy and its link with identity

Many occupational therapists have written about the occupational therapy perspective that centres on occupation, holism, justice and enablement. Over the years many different ways in which this may be achieved have evolved, reflecting our applied body of knowledge. The WFOT acknowledges that it is becoming increasingly difficult “to recognise and articulate the
commonalities that unite the profession as knowledge, skills and modes of practice diverge.”  

This does not alter the fact that throughout practice the central theme of occupational therapy remains that the client can change through engaging in what s/he considers to be meaningful and purposeful occupation. Therefore, the therapist requires an inter-subjective understanding of the client so that s/he may enter that life world, including the person’s physical and social reality, in order to discover their needs. 

In his Eleanor Clark Slagle lecture article Christiansen makes the assertion that “occupations are key to not just being a person, but being a particular person, and thus creating and maintaining an identity.” He argues that occupations are vital for creating and maintaining an identity and that identity is threatened when people lose or never develop this fully due to participation restrictions.

Some markers of selfhood are usually taken as constants e.g. sex, ethnicity, class, but even these can change. Change is a pervasive feature of human growth and development. As time passes individual lives, bodies, beliefs, intentions, and personalities change, and psychologists have invested considerable effort in developing theories of identity development that chart these. In his cultural theory Bourdieu explained how social circumstances determined the way that human beings live and behave. According to Eriksen people “are woven into a social context that represents the symbolic reality constituting their understanding of the world. As such, human beings neither create nor select their worldview: they are embedded in it.”

Creek has described occupational therapy as a profession “that focuses on the nature, balance, pattern and context of occupations in individual’s lives, and therefore it is often concerned with complex long-term needs and problems.” If identity formation is a life long process in which each person is living and creating their own story, then all that shapes the self, including the self concept and self esteem, will contribute to identity development, that is, who is person...
is, what they do and can become. In the next section the influence of professional education on identity formation, both of the individual and the profession, will be discussed.

Identity through education

The 2002 Revised Minimum Standards for the Education of Occupational Therapists is an inspired departure from some previous formulaic and highly structured versions, promulgated in the past as guides for basic education in our profession. Each reflected educational thinking in different eras. The latest version attempts to marry essential professional knowledge, skills and attitudes with changes in health service philosophy and systems, and international health needs and crises. This has not curtailed the addition of occupational therapy perspectives e.g. the International Classification of Functioning, Disability and Health (ICF) has been interpreted for the use of occupational therapists. Hocking and Ness have identified important principles for the WFOT curriculum design e.g. non-prejudiced fieldwork exposure; research-based practice; international connections and exchanges; local knowledge and curriculum content. All this emphasises the importance of creating occupational therapy education that is appropriate and applicable to the local context. This is where the matter of professional identity comes to the forefront.

While occupational therapists everywhere ought to be identifiable by their shared characteristics and services, each country should be producing therapists who can adapt and apply the basics of their work to meet the specific needs of the character of their nation and the cultures which this serves. The focuses throughout will then fall on “the relationship between health and wellbeing and people’s participation in self-care and domestic activities; interpersonal interactions and relationships; major life areas including education, work and leisure; and in community, social and civic occupations; and, the environmental factors that support or impede participation in those occupations.”

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To explore how learners are prepared to practice it may be helpful to think about how identity shapes, and is simultaneously moulded by the relationships and contextual influences that learner occupational therapists may encounter in different practice settings. I have chosen three of these: traditional; community based; and role emerging settings; and will discuss each of them briefly. The second and third examples are based on experiences of working with learners in South Africa.

• The traditional hospital or clinic based service setting
Role definition in this type of setting is well established, with services orientated to the needs of individuals, even if they are encountered in groups. Services are designed in cooperation with the client whenever possible to identify and address particular occupational participation deficits and environmental barriers or restrictions. Of necessity therapy concentrates on the improvement of performance components and areas, and the contexts within which these occur. Conceptual models or frames of reference are used to generate guiding principles and explain how health and impairment influence occupational behaviour e.g. the Person-Environment-Occupation Model; 19 the Ecology of Human Performance. 20 Learners have the opportunity to become grounded in this clinical approach while experiencing and practising the carefully ordered and staged progression of therapy, where client and ‘therapist’ form a partnership as they work towards some specific goal that needs to be realised before the client is discharged.

The learner’s identity (as a person and a future therapist) is influenced positively or negatively by his/her relationship with the client, by other health professionals who work in the same environment, and particularly by the designated learner’s educator. This type of service is subject to medical model influences, which can be a major dilemma for learner occupational therapists whose orientation is more holistic. The development of the learner’s self-
concept and self-esteem are influenced by feedback from members of the health team and the client. The cumulative effect of many therapeutic encounters and interpersonal experiences contribute over time to the formation of a coherent image of the self as a person and therapist.

