

**DELINEATING CENTRAL EXPLANATIONS ON THE  
ARTICULATION AND CONSTRUCTION OF  
PROFESSIONAL IDENTITY WITHIN THE  
MALTESE OCCUPATIONAL THERAPY PROFESSION**

**Doctoral Thesis being submitted by  
René Mifsud  
at Cardiff University**

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## Abstract

**Aim and Focus:** To gain an in-depth understanding of how professional identity is articulated and constructed by Maltese occupational therapists through their daily experiences of it in the main practice settings.

**Research Question:** How is Professional Identity Articulated and Constructed within the Practice Environment of Occupational Therapy in Malta?

**Background and Rationale:** Professional identity has been defined as the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity. It has been posited that by not having a clear professional self-identity, practitioners may experience a challenge explicating who they are to third parties in the field.

In Malta, the profession of occupational therapy seems to be persistently confused with other professions and, as a professional body, it appears to be limited in conveying to the general public and other professions its specific contribution and role in healthcare. This situation appears to be compounded by, or may be the result of, the profession being a relatively small component of the workforce, combined with problems of recruitment of students into the university programme and some problems with retention of qualified staff. These issues are considered as symptomatic of professional identity issues underpinning the occupational therapy profession in Malta.

**Methodology and Methods:** This study adopted a qualitative, constructivist approach as befits the nature of an inquiry concerning identity construction. Qualitative case study methodology was used, with an emphasis on data triangulation. Data were generated from reiterative cycles of ten focus groups undertaken with occupational therapy clinicians (n=39) at the main public service sites and seven individual key informant interviews with occupational therapy managers. Concurrent analysis of the data followed the principles of thematic analysis.

**Findings:** Two principal themes were constructed from the data with an attendant cluster of subthemes. The theme 'The Experience of Professional Identity' encompasses a range of concepts assembled from the participants' experiences of their professional identity in the public domain. The second theme 'The Articulation of

Professional Identity,' covers concepts representative of the challenges that participants experience when defining and explaining the nature of their profession and finding its unique quality.

**Discussion:** The interpretation of the findings suggests that the multiple and disparate epistemologies and the complexity of interventions that underpin the professional makeup of occupational therapy could be responsible for the challenges that practitioners experience to express their identity within a unitary concept. It has also been theorised that the said epistemological diversity translates into a range of diverse roles, different ways of doing and approaches that occupational therapists embody, and these, in turn, impact on how the public and/or other professionals perceive the profession.

**Uniqueness and Contribution of the Study:** This study is the first to research the representative practice milieu of the occupational therapy profession in Malta. It has fundamental value for the Maltese occupational therapy community and for students as it manages to portray professional identity tensions experienced in the occupational therapy profession through a lens of rationality as a result of the central explanations developed in the discussion to frame the findings.

# Table of Contents

Abstract .....	ii
Table of Contents.....	iv
List of Tables .....	xi
List of Figures .....	xi
List of Appendices.....	xii
List of Abbreviations.....	xiii
Acknowledgements.....	xiv
Dedication .....	xv
Statements .....	xvi

## Chapter 1 Introduction

1.1	Outline of the Chapter .....	1
	1.1.1 Basic Terms of Reference and Perspective of the Study .....	1
1.2	Reflection on Personal Value of the Study, Background & Setting .....	2
	1.2.1 Local Origins and Establishment of the Profession .....	3
	1.2.2 Development of Occupational Therapy Education in Malta .....	4
	1.2.3 Introduction of the Occupational Therapy Bachelor's Degree in Malta .....	6
	1.2.4 A History of Collaboration with Foreign Academics.....	8
1.3	Rationale, Aim and Research Question .....	9
1.4	Brief Outline and Summary of the Study.....	11
1.5	Conclusion .....	13

## **Chapter 2 Literature Review**

2.1	Introduction .....	14
2.2	Rationale for Approach and Form Adopted for the Literature Review .....	14
2.3	Scene-Setting .....	15
2.4	The Professional Development of Occupational Therapy: A Synopsis .....	16
2.5	Key Aspects of the Debate on Identity in Occupational Therapy .....	19
	2.5.1 Some of the Other Voices and Debates.....	22
2.6	The Sociological Lens .....	27
	2.6.1 Tensions relating to Professionalisation in Healthcare .....	27
	2.6.2 The Professional Project – A Blueprint for Professionalisation? .....	29
	2.6.3 Snapshot of the Emerging Profession of Occupational Therapy in the UK .....	31
2.7	Profession-Specific Knowledge in Occupational Therapy – Some Foremost Points.....	33
	2.7.1 Addressing the Problem of the Application of Professional Knowledge and Professional Identity in Practice – Some of the ‘Shorthands’ Adopted .....	36
2.8	Cultural Dimension and Professional Identity .....	37
2.9	Overview of Empirical Studies on Professional Identity .....	38
	2.9.1 Studies in Occupational Therapy .....	39
	2.9.2 Studies from other Health Professions.....	46
2.10	Conclusion .....	50

## **Chapter 3 Salient Methodological Points**

3.1	Introduction .....	51
3.2	Operational Definitions.....	51
3.3	Reiterating and Differentiating of the Purview of this Study .....	52
3.4	Overarching Epistemological Characterisation of the Inquiry on Professional Identity .....	53
3.5	The Quandaries of Selecting the Qualitative Methodology .....	54
	3.5.1 Selecting Qualitative Case Study Methodology as the Research Design – Influences, Concerns and Rationales.....	55

3.5.2	The Typology of the Case.....	57
3.5.3	Sampling Issues: Case Selection and Selection of Participants.....	61
3.5.3.1	<i>Sampling Concerns in Qualitative Research</i> .....	61
3.5.3.2	<i>Case Selection</i> .....	62
3.5.3.3	<i>Choice of Participants and Sites</i> .....	63
3.6	Choice of the Data Collection Methods – an Overview.....	64
3.6.1	Theoretical Preamble.....	64
3.6.2	Rationale for the Choice of Methods.....	65
3.6.3	Additional Methods that could have been considered for this Case Study - Observation and Use of Documents.....	66
3.7	Quality Issues: Reliability, Validity, Triangulation & Respondent Validation ...	68
3.8	Introductory Explications of the Overarching Reflexive Stance.....	69
3.9	Summary and Conclusion.....	71

## **Chapter 4 Details of Fieldwork Issues and Methods**

4.1	Introduction.....	72
4.2	Details of Settings, Participants, Access, Recruitment & Ethical Aspects.....	72
4.2.1	Choice of Participants and Sites; Initial Access to Research Environment.....	72
4.2.2	Participant Inclusion and Exclusion Criteria – Focus Groups.....	73
4.2.3	Establishing Nominal Characteristics of the Practice Sites in the Study.....	73
4.2.4	Establishing Nominal Traits of the Participants.....	76
4.2.5	Participant Access.....	77
4.2.6	Number of Potential Participants and Extent of Participant Response.....	78
4.2.7	Ethical Approval and Recruitment.....	79
4.3	Processes of Data Collection: The Focus Groups.....	81
4.3.1	Some Considerations on the Use of Focus Groups in Organisations.....	81
4.3.2	The Enactment and Conduction of the Groups.....	83
4.3.2.1	<i>Designing the Focus Groups – Basic Underlying Concepts</i> .....	83

4.3.2.2	<i>Number of Groups</i> .....	85
4.3.2.3	<i>Location and Timing of the Groups</i> .....	86
4.3.2.4	<i>Practical Execution of the Groups - Preparation</i> .....	86
4.3.2.5	<i>Procedure of the Execution of the Groups</i> .....	87
4.3.2.6	<i>Recording and Transcription of the Focus Groups</i> .....	88
4.3.3	Analysis of the First Focus Groups .....	89
4.3.3.1	<i>Pre-Analysis Reflections</i> .....	89
4.3.3.2	<i>The Logic and Mechanics of the Analysis</i> .....	90
4.3.4	Reflexive Impressions Accompanying First Tranche of Focus Groups.....	92
4.3.5	Progressing to the Second Set of Focus Groups .....	93
4.3.5.1	<i>Thematic Areas Explored in the Second Focus Groups</i> .....	93
4.3.6	Summary of Discussion on Fieldwork Issues Related to Focus Groups.....	94
4.4	Processes of Data Collection: In-depth Interviews.....	94
4.4.1	Significance of the Use of Interviews in this Study .....	94
4.4.2	Selection and Number of Interviewees .....	95
4.4.2.1	<i>Developing the Structure of the Interview Guide</i> .....	95
4.4.2.2	<i>Initial Generic Impressions of the Interviews</i> .....	99
4.5	Temporal and Contextual Issues Surrounding the Case.....	99
4.5.1	Time Spans and Factors Affecting Duration of Data Collection .....	100
4.6	Conclusion .....	101

## **Chapter 5      Analysis of the Data**

5.1	A Note on the Analysis - Introduction .....	102
5.2	Rationale for the Use of Thematic Analysis .....	102
5.3	Procedural and Reflexive Aspects of this Thematic Analysis.....	104
5.4	The Final Thematic Map.....	112
5.5	Outlining and Defining the Themes .....	115
5.6	Labels and Definitions of the Principal Themes and their Subthemes .....	115

5.6.1	Principal Theme 1: The Experience of Professional Identity .....	115
5.6.1.1	<i>Professional Identity Misunderstood.</i> .....	115
5.6.1.2	<i>Internalised Identity Unseen by Public.</i> .....	116
5.6.1.3	<i>Professional Identity Congruence.</i> .....	116
5.6.1.4	<i>Interprofessional Awareness.</i> .....	116
5.6.1.5	<i>Cultural Intelligibility of Professional Identity.</i> .....	116
5.6.1.6	<i>Professional Identity Negation.</i> .....	117
5.6.1.7	<i>Professional Identity Affirmation.</i> .....	117
5.6.2	Principal Theme 2: The Articulation of Professional Identity.....	117
5.6.2.1	<i>Defining and Explaining Occupational Therapy.</i> .....	118
5.6.2.2	<i>The Vast Identity of Occupational Therapy.</i> .....	118
5.6.2.3	<i>Circumscribed Identity Defined by the Area of Practice.</i> .....	118
5.6.2.4	<i>Articulating the Unique Quality of Occupational Therapy.</i> .....	118
5.6.2.5	<i>Values Underpinning and Exemplifying the identity of Occupational.</i> .....	119
5.7	Conclusion .....	119

## **Chapter 6 Reporting of the Themes: Theme I The Experience of Professional Identity**

6.1	Introduction .....	120
6.2	Reflexive Points on the Interpretation .....	120
6.3	Narrative of Principal Theme I: The Experience of Professional Identity. ....	121
6.3.1	Note on the Use of Extracts from the Data Sets.....	123
6.3.2	Note on the Content and Structure of the Subthemes.....	124
6.4	Interpretative Review of the Subthemes .....	124
6.4.1	Professional Identity Misunderstood .....	124
6.4.2	Internalised Identity, Unseen by the Public .....	129
6.4.3	Professional Identity Congruence .....	133
6.4.4	Interprofessional Awareness.....	135
6.4.5	Cultural Intelligibility of Professional Identity .....	140

6.4.6	Professional Identity Negation .....	144
6.4.7	Professional Identity Affirmation .....	147
6.5	Conclusion .....	152

## **Chapter 7 Reporting of the Themes: Theme II - The Articulation of Professional Identity**

7.1	Introduction .....	154
7.2	Reflexive Points of Departure.....	154
7.3	Narrative of Principal Theme II: The Articulation of Professional Identity .....	155
7.4	Review of the Subthemes .....	156
7.4.1	Defining and Explaining Occupational Therapy .....	156
7.4.2	The Vast Identity of Occupational Therapy .....	161
7.4.3	Circumscribed Identity Defined by the Area of Practice .....	163
7.4.4	Articulating the Unique Quality of Occupational Therapy .....	165
7.4.5	Values/Traits Underpinning and Exemplifying the Identity of Occupational Therapy.....	171
7.5	Conclusion .....	176

## **Chapter 8 Discussion and Interpretation of the Results**

8.1	Introduction – Overview of the Findings .....	178
8.2	Mapping an Explanatory Framework Based on Salient Findings .....	179
8.3	Beyond Saliency – Further Mapping and Framework Reduction .....	182
8.4	A Reflexive Note on Form, Composition and Content of the Discussion.....	185
8.5	Discussion of Personal Domain Identity Issues. ....	185
8.5.1	Preamble.....	185
8.5.2	Importance of Articulating the Professional Self: The Antechamber to the Issue.....	187
8.5.3	The Dichotomous Condition – Epistemological Tensions Underpinning the Articulation of Identity in Occupational Therapy. ....	191
8.5.4	Occupational Therapists – Navigators of a Conceptual Archipelago.....	196

8.5.5	Complexity as a Characterising Dimension of Occupational Therapy and the Implications for Professional Identity .....	202
8.6	Discussion of the Interface/Public Domain Professional Identity issues .....	210
8.6.1	“How they See Us” - Occupational Therapy as a Mosaic .....	210
8.6.2	“This is too Small for Us” - A Question of Professional Role Restriction?.....	214
8.7	"How we can Better see Ourselves" - Reflections on Recommendations for Practice and Education in the Maltese Setting.....	216
8.7.1	"That's how we are!" - Coming to terms with the challenges of Knowledge in Occupational Therapy and Accepting one Conceptual Narrative? .....	218
8.7.2	"But it's Rote Learning!" - Developing the Skill of Talking About the Profession.....	219
8.7.3	"Practising what we Preach" - Actually Practising Occupationally. .	220
8.7.4	"We have to Improve our PR" - The Need to Promote the Profession.....	221
8.7.5	"We need to Support Each Other" The Importance of Staff Supervision.....	222
8.7.6	"We might need higher entry qualifications" - Possible Expanded Scope in Education .....	222
8.7.7	"Agreeing to Agree" Seeking Consensus across the Profession and Consolidating the Professional Project.....	223
8.8	Reflections on the nature of an Over-Emphasis inherent in a Uniprofessional the Study.....	224
8.9	Summary and Conclusion of the Chapter .....	225

## **Chapter 9 Conclusion**

9.1	Introduction .....	227
9.2	A Final Look at the Researched, the Researcher and the Language of This Case Study.....	227
9.3	Central Findings and Explanations .....	229
9.4	Uniqueness and Contribution of this Research.....	230
9.5	Final Consideration on the Study Design - Strengths & Alternative Methods .....	232
9.6	Suggestions for Further Research.....	234
9.7	Conclusion .....	234

<b>References</b>	.....	236
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<b>Appendices</b>	.....	246
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## List of Tables

Table 4.1:	Human Resource Outline of the Service Sites.....	76
Table 4.2:	Number of eligible members of staff and participation in focus groups.	79
Table 4.3:	Examples of the use of operational definitions in the interviews. ....	98
Table 4.4:	Time span overview of the data collection. ....	100

## List of Figures

Figure 2.1	Kielhofner's (1992) Concentric Layers of Knowledge. ....	22
Figure 4.1:	The basic structure of the interview. ....	96
Figure 5.1:	An example of one of the first handwritten mind maps compiling data codes. ....	107
Figure 5.2:	An early handwritten mind map outlining evolving attempts at coalescing main themes from coded data. ....	108
Figure 5.3:	An example of another handwritten mind map with an alternative code grouping. ....	109
Figure 5.4:	An early, but relatively advanced, 'cleaned -up' attempt to pin down a set of themes ....	110
Figure 5.5:	Reduced Thematic Map taking account of the research question and research objectives ....	111
Figure 5.6:	Final Thematic Map, the First Principle Theme and its Constellation of Subthemes.....	113
Figure 5.7:	Final Thematic Map, the Second Principle Theme and its Constellation of Subthemes.....	114
Figure 8.1:	Dynamics of Professional Identity Construction.....	181
Figure 8.2:	Domain-based Interplay in the Construction of Professional Identity .	184
Figure 8.3:	Outline of the Third Edition of the Uniform Terminology ....	198
Figure 8.4	Case Linked Visual Representation. ....	207
Figure 8.5:	Approaches to treatment extracted from the Occupational Therapy Practice Framework: Domain and Process.....	213
Figure 8.6:	Proposed Strategies to Improve the Description of Occupational Therapy.....	220

## List of Appendices

Appendix 1	Specimen Field Notes.....	247
Appendix 2	Specimen Supervisor Debriefs.....	249
Appendix 3	Approval from Malta Professional Lead Occupational Therapy Services.....	253
Appendix 4	Approval by the Faculty and University Research Ethic Committee, University of Malta .....	255
Appendix 5	Approval from School of Healthcare Studies, Cardiff University .....	256
Appendix 6	Participant Information Sheet for Focus Group .....	257
Appendix 7	Common Consent Form.....	259
Appendix 8	First Set Focus Group Guide .....	260
Appendix 9	Description of the Template Adopted for the Second Focus Group at the Acute Services.....	262
Appendix 10	Example of the Template for Second Set of Focus Groups.....	264
Appendix 11	Thematic Areas Explored in the Second Round Focus Groups.....	270
Appendix 12	Specimen Interview Schedule.....	271
Appendix 13	Parallel Event of Note .....	275

## List of Abbreviations

ACOTE	Accreditation Council for Occupational Therapy Education, US
AOTA	American Occupational Therapy Association
CMOP	Canadian Model of Occupational Performance
IHC	Institute of Health Care, Malta
LSA	Learning Support Assistant
MBI	Maslach Burnout Index
MRC	Medical Research Council, UK
PBL	Problem-Based Learning
PIQ	Professional Identity Questionnaire
PT	Physiotherapy
OTPF	Occupational Therapy Practice Framework: Domain and Process
OT	Occupational Therapy
MOHO	Model of Human Occupation
NO	Nursing Officer in Charge
REC	Research Ethics Committee

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## Dedication

This work is dedicated to the memory of my parents.

Unequaled, irreplaceable and unforgettable companions, guardians and soul mates; although your departure banishes much that is artifice and leaves me bereft of solace and shelter, I continue to profit from the time, patience and resources that you have lavished to cultivate me and for which I will remain forever indebted.

## Statements

### Statement 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of *PhD*.



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### Statement 2

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is it being submitted concurrently for any other degree or award (outside of any formal collaboration agreement between the University and a partner organisation).



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# Chapter 1 Introduction

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## 1.1 Outline of the Chapter

In this introduction I will seek to convey a concise overview of this study. I feel that it is important at this starting point to impress upon the reader in a compressed and incisive fashion, the germ of this research, its nature and motivation, all inextricably linked to the setting that motivated and shaped this work. For this purpose, I will be starting this account with a broad overview of the terms of reference of this research, then I progress to outline the local background and context of this study; subsequently, the rationale, aim and research question. These perspectives not only acted to shape the study, but also accompanied me throughout the arc of the project, also informing my thinking on the analysis and the interpretation of the findings. The final section of this chapter includes a summary of each of the subsequent chapters of the thesis. This chapter and the next one, the literature review, are intended to immediately establish the origin and stringboard for this research.

### 1.1.1 *Basic Terms of Reference and Perspective of the Study*

This study's perspective has been fundamentally informed by discourse on professional identity and professional issues originating from the literature of the occupational therapy profession. Another underpinning influence has been the conversation on professions from the social science. These will be developed in the ensuing chapters, most specifically Chapter Two, the Literature Review.

It would be of value at this early stage to disclose the basic terms of reference that have essentially framed my thinking about professional identity, namely these two definitions:

*Professional identity* is being defined as the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity (adapted from Kielhofner, 2004).

*Professionalisation* is the process which an occupational group undertakes to consolidate its status in society and becomes recognised as a member of the established range of socially identified professions (adapted from Witz, 1992).

Although hardly comprehensive, this brief overview of a basic framework sets the scene for the reader about what to expect from this study and describes the direction it will be taking.

## **1.2 Reflection on Personal Value of the Study, Background & Setting**

This study is about the professional identity of occupational therapists, effectively equivalent to the professional practice milieu in the country of Malta. The participants were selected from the major public health service sites, all of whom are employed by the Department of Health of Malta. This snippet of information has little value unless it is anchored in the cultural and historiographical setting where the research was prompted and eventually carried out. This is especially significant if one considers that the research was not undertaken on British soil but intended for British eyes. Therefore, a succinct account of the local setting and the historical origins of the milieu is pivotal in order to improve the reader's understanding of this research.

I have to clarify from the outset that literature sources on the profession of occupational therapy in Malta are limited, practically non-existent. The only extant overview of the history and the development of the profession in Malta was written by one of the very first Maltese occupational therapists and covers events only up to the early 1980s (Busuttill, 1986). Developments subsequent to that period, which are fundamental to this study, will be relayed from personal experience.

As I will be outlining shortly, I was one of the first occupational therapist to be trained and to eventually qualify in Malta in 1988. I feel that I have occupied a key role in the development of the profession, frequently being an active agent contributing into its growth and also having the opportunity to reflect on the profession's positioning.

Given the time I have been in the profession, I have also had the opportunity to share my experience of it with colleagues, co-workers, staff under my charge and also students. This has informed my reflections over time through a process of osmosis. I believe that this has helped me develop a tempered perspective, personal but also collective, on the possible critical needs and actions that the profession of occupational therapy in Malta is required to consider in order to continue the development that it has sustained in the past decades. This is not to say that my position before embarking on this study was absolutist and represented some sort of gold standard of objectivity on what had to be done, but served as a good enough initial staging post that instigated the impulse to seek out 'good' data from the right sources for this study. By developing this thesis, brought about by my complete investment in the profession, I hope to be able to

contribute research-derived findings that will improve the self-knowledge of the profession of occupational therapy, in Malta.

The following sections elaborate upon some key historical themes and highlights of the development of the profession in Malta, illustrating factors and events that may have contributed to its identity. Unfortunately, a mainly factual rather than discursive approach is taken. I feel that this is unavoidable; as jumping straight into a debate about the influences and tensions surrounding the professional identity would be merely presenting truncated and dislocated impressions originating immediately from my personal world. Also, for the early history, I have limited myself to key milestones as a more detailed account would have been outside the scope and delimits of this chapter. Therefore, a modicum of forbearance is solicited from the reader as I illustrate the factual with accompanying parallel impressions and argument; essentially, the factual basis prompting the impressions and motivations to study the profession.

### **1.2.1 Local Origins and Establishment of the Profession**

The origin of occupational therapy in Malta starts at the time when the country was still a British colony. Officially Malta was a British colony between 1800 and 1964, although the British forces only left the country in 1979 (Blouet, 2004). According to Busuttil (1986) the use of activity in Malta as a curative modality can be traced back to the middle of the nineteenth century. He refers to the mid-1800s, where certain activities were carried out at an institution called the Villa Franconi 'mental asylum' and he seems to imply that these were the first intimations of occupational therapy in Malta. This is depicted by Busuttil as analogous to the Moral Treatment Movement, which is regarded as the precursor of occupational therapy in western countries. Credit is given to Dr. Tomaso Chetcuti (1797-1863) who introduced Philippe Pinel's principles (the Frenchman is recognised as one of the founders of moral treatment) at the asylum shortly after his appointment in 1838; 1851 being the first recorded time of the use of activities for patients.

The first time that the term 'occupational therapy' was officially recorded in public usage in Malta was apparently in 1926 and was used by Dr Ralph Toledo, who was the Medical Superintendent of the so-called 'lunatic asylum,' now renamed as Mount Carmel Hospital, which replaced *Villa Franconi* as the major mental health asylum in Malta. This was during a visit by the British Governor of the Maltese islands. Apparently, Dr Toledo was illustrating the range of activities available to resident patients but lamenting that this was still far from what could be called occupational therapy.

Occupational Therapy was formally introduced to the islands of Malta in 1956 when two British therapists established a clinic at the public general hospital, St. Luke's Hospital. Services were offered to patients with orthopaedic conditions in the wards and in outpatients. This arrangement continued up to the late 1960s when, although formal plans were made to expand services, the expatriate occupational therapists resigned from their posts and left the island.

There was a recognised need for occupational therapists and the Government of Malta resolved to establish a local workforce. The first call for applications for the recruitment of Maltese students was in 1970. Two applicants were selected, Joseph Busuttil and Mario Scicluna, who were sent to be trained in the UK at the London School of Occupational Therapy (now part of Brunel University) in 1971. When these candidates qualified in 1974 and returned to Malta, they set up two clinical services. Mario Scicluna was entrusted with setting up a physical disabilities clinic at St. Luke's Hospital, then the main Hospital of Malta. He also offered part-time services to St. Vincent de Paule, the older adult residence. Joseph Busuttil set up a psychosocial/mental health clinic at Mount Carmel Hospital (Busuttil, 1986).

At this point I venture to suggest that this situation was the initial sowing of the seeds of a dichotomy of practice and perhaps, divergent identity in the workings of occupational therapy in Malta - services in physical disabilities allied to the medical model and services in mental health which were more occupation focused. This impression comes from and is reinforced by my knowledge of both these individuals, both my first mentors and their outlook on the profession and practice.

Running a profession with two practitioners was untenable and the authorities took the necessary action by funding further training of occupational therapists, overseas. A second cohort of students was sent to the UK in 1979 for training. With more staff qualifying in 1982, the profession could branch out in different areas of practice, also establishing occupational therapy on a relatively more stable basis in the major hospitals. Although the shortage in staff complement was still very acute. In fact, after this second wave of recruitments the net increase in practitioners after two years, was just two.

### ***1.2.2 Development of Occupational Therapy Education in Malta***

In line with advances in other healthcare professions, a move was made to establish occupational therapy education in Malta. This necessitated senior staff to undertake post-graduate studies. Joseph Busuttil obtained a post-graduate qualification in 1984 from the UK and eventually set up the occupational therapy school; the first locally

organised course programme in occupational therapy was offered in October of the same year. Mario Scicluna completed his post-graduate training in the USA in 1985 and joined the teaching staff that year, contributing the expertise he had accrued in America to the first locally organised teaching programme. Furthermore in 1986, an expatriate Maltese citizen who was a qualified occupational therapist trained in Southern California and who was at that time part of a Peace Corps volunteer programme in Malta, also joined the teaching staff.

At an early stage of its inception, occupational therapy education sustained a considerably strong influence both from the United Kingdom and the United States. Being one of the candidates in the first education programme, I can attest to the fact that American-derived knowledge, textbooks, policy documents and the like, exerted a profound influence on me and the student cohort I formed part of. Literature from the United States gave the impression of being considerably more robust and scientifically 'fleshed out' compared to the knowledge from Europe and the UK.

This was a profoundly impactful moment for me and demonstrated that there was the possibility of 'another occupational therapy;' a profession very much akin with medicine. Looking back on it I can almost imagine a burgeoning, albeit on a microscopic scale and at a much-accelerated timescale, of the paradigm shifts in occupational therapy that are so well documented in the profession but emerged over the span of decades in America, occasioned by the introduction of the American way in the course programme and the profession. I will be developing the argument on paradigms in the subsequent chapter, but I feel that making the link here, is a way of building up towards the rationale of this study.

Continuing with the narrative, to compound matters, my fellow student colleagues and I became, perhaps through our naiveté, involved in a sort of mini-revolution instigated by some members of staff in the profession who were intent on changing the name of the profession from occupational therapy to ergotherapy. This change of nomenclature was meant to shift attention from, or eliminate the use of the word occupation, with its connotation with keeping patients occupied and unprofessional work. This proposed change in nomenclature was eventually aborted but served to underscore - although not in any way an articulated form at that time - the significant identity issues inherent to the profession. Notwithstanding this experience, all members of my cohort qualified to become the first group of occupational therapists educated in Malta. I assume we were invested in and convinced of the value of the profession. We also might have felt akin to pioneers, being the first locally trained and locally qualified occupational therapists.

Quite apart from these instances of what might be perceived as indicative of strife, the profession was still progressing and making very significant achievements in Malta at that time. One of the key developments was the setting up of the Malta Association of Occupational Therapy in the late 1980s. This set the stage for international recognition for course programmes offered in Malta.

In the mid-1990s, the programme was accredited by the World Federation of Occupational Therapy, just over a decade after the setting up of the local school. Credit for all this goes to Joseph Busuttill for his unstinting work in starting and establishing professional education on such an excellent footing. However, notwithstanding these considerable achievements, the workforce remained small and the recruitment of students was somewhat contained.

### ***1.2.3 Introduction of the Occupational Therapy Bachelor's Degree in Malta***

By the early 1990s, all health profession programmes were integrated with the University of Malta within the Institute of Health Care (IHC). This was a fundamental development in health education which was previously offered by the Department of Health of Malta and not within an educational institution. The setting up of the IHC was the first stepping stone for academic recognition and a meaningful foothold within the University of health professions in Malta. The faculties of medicine and dentistry were already very well established and were able to count upon a long tradition and 'legacy' of prestige within academia locally.

By not later than 1992, the majority of healthcare professions in Malta had successfully transitioned from offering a diploma qualification to a Bachelor's degree as the entry point into professional practice. This was not the case for occupational therapy and a couple of other professions. In the case of occupational therapy, the small professional body that could count on a small group of established players who acted as the custodians and caretakers of all the key interests of the profession - from education, professional policy, professional administration, etc. - did not seem at the time to have the necessary alacrity and human resources to make the necessary commitments in order to undertake the move to a Bachelor's level of education.

A brief transitional phase seemed to be in progress as the profession was taking stock of its resources and key members of staff moved to occupy different roles. Taking into account this situation at that time (not in retrospect), I felt that the profession of occupational therapy was seriously lagging behind, as it had not achieved the fundamental milestone of introducing a Bachelor's degree level of education in Malta. I

felt that this compounded its issues of visibility and status, and its competitiveness compared to other healthcare professions. Personally, this was a source of concern.

It is also at this point that I feel I start to play a major role in the profession and hopefully effectively contributed to its professional development. In 1991, I was appointed as the manager of occupational therapy services in residential care. From 1995, I also occupied the position of President of the local occupational therapy association, for two subsequent tenures. Also, in this year, I was appointed as Coordinator of the Division of Occupational Therapy at the Institute of Health Care of the University of Malta. This effectively made me the academic administrator of educational programmes in occupational therapy in Malta. I don't want to assume some special qualities which may not be merited, but at that point I could count on a profound knowledge of the local occupational therapy milieu, a selfless motivation for my field and also an element of 'being at the right place and the right time!' These served as strong motivators for me to bring about change in the field of education.

For me, the next inevitable step was to spearhead the introduction of the bachelor's degree programme. Over the span of three years between 1996 and 1999, key members of staff and I undertook our Master's degree studies in the UK. This altered the academic profile of the Division, both collectively and individually for members of staff. In my case, I felt that I had fully realised my professional identity after completing my Master's studies.

The new knowledge and scholarship certainly opened up my mind to the possibilities of the profession, but also acted as a gelling influence that helped me integrate the many aspects of the profession. The B.Sc. Honours degree in occupational therapy was finally offered in the autumn of 1999. The move to a Bachelor's degree was not merely intended to keep up with other health professions in Malta but was an indication of the expanded scope of the profession. This is manifested in the wide-ranging clinical concern spanning many practice domains and practice environments and a corresponding and highly diversified conceptual knowledge base. Practitioners were consequently called upon to exercise and articulate complex clinical reasoning which takes into consideration not only the disease process, but frames individuals within personal coping abilities, as well as environmental and temporal factors.

Occupational therapists also needed to produce reports to agencies and third parties, playing major roles in client care, rehabilitation, welfare and community resettlement, as well as in education. These developments translated into ambitious targets for the

educational programme. Through the higher entry requirements of a Bachelor's degree, the assumption was that there would be better potential in the student cohorts being admitted. But there was also the risk that higher entry requirements could restrict the number of students registering. This could indirectly have had an impact on the access of the profession's services to its clients. But the move to a Bachelor's level of education was inevitable if the profession was to keep in step with developments in the field, internally and interprofessionally, in Malta and beyond.

The introduction of the Bachelor's degree in occupational therapy was a watershed moment for the profession in Malta and established occupational therapy on the map of the University. One could accuse us (I feel the use of the collective pronoun is unavoidable in this instance!) of bowing to strictly egoistic professional concerns by taking this route, but simply offering the diploma would have proven deleterious to occupational therapy in Malta and eventually even the clients that it served. Personally, I found that the Bachelor's programme offered me the opportunity to transmit my new learning fresh from my recently completed studies through a range of newly conceived study units within a refashioned curriculum. I might even have had the naive feeling that I would be contributing towards unravelling the challenge of pinning down the concept of professional identity or status of occupational therapy through the new graduates and their up-to-date professional knowledge. It was certainly not as simple as that! I continued to oversee the educational sector in Malta for nearly two decades.

In the year 2010, I played a key role in the transition of the Division into a University Department, which became part of the Faculty of Health Sciences. I occupied the position of Head of Department up to 2018.

#### ***1.2.4 A History of Collaboration with Foreign Academics***

Over the years, conscious of the relative isolation of its academic and professional bodies, the profession has always striven to enlist the contribution of overseas experts in the field, both in education and practice. This started with the very first educational programme held in Malta in 1984 which counted on the contribution of three visiting lecturers from the UK. In line with this trend, a considerable influence on the setting up of the Bachelor's programme can also be traced to a collaboration with a visiting Fulbright professor from San Jose State University, Anne MacRae. Although not actually prescribing the contents of the programme - that was for local staff to determine based on local health needs and human resources - Professor MacRae was a seminal influence, especially in terms of the use of terminology and occupational therapy knowledge. This continued to underscore the considerable influence of the American

occupational therapy culture has had on the Maltese occupational therapy set-up. But also, more visiting staff were engaged from the UK and Canada.

I tend to sense dissatisfaction or lack of confidence with local occupational therapy resources. Notwithstanding the fact that we have had the input of a considerable number of experts over the span of the two decades that the Bachelor's programme has been offered, we are still in a process where we expect that a solution to address any perceived shortcomings in the profession, both in education and practice, could be forthcoming from abroad. It is as if we do not have faith in local resources and are waiting for a key player or event that could spell 'deliverance.' This is not to say that consultancy and interaction with other countries is inherently wrong, but I perceive a lack of relevance for any agency or vision that we can bring about in order to affect change for ourselves.

In the foregoing section, I have illustrated a concise history of the salient events and achievements that have marked the introduction and development of the occupational therapy profession in Malta.

In tandem with this narrative, I have also provided some reflections and impressions to highlight factors that motivated me to undertake this major research in my profession. In the following sections, I look at the rationale and nature of the research that is reported in this thesis.

### **1.3 Rationale, Aim and Research Question**

Throughout my tenure as Course Coordinator and later as Head of Department, I have always been under constant pressure from the service sector to promote the course programme in order to attract more students to compensate for the shortfall of staff in practice.

From experience, I can attest that this is very likely due to the fact that within the Maltese healthcare arena, the profession of occupational therapy still remains underrepresented, with a relatively small workforce compared to real service needs. This might contribute to limit its influence, professional power and prominence in the areas where it is most needed, namely healthcare, social care and in schools. From my experience in this profession, I am also keenly aware of the fact that there is a tendency for it to often be confused with other professions. As a professional body, it also seems to be limited in its ability to convey to the general public and other professions its specific contribution and unique role in healthcare.

Over the years, I have also observed that the issue of its limited representation has been compounded by problems of recruitment of students in the university programme and possible issues related to the retention of qualified staff. As illustrated earlier, the relatively late introduction of the Bachelor's degree may also have contributed to the relative paucity of professional affirmation in occupational therapy.

Discourse and research highlighting the concern about the professional identity of occupational therapy is widespread and common place in peer-reviewed occupational therapy publications in a number of countries. It also remains a current concern for the profession internationally. For example, as recently as 2018, the Royal College of Occupational Therapists published an extensive document defining and describing practice in occupational therapy in the UK (Pentland, Kantartzis, Clausen, & Witemyre, 2018).

Professional identity can be associated with status and could be a factor that influences and sustains practice. According to Gregory and Austin (2019), not having a clear professional self-identity can lead practitioners to experience a challenge when they are asked to explain who they are to third parties in the field. It is my observation that these considerations further highlight the critical need to conduct a study which focuses on the professional identity of occupational therapists in Malta.

Therefore, apart from the strictly professional concerns related to a better understanding of professional identity - which might be construed as entirely self-serving - this study has the potential to contribute insights into finding ways to better identify the profession to the public, thus improving access to its services. It is hoped that this research will contribute to the occupational therapy profession's self-knowledge and could possibly point out the necessary educational and professional props which need to be instituted in order to bolster professional consolidation.

Personally, I find it surprising that considering the history and achievements of the occupational therapy profession in Malta, no party has felt motivated to study the profession in anything approaching its totality. Although studies (Gauci, 2018; Micallef, 2005; Scerri, 2004) have been carried out which have considered specific services and service users of occupational therapy, no research has been undertaken to explore the professional identity of occupational therapy in Malta. Therefore, this study is the first study of its kind and I believe that the local occupational therapy profession is ripe for some self-reflection and this study has been an ideal opportunity for that.

The aim of this research is to gain an in-depth understanding of how professional identity is articulated and constructed by Maltese occupational therapists within the milieu of practice. The basic research question that underpinned this study was as follows:

***How is Professional Identity Articulated and Constructed within the Practice Environment of Occupational Therapy in Malta?***

#### **1.4 Brief Outline and Summary of the Study**

Having outlined the rationale, aim and research question I feel that giving a brief outline of the study would be in order at this point. This research adopted a qualitative case study design. Data were collected from focus group interviews conducted with cohorts of Maltese occupational therapists in five major service sites and also from individual interviews carried out with key members of staff in the profession, such as heads of department and managers. Thematic analysis of this data enabled me to build themes, concepts and constructs that have shed light on professional identity of Maltese occupational therapists. Full details of these different facets of the research are developed in subsequent chapters of this thesis.

The thesis is comprised of nine chapters which represent the developmental process of the research. Chapter 2 (Literature Review) and Chapter 3 (Methodology) constitute of the preparatory aspects of the research. Chapter 4 reviews the methods used and records work in the field and is part of the enactment process.