- Community based service

This is a fast growing area of occupational therapy practice within which the possibility exists of working from a primary health care base in a similar way to the traditional model, but with the added advantage of being able to visit and treat people in their own homes. Another possibility exists, which is that of embracing the philosophy of community based rehabilitation (CBR), which offers practitioners the option of becoming involved in community development. CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of people with disabilities, and therefore not merely a way of overcoming a health problem. It is implemented through the combined efforts of community stakeholders and with the active participation of disabled people themselves, their families and communities. It facilitates both their access to and participation, as both consumers and providers, in appropriate health, education, social, vocational and other services. The CBR principles are health, education, livelihood, social development and empowerment, and are achieved through promotion, early child development, skills development, personal assistance and social mobilisation. International development agencies are increasingly recognising the importance of CBR in poverty alleviation projects. Heavily dependent on intersectoral collaboration, CBR is in essence an approach to community development that includes and extends beyond the needs of disabled people to the communities in which they live, work and play. Its tenets are closely aligned with the goals of poverty alleviation thereby contributing to social justice and economic change.
What influences would shape a learner occupational therapist's identity in CBR? There are two possibilities. A learner attached to a primary health care facility which practices medical routines might be enriched through first-hand experience of the client’s circumstances and reality testing in situ, and confirmed in the role of effective therapist. If a learner became part of a CBR development project, where poverty and disability issues were problematic, it would be important for him or her to engage with the historical and political context of the community, and to be ready to learn about the impact that circumstances have had on their health, wellness and occupational behaviour.

Learners could be exposed to the injustices of occupational deprivation and challenged to grapple with issues of prejudice, bias and stereotype. The identity of the occupational therapy learner in this context is one of naïve observer, partner and facilitator. There is a lot of scope for practice within the CBR principles, but the learner’s attitude is paramount. Learners based in existing CBR projects would need to undertake the role of a facilitator to enable change by being both helpful and supportive without usurping community member’s roles, talents and functions. An occupational therapy facilitator does not assume to take over as leader, but rather uses special talents as an organiser, educator, coordinator, resource, advocate and trainer to guide individual and group development. With the help of the occupational therapist the learner will become able to assess individual potential and match this to appropriate tasks and roles. Development can then be fostered through graduated challenges and mentored performance. The need for understanding, critical awareness and sensitive adaptability must be evident in a respectful approach, particularly within transcultural and transcontextual settings.

The learner can glean specific knowledge, attitudes and skills from CBR exposure, which while appropriate in the community context also has lasting value for working in any practice setting, making and moulding the identity of the servant learner/therapist.
• Role emerging practice.
A role emerging setting is one which does not have an occupational therapy programme or established occupational therapy role, and would be found in a place where a need exists that can be met through occupational therapy. Within historically familiar practice setting this might be a new service e.g. occupational therapy for neonates. While most services started this way what is meant here are services that fill a social gap as well as a therapeutic need. This is an exciting and challenging field because, according to Galvaan, “occupational therapy does not yet have an established protocol aimed at promoting social change.” 23 One way that new services have been established in South Africa (and no doubt elsewhere) is through placing learners in such situations and fostering the development of a service through an evolving programme that is closely monitored and recorded, and carefully supervised and supported by a qualified therapist who holds the vision for development.

The learner’s identity is moulded in an unfamiliar environment by exposure to a service need and the invitation to develop an understanding of the context and its socio-political climate, through uncovering the life world of would-be service recipients. Learners are called on to develop a personal stance, which accommodates the world view of the people and their environment, a process that enriches the discovery of the self. A combination of complex problems, unfamiliar situations and personal frustrations at the lack of ready answers can cause learners to experience a sense of disjunction (fragmentation of part of the self). 24 Yet if they are prepared to address their learning struggles by acquiring learning strategies and addressing specific questions as they arise, they can be helped by the educator and other experienced people to both serve their clients and grow at the same time. “Answers are learnt through doing and reflecting, and occur through the process of contributing to community development.” 23
It is very challenging for a learner to find that there are no pat answers or familiar protocols to be followed in such demanding and unfamiliar situations, and yet be expected to be making a difference. A learner anticipates being taught, and because this is an unconventional situation an inexperienced person can quickly become frustrated and angry. The discovery that they can find their own answers through trying something out and taking the initiative themselves is a major step towards becoming a reflective and dynamic practitioner, and contributes yet further to the construction of a learner's professional identity. In the next section two case studies are presented which will highlight how professional practitioner's identity is moulded by specific practice demands.