Chapters 5 to 8, including the analysis, reporting of the results and discussion respectively, constitute the discovery aspect of this study. I consider Chapter 5 (Analysis), brief as it is, as representing the 'breakthrough' moment or juncture that unlocked the study and ushered in the results and the subsequent interpretation of these. In the final chapter, I attempt to abridge the overall significance of the study and bring the process to a close. An outline of the contents of each chapter follows.

**Chapter 1, Introduction:** This introduction has served to provide the setting and context of this study. It also introduced the nature of the research, the rationale and some indications around the thinking and theoretical framing that has supported both its formulation, enactment and conclusion. The chapter also provided an overview of the thesis as a taster and a guide to the reader.

**Chapter 2, Literature Review:** This chapter comprises a literature review that continues to elaborate the context of the study. It gives prominence to the development of

occupational therapy in the USA, not simply as a historical narration, but as a template for the paradigmatic changes that the profession has sustained during its growth and, by extension, transformations of its identity. The chapter also provides a synopsis of the prevalent discourse on professional identity in occupational therapy and establishes the significance of the idea of a profession from a sociological perspective. A significant part of the chapter consists of a review of the research on professional identity in the field as well as in other professions.

**Chapter 3, Salient Methodological Points:** This chapter provides a description of the qualitative case study methodology and a rationale for its use in this research. It also carries the first instance where the idea of reflexivity is introduced and explicated.

**Chapter 4, Details of Fieldwork Issues and Methods:** This chapter captures the enactment of the research in the field. Although theory and discourse about the methods of choice feature, the main thrust of the account portrays the dynamic and constantly developing process of data gathering and its initial handling and processing between the subsequent phases of its collection.

**Chapter 5, Analysis of the Data:** This is a brief but fundamental chapter. It is the watershed or intersection that establishes the 'discovery' realised from the raw material of the data; a weaving of cotton into gold thread. More specifically, it illustrates the process of thematic analysis that culminates with the definitions of the two major themes and their allied subthemes. It is effectively the first time that the results of the study are articulated.

**Chapter 6, Reporting of Theme I – The Experience of Professional Identity:** This chapter basically constitutes the reporting of the themes constructed from the analysis; it represents Phase 6 of the thematic analysis process, as outlined by Braun and Clarke. Seven subthemes were constructed around the first principal theme 'The Experience of Professional Identity.' Each of these subthemes is elaborated by means of a narrative process substantiated by citations from transcripts. I have termed this process as 'involution,' implying that the internal complexity that the theme encapsulates is carefully developed and revealed.

**Chapter 7, Reporting of Theme II - The Articulation of Professional Identity:** In this chapter, I report the second major subtheme which is 'The Articulation of Professional Identity.' Allied to this theme were five subthemes. The tract basically follows the template established in the previous chapter.

**Chapter 8, Discussion and Interpretation of the Results:** This chapter develops the scope of the findings illustrated in the previous two chapters. The point of departure is a synthesis of the wide-ranging findings which was undertaken in two stages. First, the mapping of an explanatory framework of the salient findings and second, a domain-based model that subsumes the findings into two interacting and mutually influencing domains. With this newly constructed synthesis, the interpretation of the findings is advanced with supporting arguments drawn from extant discourse and research, in order to propose central explanations that can be used to make better sense of the themes and develop insights that have a practical implication.

**Chapter 9, Conclusion:** This chapter starts by taking a reflexive look back at the study and tenders some final insights to account for the positioning of the researcher, the researched and also the language which has characterised the thesis. The main findings are concisely illustrated, underlining the uniqueness and contribution of the study. The conclusion points towards an important professional 'moral of the tale' and a general drawing together of the facets of the study.

## **1.5 Conclusion**

The next chapter will synthesise some of the significant related literature with the aim of continuing to build a background for this case study from an international perspective and also reviews some of the extant literature that has been a strong influence in the conceptualisation of this work.

## Chapter 2 Literature Review

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### 2.1 Introduction

In this chapter, I will outline some of the discourse, historical themes and research concerning the issue of professional identity and professionalisation, with specific emphasis on the case of occupational therapy. The review commences by discussing the evolving identity of the profession of occupational therapy throughout the twentieth century. It then moves to highlight the key debates over the tensions involved with professional identity issues in occupational therapy. The social science analysis of professions is briefly brought to bear in order to highlight some of the well-established constructs associated with the traditional professions and which ideally form the springboard for an informed discussion of professionalisation. Then, strategies employed by occupational therapy to address the issue of identity and professionalisation are illustrated, followed by a brief note on cultural factors and the profession. The concluding section of this chapter is reserved for a discussion of empirical studies carried out to investigate professional identity.

### 2.2 Rationale for Approach and Form Adopted for the Literature Review

The approach that informed the construction of this literature review was a narrative, rather than systematic review method. This approach draws upon the principles of discursive methods to the review of literature, such as narrative reviews (Greenhalgh, Thorne & Malterub, 2018), meta narrative reviews (Wong, Greenhalgh, Westhorp, Buckingham, Pawson, 2013) and critical interpretative synthesis (Dixon-Woods *et al.*, 2006).

As the introduction to this chapter makes clear, the perspectives, areas and disciplines that are brought to bear in this review (including different research methodologies in empirical studies) are diverse, and the implementation of a systematic approach to their review would have been limiting, inappropriate and counterproductive. Adopting a narrative approach allowed me to review a heterogeneity of sources, across various types of research designs (Jones, Hannigan, Coffey & Simpson, 2018).

I have found the subject of professional identity in occupational therapy scattered in different types of discourses and often can only be indirectly inferred. It is also rather difficult to capture within a specific strand of inquiry. There is also a fair amount of repetition, albeit carried in different argument configurations in the literature. I feel that any critique, review or historical record of the professional identity in occupational therapy would only be hamstrung if it were to be specifically enclosed from the point of departure by some sort of detailed pre-determined framework, single search term or aggregation of related trends or facts as would have been required for a systematic review. Such an approach could also have strongly prefigured, biased or restricted my subsequent interpretation of the results; akin to attempting to establish a pattern in discourse which might not actually be representative of the realities in the field.

In the case of this research, it has been principally the other way round: the results of the study have prompted me to seek out literature which I use to impel explanations for the findings in the discussion chapter. As a broad starting point for the search of literature for this chapter, I have relied on online data bases, principally CINAHL, using basic search terms such as 'occupational therapy and professional identity,' 'construction of professional identity.' Further search terms were prompted by the findings in the results and were used to elicit additional literature sources which I then used in the discussion chapter. I have also made extensive use of reference lists to find sources and also my personal acumen on the subject.

The fundamental assumption that has guided me in constructing this review is best characterised as "The narrative review ... [ ] ... deals in plausible truth. Its goal is an authoritative argument, *based on informed wisdom that is convincing to an audience of fellow experts.*" (Greenhalgh *et al.*, 2018, p3 - italics added). With this assumption in mind, whilst I drew on recent literature on professional identity, I have also taken the liberty of using literature sources which might appear dated, but which I consider seminal in appraising the subject matter.

This chapter is exploratory and interpretative in nature and my aim was to develop a sound and multifaceted understanding of the subject that sets up some important signposts and terms of reference.

### **2.3 Scene-Setting**

In this section, I will briefly articulate the two most basic terms of reference that have acted as the anchor for this narrative literature review and have also broadly exerted a lingering influence throughout this thesis. These are the concepts 'professional identity'

and 'professionalisation' which I attempt to define in the ensuing paragraphs and also draw out some significant implications that have informed the logic of the narrative of this review.

'Professional identity' can be understood as the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity (Kielhofner, 2004). Professional identity has implications both for the collective, i.e. how a profession is perceived by third parties, but it also has a bearing on the individuals belonging to a profession since it is a part of the meaning which they attribute to themselves. Therefore, professional identity is part of the continuum of attributes of personal identity and it can be construed as influencing self-definition as well as how others view an individual (Slay & Smith, 2010). With such fundamental social and psychological implications, professional identity has far-reaching connotations which go beyond merely imparting a signature signpost for a particular profession. A weak sense of professional role may lead to a lack of commitment to the field (Kielhofner, 1992), burnout and eventual change of job (Lloyd & King, 2001). Furthermore, professionals without a clear understanding of their professional identity could experience a challenge to convey to the public and other professionals the remit and value of their profession, thus potentially downplaying its contribution and access to patient care (Gregory and Austin, 2019).

'Professionalisation' is the process which an occupational group undertakes to consolidate its status in society and becomes recognised as a member of the established range of socially identified professions. 'Professionalisation' is a product of or related to a 'professional project' (Witz, 1992), as identified in sociology. I posit that insights and knowledge into the constructs and mechanisms of professionalisation as identified by social sciences, are fundamental to develop a comprehensive understanding of the nature of a profession and explore its identity.

In the next section, I will review the development of the profession of occupational therapy as documented and critiqued in the United States. This historical account and critical analysis of the evolution of the profession depicts the heritage of occupational therapy and is also a glimpse of its evolving identity and possibly the identity baggage that it still might be carrying. It is the most fundamental component of this narrative.

## **2.4 The Professional Development of Occupational Therapy: A Synopsis**

The issue of professional identity and professionalisation of occupational therapy has been a recurrent concern in the field and can be traced in many professional papers

published in the past decades (Mosey, 1985; Kielhofner, 1985; Parham 1986; Wallis, 1987, 1987b; Vogel, 1991; Creek & Ormston 1996; Fisher, 1998; Hooper & Wood, 2002; Turner & Knight, 2015, to mention just a few). The fact that discourse on professional identity in one guise or other still recurs into the 21st century can be taken as an indicator that the tensions identified in earlier literature still has a bearing on the present and still maintains a distinct ring of truth.

Kielhofner and Burke (1980) maintain that occupational therapy lacks a unitary conceptual foundation to shape its identity and guide its practice. These authors consider that the proliferation of conceptual and practice frameworks vying for dominance in the field is indicative of a crisis period that is bound to eventually usher the unification of the discipline under a single paradigm. Their conviction is that occupational therapy must select as its cornerstone a paradigm of occupation.

Using the concept of scientific paradigms, Kielhofner (1992) produced a review of the history of occupational therapy and its attendant professional development in the form of a narrative enactment of ensuing paradigms and, by extension, its evolving identity. Taking the formal inception of the profession in the United States in 1917 as his starting point, he outlines periods in the professional history marked by the predominance of one particular paradigm that influences professional interests, endeavour as well as the collective vision of the field. Changing social, scientific and health trends have tended to impact the paradigms held to be absolute by practitioners and this has led to periods of crisis, followed by the eventual adoption of new paradigms. Kielhofner (1992) identified an early paradigm of occupation predominant from the beginning of the profession and up to the end of the 1940s. This was eventually replaced by a 'mechanistic' or 'reductionistic' paradigm, which was gradually adopted as occupational therapists competed with a medical profession increasingly strengthened by a growing body of scientific research.

Reductionism tended to align occupational therapy to a biomedical perspective and brought benefits to the profession in the form of a more empirical basis for intervention (Duncan, 2006a). However, it also contributed to the diminution of the importance of some of the fundamental tenets of the profession, such as holism and the occupational nature of humans. Furthermore, practitioners at this stage, seemed increasingly embarrassed by the use of daily living tasks and therapeutic activities (Kielhofner, 2004).

Reductionism was evident throughout the 1960s and 1970s. This state of affairs eventually led to a second crisis in the profession. With the rejection of occupational

competence as the central concern of the field and the increasing reliance on interventions addressed to remediate biomechanical, neurological and intra-psychical components of human function (Kielhofner, 1992), occupational therapists assumed roles not dissimilar to those of other healthcare practitioners. This led to the realisation that the profession had lost a unifying identity and become too fragmented in apparently unrelated specialities. Concurrent to these developments in the early 1980s, there was also a realisation that the occupational therapy profession had developed sufficient scholarship to allow it to recapture the distinctive qualities of the first founding paradigm of occupation by subscribing to a researched scientific base set around interdisciplinary thinking on human occupational behaviour. It is in this setting that an emerging or contemporary paradigm comes into being, one in which there is a modernised understanding of occupation born out of interdisciplinary knowledge and supported by new clinical technology developed for and by occupational therapists (Keilhofner, 2004).

The foregoing is a mere outline of the multi-faceted and highly ramified process that is the professionalisation of occupational therapy and attendant development of its professional identity. This treatment of the matter has excluded, for the purpose of concision, an exhaustive review of the history of the profession. Furthermore, it may not be representative of professional development of occupational therapy in countries outside the United States. It also gives the impression of 'closure,' when in fact the debate on identity is still ongoing and remains one of the major obligations of the profession, as evidenced by new literature purporting to describe the scope of practice in occupational therapy (Turner & Knight, 2015). My perspective is that Kielhofner's analysis of the evolving professional paradigms in occupational therapy is perhaps unique and one of the strongest and most clearly articulated of dialectics on the field ever committed to writing. It serves as an ineluctable point of reference for any scholar trying to make better sense of the coming into being of occupational therapy, that goes beyond a mere knowledge of its history.

In the case of Malta, as I have alluded to in the previous chapter, I feel I cannot rely on an extensive and minutely documented record or critique of the development of the occupational therapy profession as it is not available. I hazard to suggest that the evolution of the profession locally occurred much more rapidly than it did in the US. Although definitive periods where the practice was dominated by the specific paradigms outlined in the foregoing discussion, is not identifiable, the incident which I document about the proposed change of professional nomenclature was perhaps symptomatic of very strongly held and contrasting perspectives, or 'worldviews' that dominated

occupational therapy practice in Malta, in turn emanating from the very contrasting views of the personalities of the founders of the discipline.

In the next section, I further develop the scope of the narrative of this review by pinning down crucial terms of reference on the dialectics underpinning professional identity in occupational therapy.

## **2.5 Key Aspects of the Debate on Identity in Occupational Therapy**

Two of the most influential thinkers in occupational therapy in recent years have been Anne Cronin Mosey and Gary Kielhofner. Their influence stems from the fact that they have developed highly articulated and distinct dialectics on professional identity, and this generated some debate between these two *eminences gris* of occupational therapy. An analysis of the perspectives of these two authors I feel yields a profound understanding of fundamental dimensions and possibilities concerning the identity of occupational therapy. Ultimately, it was more a question of two miners tunnelling through a mountain from opposite sides, who eventually meet at a common destination in the middle, rather than two diametrically opposed views.

Mosey (1981, 1985) took as her starting point the conceptualisation of a profession from a social science perspective. She outlined a number of elements, such as philosophical assumptions, a code of ethics, a body of knowledge etc., and applied these to occupational therapy. In her Eleanor Clarke Slagle lecture of 1985, she made a distinction between 'monism' and 'pluralism' as possible general perspectives of professional identity. 'Monism' is the idea that one basic perspective is the essence of reality; in the case of occupational therapy, this could be elements such as a philosophical stance or a frame of reference which governs all other elements of the profession; "a comprehensive or grand theory with broad parameters" (Mosey, 1985, p.506). Mosey felt that such an approach tends to be relatively static. On the other hand, pluralism is a position which holds that reality cannot be reduced to a single principle; it suggests a broader perspective. In a profession this would mean that all elements constituting it have to be considered together: "the whole can only be defined by all its parts" (Mosey, 1985, p. 504) and in a way which allows for the accommodation of a continuously changing professional nature. Mosey also carefully illustrated her reservations about subscribing to a monistic approach for occupational therapy, citing a number of frames of reference and the Theory of Human Occupation as expounded by Kielhofner to illustrate her point.

In the case of the Theory of Human Occupation, Mosey felt that certain simplifications were too broad to be of significance for practice; by merely conceptualising the human as an open system modified by and modifying the environment with which he/she interacts, does not necessarily help the therapist address something like an eating disorder in a client. Furthermore, a comprehensive unique framework could be so esoteric in its articulation as to alienate any but the most committed of academics. Another important point that she underscores in her lecture is the artificial use of the history of occupational therapy being made by promoters of a monistic approach to identity. The claim that occupational therapy was established in 1917 is fact, but to sustain that it is based around the shared idea of the health-giving potential of occupation emanating from its founding fathers, is simplistic and cannot really be verified. Moreover, the knowledge, beliefs and issues of that time are not identical to those of the late twentieth century. On the other hand, pluralism in occupational therapy is a matter of daily practice: observation of therapists confirms that what they do is actually very diverse and not tied down to one ideology. A pluralistic identity may have been a fact for some time and therapists should not be limited to just enhancement of occupational performance, but also performance components. Mosey's (1985) design for uniting the profession is to have a taxonomy, rather than a closely constructed unique theory. Such taxonomy could classify and order a number of phenomena of concern to the profession. The identity of the profession would be the elements of this taxonomy. Mosey (1985) admits that this is a simple articulation, but given the pluralistic realities in the field, it is possibly the only authentic one.

Kielhofner's perspective seems to be profoundly influenced by the work of Mary Reilly on occupational behaviour (Blount, Blount & Hinojosa, 2009), filtered through that of Thomas Kuhn on paradigms of scientific knowledge (Kuhn, 1996). In one of his seminal articles, Kielhofner (1985) noted that occupational therapy persists in being a diffident profession with a "timidity [to] bring its work to the attention of others" (p.165). He suggested that it should undertake strategic action to address this diffidence by concentrating its efforts on "three levels of labour." The first level of labour concerns clinical practice. This involves explaining and justifying the use of traditional media, ensuring advocacy for services for chronically disabled clients and clarifying the purpose and professional boundaries of occupational therapy. The second labour concerns the theoretical articulation and empirical validation of practice. This would be an effort to explain the complexity of the therapeutic process and to conduct basic and applied research. The third labour is the commitment of occupational therapy to articulate a basic philosophy for the profession that concerns itself with the nature of the field and its *raison d'être*. It is this 'third labour' that is of interest here.

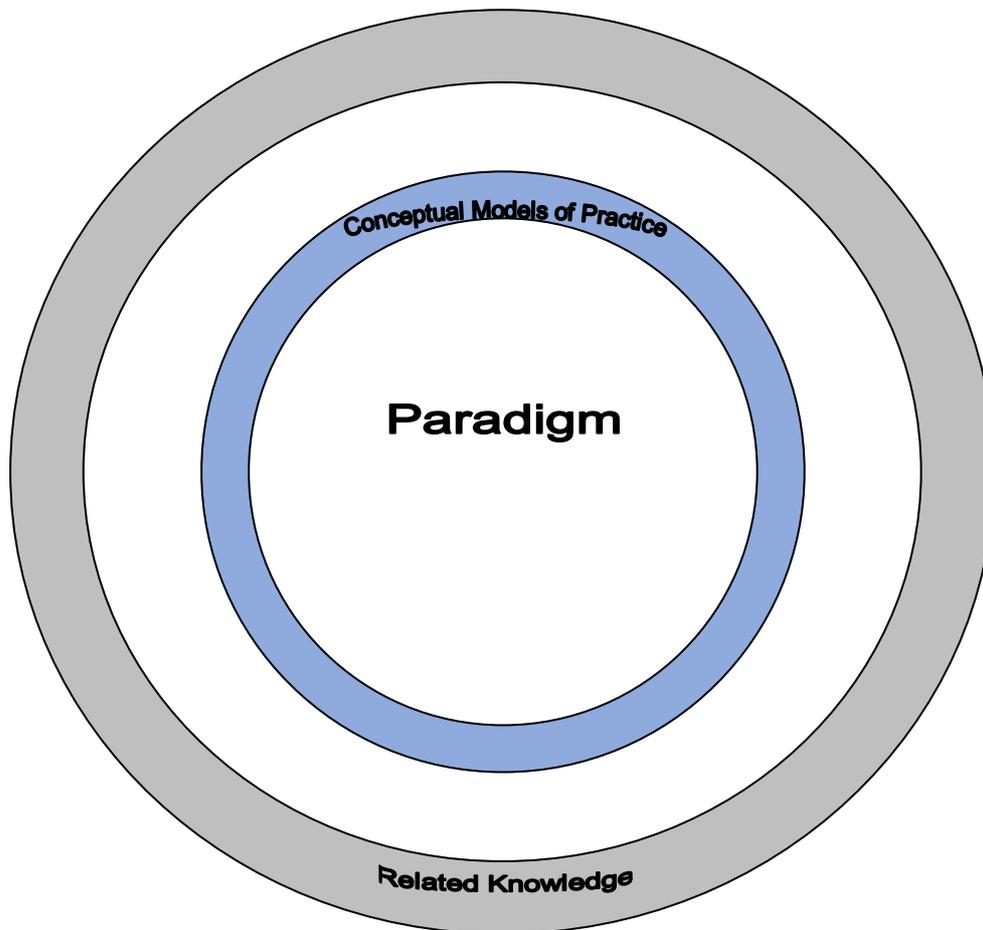
Kielhofner launches his arguments from the principles underpinning the call made by Reilly (1962), namely that the profession had adopted knowledge and know-how from other fields, principally medicine, and had not articulated its own epistemology, nor put into practice the mission it inherited from its founders. Kielhofner further asserted that the position argued by Mosey, that the field should choose between monism and pluralism, is an oversimplification. The challenge for occupational therapy lies in finding a thread which imparts unity in a field characterised by a richness and diversity of techniques. He noted that the considerable demarcations in practice are such that practitioners working in different fields (e.g. mental health and physical rehabilitation) experience difficulty finding commonalities and this is evidence that the development of an integrating epistemology is essential.

Pluralism is fraught and practitioners who maintain an eclectic orientation run the risk of having only a superficial understanding of their field. Moreover, Mosey's (1981) recourse to conceptualise the profession within a configuration is insufficient, as it does not refer to an element that integrates and gives consistency to the field. A configuration would also risk being so fragmented and lacking in a sense of vision and direction, that it divorces occupational therapy from a recognisable social contract. Without a clear social contract, a profession would be in danger of being regarded as lacking a critical role in servicing society. Therefore, the mandate of occupational therapists should be to find a binding philosophy which highlights their common mission in addressing a fundamental social problem.

According to Kielhofner (1985), this philosophy is encapsulated in three statements: human beings are occupational beings; they experience occupational dysfunction and that engagement in occupation, as employed by occupational therapists, is a major therapeutic medium. These basic principles could be the foundation for the development of theory and practice, as well as being the major elements to bring a much-needed coherence to the field.

It should be noted that when Kielhofner published the first edition of his *Conceptual Foundations of Occupational Therapy* in 1992, he actually did recognise the element of pluralism in his scheme of knowledge. He emphasised the need to reconcile unification and diversification in the profession's knowledge and interests, after all "occupational therapists employ different types of knowledge" (Kielhofner, 1992, p. 13). He proposed that the knowledge of the field could be cast into three layers (Figure 2.1). A central paradigm which gives a strong sense of identity and purpose to the profession but is not necessarily prescriptive; although it influences perspectives in other aspects of

knowledge. The second layer consists of a number of models of practice. This includes the main thrust of practical work in the field and accounts for rationales of intervention. The final layer is termed 'related knowledge' and involves concepts and techniques not unique to occupational therapy, but necessary to compensate for certain gaps in the specific professional knowledge. This approach seems to incorporate Mosey's ineluctable arguments, while highlighting a strong individual professional identity.



**Figure 2.1** Kielhofner's (1992) Concentric Layers of Knowledge.

### **2.5.1** *Some of the Other Voices and Debates*

Mosey and Kielhofner could be considered as representing major reference points for a consideration of the issue of professional identity in occupational therapy. Other writers have represented different and equally important aspects of this concern in a way which is arguably less elemental or all-encompassing, but closer to the everyday clinical endeavour of clinicians. It is a challenge synthesising these diverse voices into a distinctive recognisable pattern or thread, as the points they make add to the narrative on identity and professionalisation of occupational therapy, but not in a systematic manner or as part of a tradition of discourse specifically focussing on the subject of

professional identity. I also feel that it is important to stay true to the contents of these articles; an effort to ascribe connections which do not really exist could cause a drift away from the true spirit of what the authors wished to convey. With the exception of Creek and Ormston (1996) and Turner and Knight (2015), most of the papers considered in this section are from the US. Some of these are briefly considered in the following account.

Parham (1986) takes as her point of departure the distinguishing feature of occupational therapy. She asserted that occupational therapy was unique as a profession because it was the only discipline dedicated to the understanding of an aspect of health, which was insight into human occupation. Yet, as evidenced by the attitude of some third-party payers in the United States that reimburse health services, occupational therapists were sometimes not regarded as professionals but as technicians with limited authority and dependent on doctors for referral. Occupational therapy practice was often too narrow in focus; technique-based and lacking a theoretical rationale which sites the client in a holistic context. Parham (1986) blames this situation on the fact that, as a profession, it had not taken the responsibility to demonstrate that it could contribute to society a unique body of knowledge and sound, research-based interventions.

Covering a dialectic territory closely allied to Parham's views, Fisher (1998) has pointed out that although practitioners possess unique knowledge and expertise, they have difficulty articulating their uniqueness. Furthermore, their assessment and treatment were often indistinguishable from that of their professional colleagues, making any claim to uniqueness difficult to support. Although occupational therapists professed an understanding of occupation, this was often not manifested in practice. She analysed common practice strategies demonstrating that practitioners were resorting to "contrived occupation" (p.512) or even exercise as a means of intervention. Fisher therefore proposed a framework for practice that emphasises a focus on occupation, both as a means and an end to occupational therapy intervention.

Partly in a similar vein, Yerxa (1995) advised caution over proposals by various United States' health professional bodies proposing cross-training and cooperative practice between professions. She suggested that this was a ploy to alter the identity of professions by merger and creation of a single rehabilitation professional. Faced with such a challenge, Yerxa (1995) felt that occupational therapy must strengthen its position and autonomy as a profession by understanding its identity and developing new ideas and models of practice which aim to empower patients' autonomy and self-direction. Although starting from a different dialectical position, Yerxa's arguments appear to

develop the idea of the importance of articulating the unique professional knowledge and contribution of occupational therapy and dovetails with the points made earlier by Parham and Fisher.

According to Creek and Ormston (1996), the development of occupational therapy is motivated by three basic elements, namely philosophy, theory and practice. The authors further maintain that the natural interaction of these elements is what pushes the profession forward and maintains professional motivation. They also identified factors, both internal and external to the profession, that are eroding the nature of occupational therapy by causing a disconnection between these basic elements. Internally, there is an apparent separation between what theorists profess and what is actually practised. The profession also frequently modelled its practice on medicine with a resultant reductionistic approach to rehabilitation that may not provide holistic care for clients with lingering and complex disability. Externally, the pressures of managed care reduced practice to mainly curative goals geared to ensure rapid discharge of patients, rather than giving priority to the professional philosophy of addressing the full range of the client's needs. The authors ascribe this to practising without a sound theoretical base, which made occupational therapy more prone to being dominated by other professional groups which are more 'articulate,' such as medicine and psychology. Occupational therapy was at risk of not having an internal locus of control and becoming less autonomous.

The issues of 'domination' by other professions and encroachment were also spot lit by Kornblau (2004), during her presidential address at the annual conference of the American Occupational Therapy Association of 2003. She noted that the physiotherapy profession in the United States, when drafting a new position paper and presenting a new definition, had used terminology which was patently occupational therapy in nature. Moreover, physiotherapy was assuming a position of power with respect to occupational therapy by aspiring to adopt a doctoral-level professional entry point and becoming the lynch pin in rehabilitation with diagnostic and referring jurisdiction. Kornblau (2004) advocated that occupational therapists should be more proactive in promoting what they can offer, instead of complaining about encroachment. Poor promotion of a profession may have serious consequences and could compromise its possibilities of being funded and recruited in a highly competitive and cash-strapped healthcare environment (Wilding & Whiteford, 2007). Kornblau (2004) suggests that occupational therapists are uniquely placed to carve out a professional niche by exploiting the broad concept of enabling participation. They could also develop their practice outside the medical model. Her presidential address significantly expounded the fact that occupational therapists should

establish themselves with policy makers within social systems where they can develop programmes “from the ground up” (Kornblau, 2004 p.12). She highlights occupational therapists’ potential to contribute to areas, such as retirement preparedness, community mobility, driving safety, as well as prevention and wellness.

Vogel (1991) characterised the issues of identity in occupational therapy, as residing in three problems. The first was the continuing debate over the philosophical base of the profession, with those proposing occupation and purposeful activities as the unifying themes, juxtaposed to those who adhere to the use of non-purposeful treatment modalities. The second problem is the diversification of the profession into disparate technical specialities that tended to diminish its recognition and autonomy. This occurred, according to the author, because of the absence of a common base for professional knowledge and practice. Endorsing occupation as the common core of the profession was considered limiting and met with resistance in the United States at the time, especially with some occupational therapists using physical agent modalities in their treatment in physical settings in the 1970s and 1980s. The third problem was the lack of status accorded to the profession by those outside the field (Vogel, 1991). In this instance, the author cites previous studies which had indicated that practitioners were concerned about the low visibility of the profession and the lack recognition of its value by payers, the general public and other professionals.

Hooper and Wood (2002) maintain that although the issue of professional identity struggle in occupational therapy is complex and multi-faceted, one prominent discourse which has shaped it is the ‘conversation,’ often conflicted, between pragmatism and structuralism. ‘Pragmatism’ is the perspective which assumes that individuals can be free agents to bring about change in their condition and that knowledge is dependent on the particular contextual experience. ‘Structuralism’ purports that humans can be viewed as “composites of recurring general frameworks” (Hooper & Wood, 2002, p.43), while knowledge is objective and generalisable to a number of contexts. Occupational therapy practitioners often depict their practice as holistic and pragmatic, but have struggled to actually operationalise this depiction, frequently adopting structuralist and reductionist stances prevalent in other professions working in their immediate proximity (Hooper & Wood, 2002).

Turner and Knight (2015) assert that there is recurrent evidence in occupational therapy literature from the UK and to some degree from other countries that occupational therapists continue to experience problems with their professional identity. To investigate this observation the authors undertook a review and analysis of professional

literature that extended back for up to ten years. From their analysis, Turner and Knight (2015) identified a cause and effect of the professional identity of occupational therapists for which they constructed into two major themes: the *reasons for issue with identity* and the *consequences of the issues with identity*. As the major *reason* of identity issues for practitioners was the tension between the dominant health and social care discourses, and the occupational perspective on health, with the latter perspective frequently being a minority viewpoint that is given limited credibility or authority in medical practice.

According to Turner and Knight (2015), another cause for identity issues was the inability of practitioners to articulate a rationale for what they do that emanates or adheres to a single paradigm of occupation. An additional important factor that impacted identity was the issue of a perceived lack of status that relates to the apparently commonplace concerns of everyday life that occupational therapists deal with, which is not valued by other health professionals. These identity issues had considerable effects ("*consequences*") on practitioners, the most prominent of which was an inability to think strategically in order to realise the unique potential of the contribution of their professional roles. The absence of a strong identity also led to occupational therapists being influenced by the 'ways of doing' of other health professionals in their area of practice and a rejection of what appeared to be their mundane roles. The authors maintain that although these issues were identified from UK and Australian occupational therapy journals, in fact these stood for the views of research participants and academics from four different countries, suggesting that professional identity concerns actually occur across the international occupational therapy community. They also frequently crop up peripherally in research literature even when the focus is not specifically on professional identity (Turner & Knight, 2015). These considerations underscore the currency of professional identity concerns in occupational therapy.

Turner and Knight's paper more or less summarises and cuts across of the voices and facets that have directly or indirectly contributed to unpacking factors related to professional identity in occupational therapy. The highlight of these dialectics is the fact that there is a lack of emphasis, confidence or articulation of the unique feature, focus and contribution of occupational therapy to health around participation in occupations. The consequence of this was the adoption by occupational therapists of the paradigms and ways of doing prevalent in other professions in an effort to accrue more professional validity and meeting the expectations of the immediate practice arena. This diluted their identity and the value of their potential fundamental contribution to the health arena.

The scope of these narratives is extended further on in this thesis in the discussion chapter, as concepts and discourse are used to build explanations that frame a number of the key findings of this study. In the next section, I move the narrative of this review into a different direction, as I outline another essential term of reference of this study which is the consideration of a profession as a sociological construct with recognisable characteristics. This discussion goes to the heart of the matter of understanding of what makes a profession and offers some insights that inform about the nature of the tensions experienced by professions, such as occupational therapy, as these progress through their development.

## **2.6 The Sociological Lens**

A review of the social constructs, processes and key characteristics of or associated with professions and professionalisation was essential as one of the fundamental terms of reference of this study. It has informed my thinking and was a major factor in establishing a perspective for this research that has acted as an influence at nearly every stage, starting from the literature, fieldwork and data collection.

The nature and traits of a profession is a subject which has received considerable attention in social science literature. In order for an occupational group to advance from beyond a “mere fact of social life” (Macdonald 1995, p.188), a simple aggregate of skills, knowledge and ethics, its members must be involved in a “professional project which emphasises coherence and consistency” (Macdonald 1995, p.10) and which maintains and enhances the position of the group in society.

The key agencies within an emerging occupational group may tailor an agenda for such a professional project. Social sciences provide knowledge that can help to organise the many voices and perspectives of a developing occupational group through a highly articulated framework which has been applied to the study of established professions (Wallis, 1987).

### **2.6.1 *Tensions relating to Professionalisation in Healthcare***

The tensions associated with professionalisation in healthcare are comprehensively illustrated perhaps for the first time by Etzioni's (1969) study of semi-professions. Although featuring only nursing from the health sector, this nearly fifty-year old study still holds currency and its insights can be extrapolated to other health professions. The patronising and arguably paternalistic tone of the monograph, attributable to an era when political correctness was not an uppermost concern, can be grating and even demoralising but, the author assures, all is for the benefit of better self-analysis of the

(semi) professions concerned. Etzioni (1969) establishes the terms of reference of the analysis, namely administrative versus professional authority.

In the case of the traditional professions, these are viewed as possessing knowledge which is owned individually, allowing autonomy and authority by virtue of the fact that the holder of the knowledge is allowed the discretion to exercise fundamental decisions (in the case of doctors, decisions involving matters of life or death), justified by the fact that such decisions are made "to the best of the professional's knowledge, ... the right act" (p.X). This contrasts with administrative power, where an administrative act is justified by the rules and regulations of the organisation and has been sanctioned by a higher rank. By implication, this second exemplar is representative of semi-professions or non-professions. This exemplification is applied by Etzioni (1969) to distinguish between traditional fully-fledged professions with their respective professional organisations and to semi-professions and semi-professional organisations.

The basis of professional authority is knowledge (Etzioni, 1969). This is usually transmitted through a long period of training, which has to do with addressing fundamental social issues and can be applied in non-organisational contexts, such as direct, private interaction with clients. On the basis of this rationale, development of an authoritative professional body of knowledge is one of the basic requisites for an emerging profession seeking to improve its status. Such knowledge must not only be distinct, it also has to be accorded legitimacy by significant parties outside of the profession.

Knowledge also equates with authority (and power) and those who wield it are in a position to exert influence in society. Specific professional knowledge that characterises a distinct professional identity has been a fundamental concern in occupational therapy and this, I think is well-evidenced in the foregoing sections of this review and will be specifically considered later in this account.

Professional knowledge (Etzioni, 1969) is further characterised as follows: it is knowledge that that should be abstract and organised into a body of principles; knowledge that can be applied to concrete problems of living (as opposed to elaborate metaphysical knowledge which has no real-life application); that society believes that such knowledge can truly address basic problems. Society also accepts that these problems are best addressed by a specific occupational group as this is the possessor of the knowledge in question; the profession should generate, organise and convey this knowledge; the profession should also be the final adjudicator for the problems falling

within its area of expertise and, decisively, that professional knowledge is invested with enough complexity that it cannot be acquired other than through the special circumstances of training.

Etzioni's discussion of these so-called semi-professions has been considered as a trait-based approach of analysis (Hugman, 1991) and has been the subject of a number of critiques. It takes as exemplars of models for professions traditional occupations such as law and medicine when, in fact, these should have been amenable to a sociological evaluation and not held as unquestioned reference points (Hugman, 1991).

Witz (1992) notes that theorising around semi-professions emanates from an "androcentric model of profession" (p.60). This assumes being the defining quality of professions, the "successful professional projects of men at a particular point in history" (Witz, 1992, p.60-61). It is therefore a prejudiced perspective embedded in a patriarchal culture that may have denied the requisite legitimacy to female-dominated occupations. Nursing, and indeed occupational therapy, arguably qualify as traditionally female-dominated professions and perhaps easy targets for those seeking out some manifestations of vestigial semi-professionalism. The participants in this study were all female, with the exception of two and the researcher, himself!

### ***2.6.2 The Professional Project – A Blueprint for Professionalisation?***

Professionalisation is the trajectory that an occupation must traverse in order to become a profession (Witz, 1992). Wilensky (cited in Mieg, 2008) recognised professionalisation as a series of seven steps: (1) a job becomes a full-time occupation; (2) establishing a training school; (3) establishing a university program; (4) founding a local professional association; (5) founding a national professional association; (6) creation of a state license; (7) creation of a code of ethics. (Mieg, 2008, p.42)

A professional project is akin to a strategy played out by an occupational group to develop and consolidate its status as a recognised profession, as it essentially goes through the process outlined by Wilensky. As will be seen in the ensuing discussion, the occupational therapy profession in Malta has achieved all the steps and conditions annotated above, although it may have sustained potential consequences due to the comparatively delayed introduction of the Bachelor's university programme.

In his examination of the professionalisation of accountancy in the United Kingdom, Macdonald (1995) outlined a narrative unfolding for a professional project grounded in the historical roots, cultural contextual influences, as well as institutional and statutory

factors involved in the consolidation of this profession. Such an approach is perhaps more consonant with Witz's (1992) views of what should constitute a professional project. She is reluctant to consider a professional project as a generic construct which can be used as an arbiter to adjudicate how much a profession has "professionalised." She claims that this would run the risk of bringing to the argument a historical, male-dominated perspective, and it is this stance which has brought about the labelling of some professions, especially those in healthcare, such as occupational therapy, as being semi-professions, without them being evaluated on their own specific merits. Despite these reservations she conceded that a general statement about what makes up a professional project can be made as follows:

Professional projects are strategies of occupational closure which seek to establish a monopoly over the provision of skills and competencies in a market of services. They consist of strategic courses of collective action which take the form of occupational closure *and* which employ distinctive tactical means in pursuit of the strategic aim or goal of closure (Witz, 1992, p.64).