**How client identity and professional identity interact**

Working in an unfamiliar environment raises many questions about how practice should be introduced and applied. The summary Table which follows presents some information about two people encountered in a remote under resourced rural area in the Eastern Cape Province of South Africa. (table nº1)

How should the therapist proceed? A clinical approach might assume control in practice, but this would be inappropriate because the problems speak of a particular physical and cultural context which would need to be accommodated. CBR would not be an option initially either, because in a new service a situational analysis would have to establish the needs of both individuals and the community. The first step would therefore be to get to know something about the people and to find out about their requirements, and what they needed and wanted (there are some similarities here to role emerging practice described above). In the case of the two individuals their identity, and indeed that of other future clients, would shape the way that service was provided and the particular direction that it took. At the same time the therapist would also be changing his or her occupational therapy identity to fit these new
circumstances. A co-construction therefore occurs where the old identity of the clients must perforce change, while the therapist modifies a previous therapeutic stance to meet new challenges.

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<th><strong>Client 1</strong></th>
<th><strong>Client 2</strong></th>
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<tr>
<td><strong>General characteristics</strong></td>
<td>Phumzile is a 25 year old widow and mother of 3 children. She lives with her father, whose old age pension is their only income. She has never left her village and has not been employed outside of her home. Phumzile is feared by the neighbours because of the way that she sometimes behaves.</td>
<td>Thembalaka is a 46 year old man and father of five children, of whom three are at school and one is looking for work. They have no income, with the exception of two small child support grants. He was working as a miner at the time of the motor accident that caused his injury. He cannot be accommodated as a worker by his previous employer.</td>
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<tr>
<td><strong>Roles and responsibilities</strong></td>
<td>All household tasks including fetching water from the river and collecting firewood, and the raising of her three daughters, who must learn to assume all a women's tasks and activities, including building and maintain their mud brick home.</td>
<td>Thembalaka is expected to be the breadwinner and provider for his family. His responsibilities include tasks assigned to him by the local headman and the appropriate execution of traditional ceremonies e.g. births, deaths marriages and initiation.</td>
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<tr>
<td><strong>Health status</strong></td>
<td>A five year history of paranoid schizophrenia. Her current medication has severe side effects, so if she needs to do something important e.g. the family washing, she does not take her pills.</td>
<td>A head injury led to a hemiplegia from which a year later he has not fully recovered. He can walk with a stick but his arm function is poor and he is very worried about the future.</td>
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<td><strong>Occupational disruption</strong></td>
<td>Illness incidents disrupt Phumzile's routines and cause havoc in her household. The children are scared of her at these times and the neighbours keep their distance.</td>
<td>Thembalaka is unlikely to work again and must begin to make some plans for the future. His own non-work related occupations can continue, but those of his family are seriously threatened, as is their general welfare.</td>
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**Table 1: Contextualised Occupational disruption**
In the final part of the article the way in which the identity of the occupational therapist is shaped by accumulated experience and extended over time will be discussed.

**Identity through experience**

Doing occupational therapy is not a passive experience. Despite our need to categorise in order to understand and interpret different phenomena, “whatever is essential cannot be seen as merely a part, because life can take place only in wholes. You have to struggle day in and day out to affirm that occupation is the ‘web and woof’ of being for humans, and not an instrumental component that is inserted here and there.” 25 If the practitioner is alert to the client, other people in the environment and the context, observations become the basis of practice and learning, providing information for the immediate situation as well as an ever increasing store of recollections. The reflective practitioner gleans insights from every therapeutic encounter through clinical reasoning, and by continually building associations between past experience and theory. An awareness of the significance and usefulness of available occupational science research is also important because occupation is central to all people’s lives and pivotal in therapy.

Knowledge and a deep appreciation of the importance and significance of occupation, not only in therapy but also in all people’s everyday lives is a wonderful contribution that the profession of occupational therapy can and is making to broader society both within and beyond health and social care domains. Being associated with occupation as our first and most important characteristic highlights what is essential to our therapy, and emphasises our professional identity. The application of our knowledge should always be an expression of this. Yet despite growing internal professional awareness of these matters occupational therapists continue to struggle to describe what they do and to engage in occupation-based practice, particularly in predominantly
biomedical settings. Wilding and Whiteford found that this could be overcome “through in-depth reflective processes undertaken collectively within a supportive community of practice milieu.” ²⁶

We need to ask ourselves if we put sufficient energy into this particular type of professional growth and development. If there is any uncertainty about what our profession represents, both in specific fields of application or generally, we will continue to experience difficulties in making our services available to all the people who need them. Our identity shapes and is shared through relationships.¹¹ What we think and feel about ourselves as occupational therapists in relation to what others think of us and our work moulds the image we carry and our contribution to the profession. This grows and changes over time; professional identity is always under construction.
References