According to Macdonald (1995), the major objective of a professional project is to enhance the position of an occupational group in society. Fundamentally, this must translate into an effort to monopolise a market, based on the purported expertise professed by the occupational group in question. Professionalisation also entails the growth in the status of the occupational group within society. One way of ensuring this is by establishing a system of credentials (Friedson, 1986). The setting up of a university programme which grants a degree as a professional qualification, is one way of doing this. A degree qualification requirement for practice creates 'closure,' which is a way of barring unqualified parties from having access to a specific professional knowledge base and, by extension, the 'market' of clients potentially recipient of the services provided. Another facet of the credentialing system is that which involves the occupational group seeking institutional, often public, approval through the granting of registration or licensure as this furthers the social standing of the occupational group and confers 'moral authority' (Macdonald, 1995). Witz (1992) considers this as a legalistic stance to introduce closure for a profession within the institutional milieu of the state.

Credentialing is therefore one of the major characteristics of the professional project. And a significant part of this lies in the conferment of higher degrees for practice of a profession. Indeed, Friedson (1986) declares that "a critical criterion [in demarcating the professional group] lies in some degree of exposure to higher education and the formal knowledge it transmits" (p.59). Knowledge, apart from being pivotal to professions, is the result of scholarship. Therefore, an important mandate for a profession is to

demarcate and pursue the development of its knowledge base. Issues concerning the development of a professional knowledge base in occupational therapy will be overviewed in the ensuing sections.

The import of this discussion can be extended to the situation of occupational therapy in Malta. The relatively late introduction of a Bachelor's level of education could have been a key factor that may have impacted professional consolidation of the profession. It can be considered as a missed strategic or 'landmark' juncture that might have hampered the necessary fundamental evolution in credentialling of the profession in Malta. It could also have affected the type of profession-specific knowledge that could be taught, with the professional training being temporarily suspended at and limited to diploma programmes. Both of these considerations could be looked upon as important 'inflexions' on the process of the development of occupational therapy in Malta, that, by extension, may have impacted on its professional identity.

Notwithstanding what could be construed as a patently negative and limited standing of the profession of occupational therapy in Malta at a particular stage of its development, there were considerable achievements made by the profession locally. These were in themselves important milestones in the progress of its very own professional project. For example, in the mid-1980s, a school of occupational therapy was set up in Malta; also at around that time the Maltese Association of Occupational Therapy was established and this was before an analogous association was created by the local physiotherapy profession. Another important achievement was the official recognition of occupational therapy educational programmes offered in Malta by the World Federation of Occupational Therapists which occurred around in the mid-1990s and before the introduction of the Bachelor's degree programme.

### ***2.6.3 Snapshot of the Emerging Profession of Occupational Therapy in the UK***

Although strictly speaking not a sociological treatise, perhaps the ideal starting point of the study of occupational therapy as an emerging and evolving professional group is the report commissioned by the College of Occupational Therapists in the United Kingdom on the state and future prospects of the profession in the late 1980s (Blom-Cooper, 1989). Although in many respects the situation of occupational therapy in present day Malta is not directly comparable to the context described in the UK in this report, there are a number of issues which resonate with the Maltese situation. This report can also be considered as the review of a particular professional project in occupational therapy.

The account is significant for its consideration of the historical origins of the profession of occupational therapy (Blom-Cooper, 1989). It also annotates broad areas of knowledge and skills required by occupational therapists, underscoring the fact that no other profession can lay claim to this particular combination, although aspects of it are shared with other professional groups in the then burgeoning field of rehabilitation. The report also expresses concern over the prevailing stereotypes associated with occupational therapy, which act as a hindrance for the proper emancipation of its status. It suggests that by its connotations the very title 'occupational therapy' could be the reason for it to remain a 'submerged' profession.

The Blom-Cooper (1989) report offers suggestions to explain the continued struggle to establish a professional identity and autonomy in occupational therapy. The first problem noted was the dominant position held by the medical profession and that of social work in the area of health and social care. It was suggested that occupational therapy could meet resistance if it is perceived as challenging the authority of these established professions. The second problem is the fact that occupational therapy depends on doctors and social workers for referral, with the result that it does not have direct access to the beneficiaries of its services and their support. The third problem is that which was described earlier, namely that of stereotypes associated with the profession or, more damaging, the seemingly "unskilled, common sense tasks [performed by occupational therapists] which do not merit the prestige accorded to doctors" (Blom-Cooper, 1989, p.19). The fourth issue is the predominantly female composition of the profession which could be regarded by the general public and the service sector as not constituting a dependable workforce, prone to being depleted due to child-rearing obligations.

The fifth and final problem is the emergence of managed care. This was seen as a threat to occupational therapy because of challenges it faces in measuring its outcomes. In a situation of limited funding and agencies competing for funds, the services of occupational therapists therefore run the risk of being undervalued, replaced by minimally trained technical staff, while resources are directed to the acquisition of high technology medical equipment. This final point also links to the paucity of experimental evidence demonstrating the effectiveness of occupational therapy interventions available at the time and was interpreted as being a direct result of the weak emphasis on research in the profession. Notwithstanding, the Commission of Inquiry did find ample informal evidence from doctors, other health professionals as well as clients, to support the need for and to appreciate the work of occupational therapists.

To conclude this brief review, it is worthwhile considering one very significant insight which has implications for the Maltese situation. This is the characteristic of a small workforce where young and newly qualified staff find themselves isolated and in a position where they have to make frequent fundamental decisions about the course of treatment of clients. They may also be required to supervise technical staff, without themselves having the necessary mentoring and supervision. The report highlights this as a potential source of frustration, strain and staff attrition (Blom-Cooper, 1989).

Although some of the points made in Blom-Cooper's report may appear to be dated. For example, the fourth point referring to female staff tied down to child rearing, it does portray some very significant issues relevant to occupational therapy in Malta. It also constitutes a sort of occupational therapy-specific and very pragmatic application of the constructs derived from the social science conceptualisation of professions.

Taking the question of profession-specific knowledge as one of the basic attributes of professionalisation, I now steer this narrative review to cover another important term of reference for this research which is the unique professional knowledge of occupational therapy.

## **2.7 Profession-Specific Knowledge in Occupational Therapy – Some Foremost Points**

Macdonald (1995) claims that knowledge is the fundamental trait of professionalism and that this is a fact acknowledged by all sociological discussions on professions. Therefore, some discussion of occupational therapy's professional knowledge would be obligatory in the current review.

As a point of departure, Friedson's reflection on "formal knowledge of any discipline can be characterised by a single, central paradigm ..." (Friedson, 1986, p.215) appears ideal and can be taken as an underlying assumption for the evolution of profession-specific knowledge in occupational therapy. What follows will hark back to and develop some of the concepts alluded to in the earlier sections, namely the centrality of occupation as a paradigm for occupational therapy, but now the emphasis is on knowledge development rather than strictly professional identity issues. This brief overview also serves to highlight the different types of knowledge that the profession of occupational therapy tended to emphasise or was predominant during its course of development. The discussion is again based on the US for the simple reason that knowledge development arguably appears more robust with the support of professional practice frameworks and antedates that of other countries. Its development also appears to be very clearly documented and discussed.

As a profession, occupational therapy experienced a dominant influence of the biomedical paradigm and for a time the profession, especially in the US, was characterised by its alliance to the medical profession and as a purveyor of rehabilitation services (Barker Schwartz, 2003). Around the mid to the late 1960s, it was becoming increasingly evident that occupational therapy's close modelling of its practice on the reductionist medical model, was threatening its holistic and occupation-based foundational ideals. Another important consideration that was transpiring was that little theory or research was available that could frame the occupation-based nature of the profession on a sound scientific or epistemological footing. Leading figures in the field were challenging the profession to reconcile its development in the medical system with its founding ideals "to practise both the art and science of occupational therapy" (Barker Schwartz, 2003, p. 10).

The first intimations of a "science of occupation" (Molineux & Whiteford 2006, p. 298) can be traced to the very beginning of occupational therapy in the US in 1917. At the time, the founding fathers of the profession had affirmed their aim to focus on occupation as a therapeutic measure, research its effects on the human being, as well as to disseminate scientific work on the subject. But with the development of the profession in the ensuing decades, it was only the therapeutic aspect of occupation that received much attention (Molineux & Whiteford, 2006). The real breakthrough moment for the 'scientification' of occupation occurred in the late 1960s by the creation of the occupational behaviour frame of reference by Mary Reilly at the University of Southern California (Larson, Wood & Clark, 2003). This construct purported to elucidate the occupation's richness by an emphasis on occupational roles, human adaptation, competency, work and play (Barker Schwartz, 2003). It also allowed Dr Reilly's students to research around the basic founding philosophical tenets of the profession. For example, how the environmental context and life history are related to occupational behaviour; how the use and awareness of time relate to capacities for adaptation (Larson *et al.*, 2003).

The 1970s and onwards saw the strengthening of theory, practice and research in occupational therapy (Barker Schwartz, 2003). This was a period characterised by the emergence of a number of frames of reference such as sensory integration by A.J. Ayres in 1972 and cognitive disabilities by Claudia K. Allen in 1985. Other notable developments were the publication of Gary Kielhofner's Model of Human Occupation in 1980 which was referred to earlier, and the appearance of occupational science, attributed to Elizabeth Yerxa and Florence Clark at the University of Southern California,

in around the late 1980s. The latter two developments are regarded as the direct offshoots of Reilly's occupational behaviour frame (Barker Schwartz, 2003).

The introduction of occupational science can be considered as a bold move by a confident academic body. It was proposed as a scientific discipline that "provides, explanations of the human as an occupational being" (Clark *et al.*, 1991, p 300). Its originators (Yerxa *et al.*, 1989) regard it as a basic science and its relationship to occupational therapy (the applied science in this case) as akin to that of anatomy and physiology to medicine. Yerxa *et al.* (1989) also suggest that this approach allows more freedom for researchers, as they are not hampered by the obligation to limit their enquiries around practical or clinical applications. The proponents of this 'new' science further justified its value citing the fact that occupational therapy still "[had] not reached a consensus about its scientific foundation ... nor [had] it found a coherent synthesis of knowledge ... [had] been an applied discipline without a science to apply." (Yerxa *et al.*, 1989, p.4).

Therefore, the relationship between occupational science and occupational therapy is one of symbiosis (Larson *et al.*, 2003), with the knowledge being generated in the scientific discipline supporting the fundamental belief in the value of occupation as the basis of the profession of occupational therapy. Some have argued that occupational science has the potential to motivate occupational therapists to become agents of social change and will enable them to work with client populations outside the predominant medical hegemony, pursuing a more authentic portrayal of their professional identity (Pollard, Sakellariou & Lawson-Porter, 2010). These are populations characterised by occupational disenfranchisement, often residing on the fringes of society.

Numerous efforts have been made to frame occupational therapy practice within the lens of profession-specific theories and discourse that have been appraised in the foregoing. The profession of occupational therapy, especially in the United States, cannot be accused of not attempting to bridge the gap between theory and practice. The American Occupational Therapy Association (AOTA) has pursued this end starting from the late 1980s, arguably up to the current time, with a series of publications intended to guide practice in occupational therapy and bring about professional identity consistency across disparate areas of practice.

In the next sub-section of this narrative review, I will outline how occupational therapy knowledge has been applied in practice.

### **2.7.1 Addressing the Problem of the Application of Professional Knowledge and Professional Identity in Practice – Some of the ‘Shorthands’ Adopted**

As has been seen, formal knowledge has been regarded as one of the basic traits of professions (Friedman, 1986; Macdonald, 1995). To this end, occupational therapy has sought to develop its own specific branch of professional knowledge which is exemplified in occupational science (Yerxa *et al.*, 1989) and occupation-based models of practice (Cole & Tufano, 2008).

Levels of theory and knowledge in the field have been defined and mapped out extensively (Creek & Feaver, 1993; Feaver & Creek, 1993; Kielhofner, 2004; Cole & Tufano, 2008), while occupation-based models of practice, with their attendant technology and research, are widely available (Townsend & Polatajko, 1997; Kielhofner, 1995). The latter purport to be the repository of specific knowledge, services of occupational therapy and subscribe to the tenets of occupation-based intervention. However, there is evidence that such knowledge is rarely translated into practice by clinicians who find it of limited value and impractical to implement (Kielhofner, 2005).

An effort to address the problem of the confusing diversity of practice in occupational therapy (Mackey, 2007) was first attempted by the AOTA when it published the Uniform Terminology (AOTA, 1989, 1994). This document established a set of phenomena that made up the profession’s domain of practice, with the aim of ensuring intelligibility between practitioners working in different settings (AOTA, 1994). It appears to be patently influenced by Mosey’s (1981) formulations. The utility of the Uniform Terminology can be fully appreciated within the context of the reimbursement system of healthcare in the United States as it contributed to avoiding “disparity in the types of coverage from one region to another” (Perinchief, 1993, p.389), so its aim may actually have been more utilitarian rather than directed to address issues of identity. The Uniform Terminology included a comprehensive inventory of performance components of concern to occupational therapists and this seemed to emphasise intervention based on problems related to underlying components of occupation rather than a focus on occupation and context (Cyzner, 2009). In order to address this shortcoming, AOTA published the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2002), which supplanted the Uniform Terminology.

The Occupational Therapy Practice Framework portrays an expanded scope of practice in occupational therapy and links it to the proclaimed fundamental core of participation in occupation and client-centredness. The Framework is intended to inform both an internal and an external audience and in the latter case, could help the general public better appreciate occupational therapy knowledge and skills (AOTA, 2002). The

Occupational Therapy Practice Framework has since its publication, gone through three iterations and is currently in its fourth edition (AOTA, 2020) and this is testament to AOTA's pursuit of ensuring that the document remains current and truly reflects the identity of occupational therapy as it evolves and moves into ever-new practice niches.

The potential of this document to advance the cause of occupational therapy by better illustrating its identity to an external audience is undeniable, but it is difficult to ascertain how influential it has been in the United States and, more significantly for this study, whether it has had any effect in other countries. It has been pointed out that “cultural bias may be inadvertently embedded in occupational therapy” (Kondo, 2004, p. 174). This could impact on the cultural appropriateness or congruence of professional documents, such as the Occupational Therapy Practice Framework and the attendant possibility that such documents are adopted by or applied successfully in other countries. Some points on the cultural dimension and occupational therapy are developed in the next section of this narrative review.

## **2.8 Cultural Dimension and Professional Identity**

The following quotation succinctly portrays and powerfully underscores the basic significance of cultural considerations in relation to occupations and by extension the tenets and processes of occupational therapy:

Culture not only assigns a name to occupation through its language, but it also shapes the form it takes and the meaning with which it is imbued. When an individual chooses an occupation, psychological and physical concerns, as well as cultural practices, values, and beliefs come into play (Kondo, 2004, p.174).

Reed and Sanderson's (1999) reflection on culture is an important starting point in a consideration of cultural issues and occupational therapy as the authors question some of the fundamental assumptions of the mission of the profession. They pointed out that the terms ‘independence’ and ‘independent functioning’ as used in some definitions of occupational therapy, are very much a view of a return to independent living without assistance, an assumption prevalent in the cultures of Northern Europe and North-Eastern United States. The authors argue that this view of independence may not be a norm in other cultures, where assistance to persons with limited function from members of an extended family may be expected. Considering the fact that the promotion of independence is one of the founding tenets of occupational therapy, it begs the question whether a potentially profound disjunction exists between the salient characteristics of

this profession and certain culture-specific norms which, in turn, could constitute a source of professional identity conflict.

Iwama (2006) suggests that clients can be alienated if subjected to procedures that have limited cultural relevance since these may be construed as not respecting their “world of meaning” (p. 49). Western notions of well-being are associated with mastery of the environment and the self. Occupational therapy practice models have tended to represent these ideals of healthy functioning, with their attendant individualistic values. Iwama (2006) questions the appropriateness of transplanting such values into societies with divergent social and cultural realities, especially those where individual agency is not given particular prominence. From his experience of occupational therapy practice in Japan, the author noted that a considerable professional crisis was precipitated by attempting to fit theory and assessments imported from another culture.

Japanese practitioners reported poor understanding of theory and resorting to a narrow scope of service delivery dominated by the medical model, as well as a practice disconnected from the significance of Japanese daily life (Iwama, 2006). One is therefore inclined to question whether such a scenario can be delineated in other countries which are adopting occupational therapy theory in their respective practices in a canonical fashion, without properly heeding the implications of cultural relevance.

The introduction of occupational therapy theory, assessments and practice documents such as the Occupational Therapy Practice Framework in Malta could potentially constitute a situation that occasions a cultural tension and intelligibility for occupational therapists practising with Maltese clients, in a way similar to that posited by Iwama. It is a situation where a southern Mediterranean country is adopting conceptual knowledge related to such a culturally embedded construct such as occupation, that was conceived and developed in a northern Anglo-Saxon culture. Although in the absence of research evidence to this effect, such a reflection is bound to remain entirely in the realm of possibility. The fact that Malta was a British colony and had been exposed to and interacted with the British culture for an extended period, could have acted to mitigate cultural incongruence with principles embedded in occupational therapy principles. The fact that English is a second language could have helped. But again, these reflections are simply speculative.

## **2.9 Overview of Empirical Studies on Professional Identity**

Research concerning professional identity in occupational therapy appears limited, although there are many opinion pieces, position papers, lectures and monographs

concerned with issues related to identity in the profession and professionalisation. These include both quantitative and qualitative studies. A significant number of published research seems to address identity in a pre-determined fashion, as a construct in relation to another variable in quantitative studies (Davis, 2005; Edwards & Dirette, 2010; Ikiugu & Rosso, 2003; Rogers & Dobson, 1988), rather than addressing it as a main concern or considering it as a construction. There are at least two dissertations which have considered professional identity in occupational therapy specifically and these are briefly reviewed here. The range of studies reviewed also includes studies that have looked at students rather than staff. The inclusion of these might be thought of as questionable, but this type of research has produced vital insights into factors related to identity in occupational therapy which contribute to its construction. Empirical studies cover a range of factors that are closely, but sometimes remotely or even peripherally related to issues of identity. For this reason, it has been challenging to synthesise them into overall patterns or trends, although each has a significant value in contributing to the understanding of professional identity in occupational therapy.

Valuable work on professional identity construction has been conducted in nursing and in the medical profession. Other important insights have been gleaned from other health professions, as well as from other professions. Identity (not necessarily professional identity) is one of the most widely researched areas in organisational studies (Sveningsson & Alvesson, 2003). Although extrapolating findings from managerial and business studies to healthcare may warrant caution because of the fundamental differences of the professions involved.

Another point which merits clarification is the fact that most studies on identity have researched the development of individual professional identity within the context of a specific profession, rather than looking at the identity of a profession in the form of a case study, for example, as a snapshot of the current status of the professional identity of a profession. These studies will be reviewed in the ensuing segment of this literature review, starting with studies carried out in occupational therapy and followed by those in other health professions.

### **2.9.1 *Studies in Occupational Therapy***

Ásmundsdóttir and Kaplan (2000) surveyed the whole population of occupational therapy practitioners (n=80) in Iceland in order to capture key demographic information and attitudes towards professionalisation prevalent at around the time of the late 1990s. The value of this research lies in the fact that it outlines an occupational therapy professional environment that uncannily mirrors that prevalent in Malta until relatively recent times,

rather than any light it sheds on the issue of the professional identity of occupational therapists *per se*. Essentially this is a study that examines the 'level' or process of professionalisation.

The demographic data reported elucidates possible threats to professionalisation. For example, the relatively low working hours, with only 46% of the occupational therapy workforce working full-time; a predominantly female practitioner population (just two registered male therapists) and a substantial portion of practitioners holding diploma entry qualifications. The authors considered that these results show that many occupational therapists in Iceland are akin to semi-professionals. The study also demonstrated that most practitioners have educational commitments apart from their clinical work. They are generally available to supervise students and they take part in research while some also teach the university curriculum. In contrast, these can be considered as characteristic of true professionals. The paper seems to suggest that the profession of occupational therapy in Iceland is in a state of transition towards its professional consolidation. Parallels can be drawn with the situation of occupational therapy in Malta suggesting that the profession locally is still in a process of development towards the conclusion of its professional project.

Other, more specific conclusions that the authors describe have to be taken with caution. Although the sample is quite small, a number of correlations are made. For example, the relationship between type of qualification and time that the practitioners were prepared to commit to the professional association in Iceland. The survey tool used was overly elaborate: 122 items carried in four sections, culled from five other questionnaires. It was piloted with physiotherapists and subjected to just face validity. This may have diminished its validity and reliability. Bearing these facts in mind, the reader is inclined to cast a sceptical eye on the robustness of the results. Nevertheless, the succinct literature discussed is very significant and works as a sufficient edifice for the research questions of that particular study.

Wilding and Whiteford (2007) conducted a participatory action research study with ten occupational therapists at a large medical hospital in Melbourne, Australia. The aim of this particular research was first to investigate the problems practitioners faced in explaining and justifying occupational therapy practice. It also looked at how a focus on occupation, theory and evidence informs practitioners' capacity to articulate their work. The authors intended to use the insights generated by the study to inform action that needs to be taken in order to improve the standing and the practice of occupational therapists in acute settings. Data was collected by interviewing each participant and

interviews were subsequently analysed by coding and thematic analysis. The resultant broad themes generated indicated problems experienced by the participants when describing occupational therapy; over-elaborate descriptions of the profession; the adoption of a 'bottom-up approach' – a focus on the diagnosis rather than occupational dysfunction – forced by the medical emphasis of the hospital; and an epistemological tension between the philosophical stance of the profession and that of the medical setting. The practitioners were in a position where they had to match the high drama of acute medical care, with the attendant 'magic effect' of medical and surgical intervention that brought about a rapid change in the patient. In this setting, occupational therapy seemed to operate at a much slower pace and its intervention concerned with the common place and executed by common-sense means.

Rogers and Dobson (1988) studied burnout in a sample of 99 occupational therapists from the Southeastern United States. The authors investigated the relationship between burnout and a number of demographic and descriptive variables, although the aim was to investigate the appropriateness of using the Maslach Burnout Index (MBI) with occupational therapists. The study indicated that occupational therapists experience less burnout compared to other professionals in the caring professions, although they are susceptible to low feelings of personal accomplishment, which indicated feelings of incompetence and ineffectiveness in their work. The authors observed that although occupational therapists scored low on the MBI indicating less burnout, they suggest that this may not be a true indicator of the level of burnout in the sample, since MBI normative data for occupational therapists was not available. They suggested that the cut off points on the subscales of this instrument, need to be revised to reflect occupation-specific norms. Although not making direct reference to professional identity, this paper gives a glimpse of occupational therapists' possible perceptions of their professional selves.

Edwards and Durette (2010) studied the relationship between professional identity and burnout in a group of 300 occupational therapists registered in the US state of Michigan. The authors developed their research questions from a review of the literature and their point of departure was the supposition that there was no clear-cut definition of professional identity, with attendant problems of role confusion, adoption of the identity of other professionals in the health sector and consequent stress originating from the promotion of occupational therapy in the healthcare setting. Using the Maslach Burnout index (MBI) and a study-specific Professional Identity Questionnaire (PIQ), the study correlated burnout with professional identity. It also correlated sub-components of burnout with specific professional identity questions. A significant negative relationship between MBI scores and scores on PIQ was found: the lower the professional identity

score, the higher the burnout score tended to be. Generally high levels of burnout were found to be experienced by practitioners who felt that the scope of their profession was too broad and that they were undervalued and disrespected by colleagues. The authors highlighted the fact that identity issues in occupational therapy remain current. They also emphasised that these should be addressed not only with junior staff, but also with the more seasoned therapists who may still have feelings of unease and anxiety over their professional role.

Gray, Colthorpe, Ernst and Ainscough (2020) have taken the findings of Edwards and Durette's study (2010) as an important assumption in their investigation of the extent of professional identity development in second year students reading a four-year Bachelor of Occupational Therapy programme at the University of Queensland, Australia. They posited that the development of a strong professional identity in the student years could have a protective effect against burnout as it imparts positive emotional well-being and satisfaction that supports practitioners when they are in the workforce. Gray *et al.* (2020) conducted a thematic analysis of the participating students' responses obtained from a course assessment task that required them to describe why they had selected occupational therapy, how they perceived themselves as occupational therapists and to describe their role models. The authors then proceeded to rank the students according to how strong their professional identity was, by the use of a rubric that helped to categorise differing levels of professional identity. The study demonstrated that, despite the fact that students were in the same programme, they exhibited a range of professional identity development, with just a quarter of the sample demonstrating strong identity development. Strong professional identity development was associated with positive influences on career choice, such as persuasive role models. The authors highlighted the importance of identifying and addressing persistent identity development problems in the students in order to forestall these issues manifesting when practitioners are in the workforce.

Ikiugu and Rosso (2003) investigated the relationship between specific coursework in a graduate programme and the development of a professional identity in occupational therapy students in the University of Scranton in Pennsylvania (US). Multiple methods of data collection were used, which included two types of course evaluation tools, graduate survey and discussions on an electronic blackboard. The investigators elicited the students' opinions on a theory course programme which included knowledge of occupational therapy history, paradigms, models of practice, as well as social, philosophical and economic factors that influence occupational therapy. The analysis was conducted using descriptive statistics based on information from the survey tools

and quantitative analysis of the data obtained from the blackboard. The findings indicated that the students gained a number of benefits from the course, including an awareness that occupational therapy occurs in a context, awareness that there is an emerging paradigm of the profession, the need for more proactivity in occupational therapy and a clearer perspective between theory and practice. The study's generalisability is limited because of the small number of participants (30). Conceptually, it is highly debatable whether students' opinions can be taken as an indicator of a 'facilitated' professional identity. Moreover, there is ample evidence to suggest that professional identity development may not simply be the result of classroom rhetoric.

Another study that purported to investigate the relationship between course work and professional identity in occupational therapy was conducted by Whitcombe (2013). The author interviewed students in the final year of a problem-based learning (PBL) undergraduate occupational therapy programme at a university in the UK, in order to elicit their perceptions of knowledge and professional identity.

The findings of this qualitative study were presented in three themes. *Knowing how: PBL skills* was a theme that captured the students' perceptions of experiential learning of the occupational therapy process on practice placements and how this was reinforced by skills accrued from the problem-based learning course work. *Know what: Knowledge as a social relation* was a theme that encapsulated what the students understood as being knowledge in occupational therapy. This was summed up as an appreciation of the philosophical beliefs, such as client-centredness and holistic practice, but not as "esoteric" (p.40) or unique professional knowledge specific to the occupational therapy profession as represented by occupational science. The students could not construct this esoteric knowledge from their experiences in practice or the PBL course. A *dispositional professional identity*, the third and last theme represented in the study, embodied the representation of professional identity that was a function of a belief system and possible intersubjective attributes not unique to occupational therapy.

The study spotlights the importance of the purposive inclusion of profession-specific knowledge, such as occupational science in the pedagogical process, as this is not readily acquired in experiential learning. Professional knowledge acquired through experiential learning tended to be specific to the practice site and not transferable, and could be liable to influence the development of an identity that is represented by individual outlooks rather than profession-specific knowledge. If the profession of occupational therapy is to safeguard professional advancement and assert a unique identity, it has to inculcate the specialist knowledge of occupation as there is the risk that

students construct their professional personas based upon values and philosophical discourse, rather than specific professional knowledge (Whitcombe, 2013). Although fleetingly alluded to in this paper - "However, simply mirroring current practice restricts professional advancement" (p.37) - the strong, but perhaps not specific implication is that students are at risk of perpetuating prevailing identity issues found within occupational therapy services unless university programmes take account and build unique professional knowledge within their teaching. Although with this notion comes the assumption that classroom influence can overcome the possible impact of the authentic and perhaps, much more fundamental experience of the profession during fieldwork as some studies suggest.

Davis (2005) considered professional identity development in occupational therapy students, specifically the images, beliefs and conceptualisations that newly recruited and nearly qualified students convey to their educational experience and how these are transformed as the student moves from classroom to practice. The study employed mixed methods. An identity Questionnaire and a Professional Identity Scale were administered to 124 student occupational therapists from three Midwestern Universities in the US. At a second stage, five nearly qualified students were selected from the same sample for individual case studies. A number of themes emerged from this second cycle. These were comparatively analysed and yielded a number of overarching themes. Of special significance here is the overarching theme which highlights that the development of professional identity is both the responsibility of the novice, as well as that of the professional community. This research, available as a dissertation only at the moment, sought to investigate professional identity development from a symbolic interactionist perspective. It purports a reconsideration of the process of development of professional identity, suggesting that it is an iterative process, with fieldwork and professional communities having a more profound effect on identity than what is taught in the classroom.

These conclusions are echoed in some of the findings made by Ashby, Adler and Herbert (2016) who conducted an online survey of final year occupational therapy students across five English-speaking countries that consisted of the US, Canada, UK and Ireland, to investigate pre-entry experiences and curricular factors that influence professional identity. The study revealed that although students considered curricular content as valuable, 96% thought that practice education was the most significant factor in their programme that largely influenced professional identity development. 64% of the students surveyed reported discrepancies between their expectations of witnessing occupational-based practice and actually observing this being enacted in practice.

The authors (Ashby *et al*, 2016) highlight the importance of the need to have university course work in occupational therapy that helps the students engage in understanding the dissonances that they experience between the patently occupation-based approaches to learning used in class and the realities of practice that they experience in clinical education. The wider generalisability of this study is limited since it was only carried out within English speaking countries.

Hanson (2009), using a grounded theory approach, explored how occupational therapists in the North Midwest of the United States constructed and enacted professional identity in a hospital setting. Data were collected by interviewing twelve occupational therapists and was analysed by a constant comparison method. Themes were extracted by open, axial and selective coding. The author utilised Tornebohm's model of personal paradigms to describe a template of factors influencing professional identity. The results highlighted a number of themes, including factors in the medical practice setting which constrain occupational therapists to focus on the underlying impairment and self-care concerns; the medical setting was seen as crucial in the development of language, knowledge and skills; holistic intervention is only provided in a 'veiled' fashion while client-centred and occupation-based intervention could only be integrated with normal practice through the opportunity of reflection. The study is significant in highlighting the tensions of professional identity facing occupational therapists working in a medical setting which presents challenges to reconcile the philosophy of the profession with that of the medical model.

Boniface *et al*. (2008) conducted an action research project with the aim of embedding the principles of an explicit occupation and client-centred base in an occupational therapy service. Participants included all the occupational therapy staff at the Primary Care Trust of Gloucestershire in the United Kingdom. The research aimed to entrench the Canadian Model of Occupational Performance at all levels of occupational therapy service and the consequent adoption of interventional technology based on this model. The project spanned over four years and comprised successive phases of reflection and action. Staff were introduced to the theoretical principles of the model by a steering committee and later proceeded to find ways of implementing the model in practice. Nominally, this involved undertaking training, adapting assessments and adopting a user manual. Data were extracted from the various phases of the project, such as from conferences, meetings and feedback sessions. The findings, which form an integral part of the action taken, highlighted the importance of properly rooting occupational therapy theory in practice. This inculcated thinking about occupational dysfunction, rather than performance component deficits. The use of intensive training and familiarisation

ensured that theory of the model is 'embedded,' which means that it should underlie clinical thinking and that the use of the model is not only limited to mere practical application of its technology.

The research also showed that theoretical model structures should be adopted flexibly within existing services in order to ensure that these attain full practical relevance. The use of the model also helped to demonstrate that a theoretical rationale underpinned clinical reasoning and the treatment pathways adopted by the practitioners. It also helped to highlight a 'corporate identity' for occupational therapy.

Looking back at the array of studies reviewed, I feel it would be too hazardous to tender an impressionistic assessment on some potential general trends, as this would be potentially omitting key voices, considering the diversity of issues uncovered by these studies. In an effort to signpost for the reader this section, I will here attempt a brief synthesis, more akin to pointing out some highlights of this subsection. This survey of research has emphasised the importance of the clinical experience for students and staff in their construction of professional identity. The tensions experienced by occupational therapists to enact their professional identity in certain settings was ascribed to epistemological dissonance between the tenets of the profession and that of the hospital environment and other professions. Studies have also identified the challenges experienced by occupational therapists to talk about and explain their profession. Some studies have highlighted the importance of identifying and unpacking professional identity issues for students as this could help them deal with professional identity concerns that they experience in practice.

### **2.9.2 *Studies from other Health Professions***

Butina and Schell (2011) investigated how professional identity could be a contributing factor in the recruitment and retention of medical laboratory practitioners in the United States. The motivation for the study was the chronic staff shortage in this profession because of weak recruitment and poor retention. Previous studies had attributed this to a lack of recognition by other professionals and a lack of awareness by the general public of the profession, as well as limited career development opportunities, amongst other factors. In contrast to these previous quantitative works, the researchers adopted a qualitative approach for their study. In-depth interviews were conducted with ten practitioners to obtain narratives which enabled the researchers to better understand what was perceived as professional identity by the participants.

The findings were described by three themes:

- A misunderstanding of the role of laboratory personnel by other healthcare professionals;
- A sense that as medical laboratory practitioners, they perform a vital role;
- “A lack of awareness of the profession by the general public” (Butina & Schell, 2011, p.13).

Although extremely well contextualised and articulated, the study is perhaps not notable for its broad scope or exceptional depth. Notwithstanding this, the professional issues which it illustrates bear very strong parallels with the situation of the occupational therapy profession in Malta. Therefore, the recommendations and implications made could be of considerable significance. Furthermore, the theoretical perspectives assumed by the authors, i.e. organisational identity and narrative identity theory, merit further exploration and could prove to be a worthy theoretical stance for this current study.

Gregory and Austin (2019) studied pharmacists in Canada in order to develop insights into their internalised professional identity or rather "the internalised psychological sense of being a professional" (p.251) of these health practitioners. These insights were developed from the pharmacists' interview disclosures of their behaviour in conditions where they were either patients or they had to assist a relative in hospital. The premise and assumptions of Gregory's and Austin's research were based on previous studies which considered the experiences of physicians as patients. It was demonstrated in these studies that physicians seem to make use of their professional persona (leverage) to take a very active role in their own medical care. This is exemplified by their close monitoring of their treatment and progress, which was considered as evidence of resorting to their professional knowledge. This behaviour was assumed to be a consequence of a melding of personal and professional identity; it was as if the physicians inhabit their professional persona as an existential condition which they carry with them in all aspects of their life.

Gregory's and Austin's (2019) research demonstrated that the behaviour of pharmacists as patients or caregivers, contrasted markedly with that of physician-patients. In this situation, pharmacists rarely completely disclosed their professional background and they also did not seem to participate actively in their medical care, even though they shared broadly similar educational and professional backgrounds with the physicians. The authors ascribe this finding to the fact that pharmacists may have a weaker sense of professional identity; although they perform pharmacy work, they may not have fully attained an integrated personal-professional identity as demonstrated by the doctors.

The latter's 'self-advocacy, self-confidence and self-interest' when in the physician-patient role could be attributed to a merged professional-personal identity. The researchers extrapolated these findings to explain interprofessional dynamics in the daily professional lives of pharmacists and found that by being less positive and assertive about their identity, they may be less effective as professionals and command less respect from their colleagues in healthcare. Some of the rhetoric and discourse in the study is undoubtedly fascinating, but the central limitation of this research is that it rests its findings on a theoretical framework which the authors admit is untested. Nonetheless, the reflections on professional assertiveness and self-confidence could have currency for the present study.

In nursing, Deppoliti (2008) conducted a qualitative study to explore how newly qualified nurses construct their professional identity in hospital environments in the United States. Semi-structured interviews were conducted with sixteen nurses who had worked in hospital one to three years after their graduation, in order to describe and explore experiences that contributed to the construction of their professional identity. The results indicate that nurses traverse a number of passage points when constructing their professional identity, such as orientation, finding a niche and the conflict of caring. These are marked by a range of themes which include learning, negotiating for power and authority, continuing education and socialisation in the hospital environment. The right balance of challenge and support offered by the system, colleagues and clients helped nurses to go through the critical passage points. The study also identified conflicts that could be precipitated by the business culture in the modern healthcare system of the United States, which may be at a variance with that of caring. Short patient stays and 'revolving door' admission and discharge policies, were seen as compromising the culture of caring. Nurses who perceived contact with clients and families and their feedback as contributing to their professional identity were at risk of losing their major supports in this environment.

Pratt, Rockmann and Kaufmann (2006) conducted a six-year qualitative study of medical residents in an American medical training centre with the aim of generating theory about how a professional creates a sense of professional identity. The investigators selected a high-ranking medical centre well known for the rigours it subjected its interns, as this was regarded as constituting an "extreme case" (p.238) which facilitated theory building by virtue of the fact that the dynamics being observed tended to be more overt than in other contexts. Medical residents were selected from three specialities: primary care, surgery and radiology. The main source of data was semi-structured interviews conducted with the residents at four different points during their tour of training.

Additional data were obtained from interviews with key staff, such as faculty members, administrators and physicians. Short surveys, archival information and observation, supplemented the primary data sources.

From the small sample of studies on professional identity summarised here, this is by far the most significant in terms of both breadth and depth. It is therefore a major challenge to paraphrase the wealth of findings that emerged and do the paper the justice it merits. On a basic level, it confirms the reiterative and interactive nature of individual professional identity construction noted elsewhere in this review. The authors found wide-ranging changes happening in the residents' professional identity throughout their training. They also noted that a dissonance between professional self-conceptualisations and the changing demands of work resulted in 'integrity violations' and subsequent 'identity customisation' i.e. identity was tailored to fit the work at hand, rather than the other way round. Another important theoretical construct to emerge was perceived competence; with work and identity changes, there were also changes in the perception of competence experienced by the residents. This may be an important reference point that could be linked to perceptions of effectiveness.

This brief survey of studies about professional identity originating from professional milieux other than occupational therapy, serve foremostly to illustrate how much primacy the concern on this area is given by a range of professions and certainly demonstrates that it is not an issue circumscribed to occupational therapy. The main areas highlighted here have to do mainly with identity construction and public awareness of it, rather than articulation of it, as it occasionally featured in occupational therapy studies. Although diverse perspectives are studied here, much as in the previous section, a very strong case is made about the impact that the practice environment has on the 'customisation' of professional identity. With this evidence in mind, one is inclined to reflect on how genuinely far reaching in influence are professional identity enhancing strategies conceived for students in class, when these influences will be fundamentally tempered by experiences in the practice field. Perhaps academics might want to impart their vision of professional identity beyond their classes for these to have effect. Academics may also need to be able to cogently account for the discrepancies between classroom rhetoric and the actual professional identity enactment in practice, especially in occupational therapy. The explanations that this study has posited to interpret the results could go some way to address this.

## 2.10 Conclusion

In the foregoing narrative review, I discussed conceptual discourse and studies which have served as the basic scaffolding of this research. As a point of departure, I have resorted to two basic concepts, themselves established from the literature, which were 'professional identity' and 'professionalisation.' The latter was developed from extensive research and considerations of discourse from social sciences concerning professions. This account then proceeded to discuss issues concerning the identity and professional development of occupational therapy. The key debates on issues regarding its identity were explored extensively.

Discourse from social sciences on professions was brought to bear in order to clarify the social positioning and power of professionals, as well as to frame the process of becoming a profession using key terms of reference. The issue of occupational therapy professional knowledge was also given prominence as this links to the issue of knowledge and power in professions. The final section of the review was a synthesis of a number of empirical studies on professional identity in occupational therapy and other professions.

Apart from Busuttill's 1986 historical monograph which was the basis of the previous introductory chapter, there is no existing systematic research of the occupational therapy profession in Malta. This lacuna needs to be addressed in order for a body of empirical information to be made available that explores issues of professionalisation and professional identity in occupational therapy in Malta. Problems of intelligibility of the profession in Malta, with it being confused with other professions in healthcare, a small work force and what appears to be a limited ability to consistently recruit the desired number of students in the undergraduate programme, can be considered as manifestations of professional identity issues. These issues are of obvious concern to the practice and educational sectors in Malta and potentially impact on the continued thriving of the profession. Occupational therapy in Malta must remain an accessible, viable and significant service to clients who need it.

This study has therefore attempted to comprehensively address a knowledge gap about the profession of occupational therapy in Malta so as to be able to effectively contribute to professional self-awareness. This also extends to being able to indicate the necessary actions which need to be adopted by practitioners in order to improve and consolidate their positioning in the health field.

In the next chapter, I will be presenting the rationale for the choice of methodology and methods that I used in order to undertake this research.

## Chapter 3 Salient Methodological Points

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### 3.1 Introduction

In this chapter, I will overview the methodology adopted for this research. The aim of this research will be developed, as well as the explication of the theoretical standpoint that has been adopted. I will also be giving a rationale for the choice of methodology and the methods of data collection employed. In this chapter, I will articulate the issue of reflexivity as it applied to my siting within the research setting. In the next chapter, I will outline procedures involved in the collection of data and discourse around the methods used in this research.

### 3.2 Operational Definitions

In order to proceed with the discussion of the methodology adopted, I believe that is pertinent to semantically anchor the key concepts underpinning this study, as these were the main drivers for the methodology and the collection of the data. After having reviewed the literature in the previous chapter and much reflection on the influences of the discourse and empirical studies reviewed, I feel that I am in a position to translate these key concepts into the following definitions:

*Professional identity* is being defined as the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity (adapted from Kielhofner, 2004).

*Professionalisation* is the process which an occupational group undertakes to consolidate its status in society and becomes recognised as a member of the established range of socially identified professions (adapted from Witz, 1992).

These definitions have played a fundamental role not only to inform my thinking by providing me with a sort of shorthand or focus to reflect on the 'grand purpose' of this research, but also were the basic discussion triggers that I used in my data collection strategy.

### 3.3 Reiterating and Differentiating of the Purview of this Study

Very much related to the construction of the definitions illustrated in the previous section and my immersion in the literature, was the further clarification and diversification of the remit of this research beyond its general aim. The aim of this research was to gain an in-depth understanding of how professional identity was articulated and constructed by Maltese occupational therapists. The research question is reiterated as follows:

How is Professional Identity Articulated and Constructed within the Practice Environment of Occupational Therapy in Malta?

Quite apart from the statement of the research question, I feel that it is important to formulate the ideas that had impelled the inquiry and that were 'behind' this question as these illustrate the true scope of the research, as well as contribute to convey to the reader's sense-making of this thesis. The first basic notion is around the term articulation and this translates into how Maltese practitioners express and describe their identity. Identity also has to do with distinction from others in a social environment. Therefore, another important area of inquiry was attempting to discover the uniqueness of occupational therapy services and what distinguishes the profession from others. This is a product of how the participants of this study recognised and expressed this unique quality. Another important dimension of professional identity is how it is understood 'externally' through the perceptions of third parties. In this study, this could only be reconstructed through the 'second hand' reports of practitioners of how they feel their work or profession is perceived. I have distilled these ideas as the research *objectives* of the study which I reproduce as follows:

- To identify and investigate the way in which Maltese occupational therapists articulate their professional identity;
- To investigate the extent to which these practitioners feel that their service is unique;
- To explore how these express the unique quality of their profession;
- To explore Maltese occupational therapists' perceptions or experience of the extent to which other health professionals and clients recognise the nature of occupational therapy in Malta.

These objectives were, together with the operational definitions, the reference concepts for the construction of the focus group guides and eventually, the interview schedules.

However, the latter also integrated influences garnered from the initial analysis of the focus groups. The underpinning concept which was constantly influencing my thinking and which in the beginning I included as an objective, was actually one of the operational definitions, professionalisation or the tenets of what it means to be a profession, developed from my review of discourse from the social sciences of professions. Although I consider this as a fundamental idea of this research that has clarified my thinking on professions, it is actually not directly developed in the data. It was an important part of the matrix of discourses that generated the data, but 'did not proceed to be demonstrated empirically;' i.e. it was not developed into evidence in the data. More specifically, I did not grasp or construct 'how professionalised' the occupational therapy profession was at the time of doing the research.

At this point, I also feel it is important to establish a contextual denomination or semantic value for the term 'construction' as it is used in the research question. This, I hope, will start facilitating the reader to see through my own eyes and perhaps understand my motivations. The term 'construction' is not meant to imply a direct and proportional relationship of contributing factors to the establishing of an identity and that these factors had been used as some sort of building blocks, for example, the education of practitioners and its relation to their identity formation, although, as I shall have time to reflect upon later in this thesis, this may have been one of my not insignificant, but rather simplistic starting points.

The concept of 'construction of identity,' which I hope will emerge more clearly after the results have been represented and interpreted, has to do more with how the professional identity of Maltese occupational therapists is constructed from their *everyday experiences* over time within their practice. It is a construction of identity mediated between internalisation and interaction with the outside world. This research has therefore allowed me to form detailed insights related to these two conceptual areas.

### **3.4 Overarching Epistemological Characterisation of the Inquiry on Professional Identity**

From the literature reviewed in the previous chapter, it is evident that there are different epistemological stances assumed in relation to the study of professional identity, both in occupational therapy and other professions. These range from the 'positivist,' where the professional identity is a pre-established construct which can be measured and correlated to other variables, to the 'constructivist' approaches, which seek to explore how professional identity is formed or developed. Both of these approaches have their value. My view is that a positivist approach, in the case of occupational therapy and especially in Malta, would ascribe a relatively absolute value to professional identity and

what constitutes it. Such an approach may also impute a fault to the individuals in relation to their professional identity, because the assumption is that the professional identity of a profession is established, visible, well-advertised, while these individuals might not be the bearers of the right qualities to develop into that identity, hence the tensions they experience. But there is abundant discourse to sustain the contention that the identity of occupational therapy is not well-established and is challenging to define. With this assumption in mind, it is difficult to have a point of departure which attributes or assumes an established value to the professional identity of occupational therapy. For me this excludes positivists and quantitative methods of inquiry. The second influential concept in this research which was 'professionalisation,' or what it means to be an established profession, which according to tenets recognised in social sciences, is highly multifaceted and not an easily quantifiable value.

With these arguments in mind, I believe that a constructivist perspective constitutes a better epistemological fit for an inquiry into the identity of occupational therapy, especially when such an inquiry is being conducted as a first major study of its kind in Malta. Furthermore, the cornerstone of this study has been the definition of professional identity derived from Kielhofner (2004) which was as follows: professional identity can be defined as the *perspective* that binds members of a profession *together* and gives them a sense of themselves and a collective public identity. I believe that this definition is a patently constructivist view of professional identity and can easily be linked to a concept from Lincoln, Lynham and Guba's (2011) interpretation of constructivist knowledge: "Individual and collective reconstructions sometimes coalescing around consensus" (p.101).

The terms "perspective" and "together" in Kielhofner's definition just quoted are equivalent to a co-construction. As will be seen in the findings and subsequent discussion, the idea of "sometimes coalescing around consensus," is especially telling in the case of occupational therapy, given the diversity that the profession holds within it and certainly, not amendable to be represented as an absolute value.

### **3.5 The Quandaries of Selecting the Qualitative Methodology**

Although aligning myself to a qualitative paradigm was clear from the outset, actually selecting the type of qualitative approach was a challenge. Part of this stems from my relatively limited experience in qualitative research circumscribed to my work at Master's level, but also to the fact that qualitative research approaches seemed to share much similarity to my initially 'untrained eyes.' As I will make clear in the following section, I have designed this research project around the principles of qualitative case study

design, adopting principles from the main proponents of this approach. As data collection methods, I have used focus groups and interviews. Rationales underpinning my choice of methodology and methods is discussed in the ensuing sections of this chapter.

### ***3.5.1 Selecting Qualitative Case Study Methodology as the Research Design – Influences, Concerns and Rationales***

The main influence which has steered the selection of qualitative case study methodology can be principally attributed to Creswell's (2007) highly instructive review of qualitative research approaches. This author is one of the few voices in the literature who posits a very comprehensive and accessible system that allows the qualitative researcher to make an informed and enlightened choice on approaches. But this initial influence has also been tempered by other literature sources.

Case study methodology offers a very rich discourse, but also presents certain semantic challenges within the canon of qualitative research literature. Some authors have pointed out that it may be difficult to determine what distinguishes and characterises the case study approach (Lewis & McNaughton Nicholls, 2014). Merriam and Tisdell (2016) claim that the term 'case study' is used interchangeably with qualitative research when novice researchers in qualitative research are at a loss to find a methodological label that goes beyond mere 'qualitative research.' Stake (cited in Thomas, 2011a) argues that case study research is not a methodology, but the selection of a case to be studied. Crotty's (1998) classification of research terminology also seems to establish case study as a type of method rather than a methodology. Silverman (2000, 2004 & 2011) discusses issues of validity and generalisability of qualitative research by making reference to 'selection of cases' and this seems to add further fuel to the argument that case study is more of a method rather than a methodology. Very much in contrast to these positions, Creswell (2007) argues firmly that case study is a legitimate research methodology comparable to approaches, such as phenomenology and ethnography.

The case for the use of the case study methodological approach (pun not intended) in this project, comes from the aim which was to gain an in-depth understanding of how professional identity is articulated and constructed by Maltese occupational therapists within their milieu of practice. Merriam and Tisdell (2016) claim that the distinguishing characteristic of case study research is the case studied which can be conceived as an entity or unit with recognisable boundaries. I feel that the five occupational therapy service sites selected for this research, situated within the Maltese public health service

sector, constitute the boundaries of the case study and firmly establish one fundamental quality that qualifies this research as a case study.

Thomas (2011a) maintains “case study is about seeing something in its completeness” (p. 23) and ventures the following definition:

Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions or other systems which are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytical frame – an object – within which the study is conducted and which the case illuminates and explicates. (Thomas, 2001a, p. 23)

This standpoint, especially the holistic viewpoint that it suggests, is the scheme most adept at capturing the holistic qualities of an entity such as a profession. To further justify the choice of methodology for the present research, more specific articulations will be presented next.

The notion of the boundaries circumscribing the case are further developed by Creswell (2007) who maintains that a case study is characterised by an investigation of an issue “through one or more cases within a bounded system” (p.73). With regard to the ‘cases’ in this study, I consider them to be the practice sites constituting the occupational therapy profession in Malta. The occupational therapy profession itself can be considered as the bounded system, being circumscribed nearly in its entirety to the public health service and, at the time of the research, made up of around one hundred practising therapists.

Yin (2009) argues that the scope of a case study involves the detailed exploration of contemporary phenomena in their natural setting. In this case, the investigation of professional identity can be considered very much as a contemporary concern associated with a continuously developing practice milieu, while the plan to collect data at various settings is a function of the contextual element (natural setting) of the case. Yin (2009) further characterises his technical definition of case study by emphasising that this type of design is more concerned with ‘multiple sources of evidence’ which need to come together to triangulate. In this study, triangulation was achieved by seeking to generate data from multiple focus groups and individual interviews. A case study approach would benefit from prior development of theoretical standpoints which would underpin data collection and analysis (Yin, 2009).

The multifaceted literature review on professional identity and professionalisation – profession-specific as well as from the wider field of the sociology of professions –

indicates that this research has quite an explicit *a priori* theoretical scaffolding to support its data collection, although I consider my analysis as having been nearly free of influence of pre-existing theoretical stances. And this is principally because of the fact that there was a considerable span of time from the conceptualisation of the methodology, the data collection and actual final analysis.

### **3.5.2 The Typology of the Case**

Devising a taxonomic label for a research study is always desirable as it locates it within a recognisable category or at least an area of established methodological approaches (or subtypes within these). Such a terminological anchor facilitates comparisons with other similar investigations and also indicates broad expectations in terms of the scope and the purpose of the study. Identifying the type of case study research in the current instance presents the usual challenges of articulating complex discourse associated with qualitative research, but it introduces additional conundrums in keeping with the latitude of perspectives in the literature on case study approach, which have been alluded to earlier.

In fact, out of the main proponents of case study methodology that I have alluded to in this chapter, Stake, Yin and Thomas have each articulated a different classification system for case study. This contributes a range of methodological nuances that motivate the case researcher to seek further understanding and attempt to align to a specific methodological label. However, I feel that, given the latitude across these authors, actually committing to a specific category of case study research represents a dilemma. In the following section, I synthesise my understanding of these classification systems and my attempts to appropriate a category or subtype that characterises the current study.

Stake (1995) suggests perhaps the simplest of classifications for case studies at the risk of being accused of outright subjectivity. He delineates three types: *intrinsic*, *instrumental* and the *collective case study*. The *intrinsic case study*'s focus is the case itself and studying it would not result into developing insights into other similar cases or about "general problems" (p.3). The interest lays in the *intrinsic* qualities of the case e.g. its uniqueness; it is usually something which is close to one's professional concerns. In the *instrumental case*, the focus is on a particular issue which can be illustrated by studying a case. As an example the author cites the introduction of a new criterion-referenced marking policy in Swedish schools and how this might affect the way teachers mark and teach their students. The focus of the study is the new policy, but this could be investigated, hypothetically, by looking at a specific case of a teacher's pedagogic style

after the introduction of the policy. If such a study were to be extended to include more teachers, or to involve a number of schools, i.e. an accumulation of case studies focused on understanding the effects of the introduction of the policy, this would be an example of a *collective case study*.

Applying these parameters to the present research, the inclination is to view it more as an intrinsic case, since the focus is on the milieu of occupational therapy profession, a holistic entity in itself, within the broad attributes of professional identity and professionalisation. It is also a subject which is very close to my professional interests and definitely has intrinsic value for me.

Yin (2009) proposes a comprehensive range of case study designs with complex rationales supported by examples from published studies. These are intended to enable the reader to move from the purely theoretical to the applied. The underlying epistemological view is quite close to a quantitative rather than a qualitative paradigm. A detailed reproduction of this system here is beyond the scope of this account, but a concise review applied to this study will be attempted. The taxonomy outlined by Yin (2009) is based on a 2x2 matrix that yields four basic designs: *holistic single-case*, *embedded single-case*; *holistic multiple case* and the *embedded multiple case* as follows:

- The focus of a single case study is a unitary phenomenon/situation analogous to a single experiment design. This is typified by a number of scenarios e.g. the critical case, the extreme or unique case, the revelatory case. The *holistic single-case* design is useful when no sub-units within a phenomenon can be identified for the purpose of exploring their potential to contribute to the understanding of the whole.
- When a single case study involves more than one unit of analysis, this would constitute an *embedded single-case* design. An example of this can be the study of an organisation involving the analysis of a number of issues associated with it, for example production output and perceptions of staff (p.50). This allows the investigation to look at phenomena in operational detail.
- *Multiple-case designs* (whether holistic or embedded) are studies where more than one case is examined. Yin (2009) gives the example of a study of the introduction of a school curriculum that involves focussing on a number of schools adopting the curriculum as cases (p.53). This is analogous to

replication of an experiment and may require the explication of a clear theoretical framework which specifies conditions under which the cases are studied in order to control the conditions of their replication.

Evidence from multiple case studies can be stronger than from single cases, but Yin (2009) cautions that such studies may necessitate the mobilisation of considerable resources and time that could prove beyond the capability of a single researcher. I tend to characterise my study as an *embedded single case study*; the focus on data from different practice settings contributing to the understanding the case of the occupational therapy profession in Malta.

Yin (2009) also advises against too much focus on the sub-units of an embedded case study since this could become an investigation of the constituting units, rather than the whole. This criticism could be levelled against the present study, but I feel that my later focus on key informants at the periphery of the profession will allow me ample opportunity to look at the profession as a whole. Moreover I feel that the practice sites are in fact scaled-down reproductions of the profession, as a whole and not completely separate processes within it. They are, in a way, a reproduction of the whole but with specific characteristics and idiosyncrasies.

The way that case studies are categorised takes up a substantial part of Gary Thomas's seminal book on this approach (Thomas, 2011a). In this author's approach towards categorisation, characterising a case study is undertaken along a series of dimensions which 'map out' the case. This is a comprehensive and richly illustrated process and is discussed over a number of chapters in a congenial style. It is not an attempt that purports to present an objectively prescriptive way of classifying a case, but suggests a logical progression starting from the identification of the type of case to be studied and moving to the methods and strategies used to collect data.

The case is categorised along four dimensions: *subject*, concerned with identifying the case to be studied; *purpose*, which expresses what the study is intending to achieve; an *approach* that can vary from testing a theory to "classic" interpretative approaches (p.124); and the final dimension, the *process*, which describes the structuring of the study, for example, a *nested case study* is one where the study of subunits contributes to the understanding of the whole, which is the actual 'case.'

Although replete with examples and anecdotes from the field which help to broaden the reader's perspective on case studies, I find Thomas's approach as somewhat equivocal and perhaps does not bear too close an analysis with a view to a precise semantic

application. Its considerable value lies in illustrating many-faceted and widely applicable scenarios, but it is less useful as a standard or precise reference point for making sense of the structure of a particular case study research. I am therefore quite hesitant in applying Thomas' tenets of classification to my study in a comprehensive manner, although I can declare with considerable confidence that this study was a *local* case, with an *exploratory* purpose which assumes an *interpretative* approach, utilising a *single, nested* process case study strategy. The final detail would make it analogous to the single embedded type of case, as detailed above using Yin's classification.

As a qualitative researcher who is seeking to be rigorous and leave no stone unturned in a pursuit to comprehensively describe his work, I feel that it is inevitable to engage with these classification systems. However, after this brief and intensive review, my impression is that all three approaches tend to court equivocation and perhaps do not stand to an absolutely objective scrutiny intended to establish a final and unquestionable demarcation of subtypes. For this reason, I feel that I cannot with confidence adopt a single, explicit typological label for this case study.

In their review and critique of published case studies, Hyett, Kenny and Dickson-Swift (2014) only refer to Stake's classification and seem to have eschewed tackling the challenges posed by classification systems. They very usefully suggest two predominant approaches in case study research: one that they attribute to Stake and Merriam and which they locate in a social constructivist paradigm and another which they ascribe to Yin, Flyvbjerg and Eisenhardt which is more of a post-positivist provenance. I feel more confident taking this approach and I therefore consider that the present research is a patently constructivist case study that is close to Stakes and Merriam's formulations.

Thomas (2011a) cautions against giving undue importance to identifying a type of case study that fits a particular research, but instead, stresses that one has to start with the research question first and see if this leads to a case study. As a starting point the research question would have to be addressing something in its entirety (p.75). It is with the broad aims of the research in mind that one can progress to a cogent discussion about the type of case study being undertaken. This point is developed in the following section where the nature of the case being studied is explicated, as part of sampling and participant selection.

### **3.5.3 Sampling Issues: Case Selection and Selection of Participants**

#### 3.5.3.1 Sampling Concerns in Qualitative Research

Purposive sampling (or purposeful sampling as it is occasionally referred to in some sources) was nominally the point of departure used for the selection of participants. In qualitative research the choice of participants is guided by how much these contribute to answer the research problems and the phenomena of interest (Cresswell, 2007).

Purposive sampling is non-probabilistic sampling where the units to be studied are intentionally identified in order to reflect specific features within a population. Selection of the participants is deliberately criterion-based to ensure that they exhibit the qualities that will be conducive to an in-depth exploration of the constructs that are being investigated (Ritchie, Lewis, Elam, Tennant & Rahim, 2014). A strategic plan for qualitative inquiry needs to indicate who will take part, how the pool of participants is selected, the sites involved and the number of individuals identified. Furthermore, sampling needs to be commensurate with the research approach adopted (Creswell, 2007). Ritchie *et al.* (2014) suggest that in purposive sampling, participants are selected firstly to ensure that the “key constituencies of relevance” (p.113) to the aims of the research are covered and secondly the selection must also guarantee that adequate variation is included which allows for the salient research characteristics to be explored comprehensively. The latter introduces an element of how many participants will be included in the study.

The explication of scientifically sound sampling criteria stem from concerns about the threats to external validity and generalisability of the findings of research in quantitative methods (Robson, 2002). This is not a major issue in the case of purposive sampling for qualitative research in general and in case study research in particular. In case studies sampling rationales merit a particular consideration due to specific implication which have to do with the assumptions inherent to this approach. A case study focuses on a particular issue, such as an event or an institution, in order to study it in great detail and from a number of perspectives.

When the focus is on the “particular rather than the general” (Thomas, 2011a, p.3), there is in actual fact little point in generalising especially when the case is so unique and contextualised. By extrapolation, there is also little cause to subscribe to sampling practices which safeguard against the threat of external validity once a case is identified for a study (Thomas, 2011a). Certain research concerns may permit the selection of cases that can be considered as representative and, to a certain extent, generalizable

but choosing a case or a number of cases for their 'intrinsic' significance is unlikely to yield widely applicable findings to other settings. Stake (1995) categorically asserts that "case study research is not a sampling research" (p.4). The commitment of the researcher is to understand the particular case of interest without the obligation that the findings can be applied to other cases. It is about "particularisation" (p.8) rather than generalisation.

Taking into consideration the arguments put forward by Stake and Thomas, it could be said aligning oneself to a particular sampling strategy in case study research is not in-keeping with the nature of this approach. Sampling implies the selection from a bigger population of individuals or collection of items, which is essentially a portion with characteristics that are representative of the whole. A case study is a choice of an entity to be studied without an expectation that it represents a wider population and it is this choice that needs to be comprehensively articulated (Thomas, 2011a). This is discussed further in the following subsection.

#### 3.5.3.2 Case Selection

As has been discussed in previous sections in this chapter, this particular case study is being typified as having intrinsic value to me, as the researcher. It is being studied because I have a strong vested interest (Stake, 1995) to learn about it, as a member of the case study community and also as an educator of the profession in Malta. I am one of the first occupational therapists to train in Malta and throughout my career, I have experienced the profession both in the service sector from clinical work in various settings, at one point also being a manager of an occupational therapy service, as well as in the educational field. This experience now goes back a number of years and I can, with conviction, declare that I am now an insider with a considered and extensive insight into the issues and challenges that the occupational therapy profession in Malta experiences. I feel that as a bearer of local knowledge (Thomas, 2011b) about the case of occupational therapy, I am 'saturated' with its professional ambience and can make strategic decisions about how best it can be investigated.

This is the first of many instances where I disclose a portrayal of my intricate relationship to the subject matter - milieu and participants - I am studying. My positioning in this research necessitates the adoption of a reflexive stance which informs my insights into how preconceived ideas I may harbour and "power relations" (Gibbs, 2007, p.92) could influence data collection and subsequent analysis. My understanding of the nature of this reflexive stance is expanded upon later in this chapter.

This will be the first research of its type in occupational therapy locally and given that the profession has now been established for over forty years, it is timely and fitting. The service of occupational therapy in Malta can, for various reasons, be termed as circumscribed: it is restricted to a small geographical area, the majority of the service sites are in the public health service and as mentioned earlier, the number of service personnel is around one hundred practitioners. This makes it rather manageable to investigate comprehensively in a manner that conveys a detailed and representative snapshot of its milieu.

Thus far, I have only identified the subject of the case study but if one had to adopt the tenets set out by Thomas (2011b) for case study research, merely outlining a subject for investigation, as I have attempted to portray in the foregoing, is not enough to justify the requirements for a case study design. An analytic frame needs to be articulated from the outset which serves as a lens through which the subject of the case can be understood. This serves as a “theory and analytic category” (p. 23) almost akin to a ‘measure,’ to adopt a descriptor from quantitative methods, which can be applied to the case.

For this study the analytic frames used were professional identity and professionalisation. These two concerns are amply documented in the literature and offer very elaborate “foreshadowing” (Simons, 2009, p.32) issues which can be brought to bear on occupational therapy as a subject. They have been treated amply in the literature review.

#### 3.5.3.3 Choice of Participants and Sites

Strategic choice of participants has to closely shadow the overarching aims of the research. It also has to be congruent with the nature of case study methodology. My first inclination was to carry out my investigation with cohorts of practitioners having different educational backgrounds, for example diploma qualification versus degree. But such a course of action would only have been a manifestation of a natural inclination born out of my background as a course leader in occupational therapy at the University, one of whose main career objectives was the introduction of the undergraduate educational programme in occupational therapy in Malta. It would have been principally an education-related project, which would not have captured the essence of the profession in its totality. With my knowledge of the considerable differences in the ways of practising in public service sites, I decided to include the majority of these. This is also congruent with the characteristics of case study research which “is an in-depth description and analysis of a bounded system” (Merriam & Tisdell, 2016, p.37), the

bounded system being circumscribed to the five major public service sites through which occupational therapy is offered in the Island of Malta. More detail of this is given in the next chapter in which I document and discuss the methods I use and the fieldwork of this research.

### **3.6 Choice of the Data Collection Methods – an Overview**

Data for this case study were generated and collected through focus groups and interviews. Two sets of focus groups were carried out in five major occupational therapy services. Interviews were carried out with seven key informants in managerial and administrative roles in the profession. In the ensuing discussion, I will develop a basis for my choice of these methods.

#### **3.6.1 Theoretical Preamble**

Broadly speaking the choice of methods used to generate or collect data should be compatible with the methodology of the research, inform the sampling of the participants and ensure the best possibilities for them to give information which answers the research questions (Steward, 2006). Denzin and Lincoln (2011) point out that “strategies put paradigms of interpretation in motion” (p.14), strategies in this case are being considered as being analogous to methodologies. The authors further explain that these strategies “connect to the specific methods of collecting and analysing empirical materials” (p14); as an example, case study is cited and this was said to rely on interviewing, observation and document analysis. A cursory survey of the key textbooks on case study shows that, in actual fact, the range of methods used is very pluralistic and comprises both qualitative, as well as quantitative data collection strategies. The guidelines are far from prescriptive, but what seems to be a common recommendation is the need to collect data from different sources. Since this study subscribed to a constructivist paradigm, qualitative methods of data collection were utilised that allowed for construction and interpretation of themes around the professional identity of occupational therapists.

Yin (2009) states quite emphatically that the key advantage of case study research is the opportunity it affords the user to collect a range of sources of evidence; it is in fact a requisite of such a methodology since it relies on “converging lines of inquiry” (p. 115), which are exploited to present a more convincing and corroborated case for the evidence. The data collection strategy adopted for this project was the result of a review of a range of qualitative methods which could inform the research objectives, coupled with more pragmatic considerations related to the local context where the study is being enacted. These points are illustrated in the ensuing section.

### **3.6.2 Rationale for the Choice of Methods**

When conceiving this project, the challenges that studying the professional environment of occupational therapy in Malta presented, were constantly guided by the requirement to look at the object of investigation as a holistic entity. Professionalisation, one area of focus of the study, is an attribute that concerns the profession as a player in the healthcare arena and its visibility in the wider Maltese society. The other focus of this study is professional identity, which is also related to how the profession is viewed, but it is also the perspective that unites the practitioners in a single vision of their discipline. These two concepts are ineluctably linked to each other and each contributes to the other's integrity. These are also considerable abstract constructs concerned with shared beliefs, professional social norms and personal interpretations. These are some of the main considerations that I feel qualify this project for a qualitative investigation.

Lewis and McNaughton Nicholls (2014) make a distinction between naturally occurring and generated data. The former resides within existing sources, such as texts, interactions and behaviours; the latter is elicited by the interactions strategically created by the research process between the researcher and participants, such as by the use of interviews and focus groups. The use of generated data from focus groups and interviews are the main sources for this study. As I have alluded to earlier, case study methodology allows for a diverse range of data collection methods. Both Thomas (2011a) and Simons (2009) cite focus groups and interviews as commonly used methods for collecting data in case studies. I feel that principal concern is not about establishing a rationale that justifies the use of these methods with case study, but more about articulating rationales that describe how these methods were fit for the type of data that needed to be elicited in order to satisfy the broad remit of this research, as well as the specific objectives that had to be attained. I will be developing these considerations in the ensuing discussion.

The use of focus groups is associated with gaining insights into organisational issues (Krueger & Casey, 2009). This is a major concern for this study. Focus groups also allow access to group meaning, processes and norms (Bloor, Frankland, Thomas & Robson, 2001). Occupational therapy service sites constitute naturally occurring groups of staff that could have shared beliefs, but who certainly have shared professional behaviour norms. Working together and sharing views in groups allows participants to develop discussion on abstract and conceptual issues (Lewis & McNaughton Nicholls, 2014). Professional identity and professionalisation are considerably abstract topics which would potentially benefit from elaborative group discussion. Two consecutive focus groups were conducted at each practice site. The first group was primarily of an

exploratory nature, while the second was intended to deepen and perhaps even broaden the understanding of participants' discourse captured in the first. The second group involved sharing of the analysis of the first group with the participants.

The use of interviews in qualitative research is so ubiquitous that a rationale to justify their use is practically a given (Silverman, 2011). Interviews are "particularly useful as a research method for accessing individuals' attitude and values – things that cannot be observed or accommodated in a questionnaire" (Byrne, cited in Silverman, 2011).

As a tool to discuss issues in depth and as a means of triangulation, individual interviews were very valuable in this case study. These allowed for the development of additional depth, alternative perspectives, as well as affording an opportunity to elicit possible explanations on discourse generated in the focus groups.

My decision to use one set of interviews stems from the fact that these would have been conducted after the groups and using an interview tool that was based upon and developed from my initial analysis of the focus groups. I considered that this would have placed me in a prime position to approach the interviewees with truly key insights and areas to explore, prompted by the range of issues identified from the focus groups. I was therefore convinced that I would not be covering 'virgin territory' as was the case with the focus groups; most of the key discourse would already have been comprehensively constructed in the groups, with the interview being a significant opportunity to clarify this discourse as part of the triangulation strategy. This may have been a significant and risky assumption, as it may have restricted the potential for data generation. In the end, it proved to be a calculated risk that was thoroughly mitigated by the extent and richness of data resulting from the interviews and which I considered as ample for the remit of this study.

### **3.6.3 *Additional Methods that could have been considered for this Case Study - Observation and Use of Documents***

Although the constructs which frame this study are patently abstract, their influence affects what practitioners do and not only what they say or discuss in focus groups and interviews. Information about the realities on the ground of professional practice constitutes a source of naturally occurring data and the potentials for tapping into this repository, is quite obvious. The main area of interest is *observation* of the practitioners in the natural setting of their clinics. From a purely objective standpoint non-participant and, perhaps the more challenging participant observation, would seem to be the most natural, even critical, options to marshal evidence for this case study. In reality, one is

faced with numerous pragmatic considerations that strongly discourage any initiatives which involve observation.

The work force of occupational therapists in Malta is relatively small and has been constituted, starting from around the mid-1970s, but the majority of practitioners qualified after the late 1980s. Most practitioners have been either my colleagues in one or a number of settings, or former students of the courses which I have led. This is quite a formidable realisation that could render non-participant observation awkward and fallacious as a source of evidence in the form of 'unselfconscious' or normal human performance - a far cry from any pretensions of naturalistic inquiry. Participant observation would render the situation still more awkward, with the researcher previously known in headship positions, now contributing to the nitty gritty of the running of a clinic. I therefore considered this route as simply not a viable option.

An important source of data that could have potentially contributed an additional dimension of understanding to this case study was *documentary evidence*. Trying to identify the nature of documents that could be a source of evidence was the first step. Although already primed with obvious insight into the matter of the existence of such items because of my knowledge of the field, I adopted an objective stance in pinpointing them and envisaged sourcing such documents as position papers published by the local occupational therapy association, practice guidelines or some robust grey literature documents. The reality is that none of these exist or the little documentation that is available offers little scope for analysis. The next best option I considered was to review assessments used by the various practice sites selected for this study, as possible signposts or sources of evidence on the epistemology prevalent within local occupational therapy practice sites. However, the diversity of the nature of the assessments used and the latitude in practices of usage across the services, presented me with a whole range of challenges such as the following questions:

- How to analyse such diverse data sources systematically?
- How to account or factor in the diversity of usage practices between practitioners, possibly within the same practice sites?
- Could I subscribe to a recognised method of analysis?
- Was I in a position to contain and marshal the potentially very wide scope presented by this source of data?

Faced with these potentially daunting challenges of what documents to actually use and how to handle them, as well as time constraints, I decided to abandon pursuing this

alternative data source. At that point, I considered documentary evidence as being ill-defined, fraught and possibly disruptive on the progress of the research project. Consequently, it was ultimately because of the realities in the field, as well as pragmatic considerations that I decided not to pursue this additional avenue for investigating this case study.

Notwithstanding these reservations on accessing alternative sources of data, I feel that characterising the professional environment of occupational therapy could prove inadequate and / or incomplete if it is limited to the utterances and verbal elaborations of the participating practitioners from focus groups and interviews. Some tangible facts and figures about the service sites and the participants are essential to realistically portray the nature of the case being studied and its context. Full details of this are documented in the next chapter

### **3.7 Quality Issues: Reliability, Validity, Triangulation and Respondent Validation**

Reliability and validity are fundamental to the concept of generalisability of research, i.e. whether it is possible to apply the findings of a particular study to situations other than the specific sample and context being studied (Lewis, Ritchie, Ormston & Morrell, 2014). Thomas (2011a) argues that ideas of reliability and validity when applied to case study research are not of prime concern. He even goes so far as to advise case study researchers that they need not concern themselves with these constructs, since they are looking into the “particular rather than the general.” He is also of the view that the concept of validity has been transposed into qualitative research, in this instance case study, from “normative research” in a way which is contrived and aberrant, principally motivated to satisfy the compulsion to validate any research by the application of normative criteria.

Silverman (2011), although acknowledging the point made by the critics of a strict adherence to normative approaches, points out that the claims of qualitative research risk losing credibility if the expectation is to accept its findings “on trust” (p.353). He concludes that the value of qualitative research rests on how much it can stand up to the sort of critical probing that quantitative research is routinely subjected to.

Interpretive case studies such as the current project, subscribe to a constructivist epistemological paradigm (Denzin & Lincoln, 2011). Such a view deals with multiple and complex issues over which it is difficult to achieve a consensual view of what constitutes social reality, but this does not exempt the researcher from adhering to processes that are rigorous and ensure an authentic representation of the phenomena being studied.

The pursuit of quality in case study needs to go beyond merely intuitive stances born out of common sense, such as simple repetition of data gathering (Stake, 1995). Stake introduces the concept of triangulation as a premeditated strategy which validates data in case study research.

Yin (2009) characterises triangulation as the use of different sources of data which are made to converge in an effort to corroborate evidence in a case; it is the use of these different sources of data that gives this type of research its strength. Thomas (2011a) asserts that triangulation is, in fact, a basic prerequisite of a case study. The approach to triangulation proposed by different authors constitutes a certain latitude of interpretation. Yin (2009) distinguishes between sources of data that converge and non-converging sources, seeming to suggest that true triangulation is the product of the former. In her consideration of triangulation, Simons (2009) states that it is equally important to explore different viewpoints and “how these do or do not intersect” (p.131) since the arena of social research acknowledges the existence of multiple constructed social realities.

The point of departure of the design of this research has been the idea of triangulation directly derived from the rationale underpinning the methodology used. Methodological triangulation is being employed by making use of the different methods to gather data, already amply discussed elsewhere in this account. Although the argument may be considered spurious, another strategy which allows triangulation of data can be attributed to the conduction of a second round of focus groups in each of the practice sites involved.

Another means by which validity was addressed was by instituting member checking and respondent validation. The former was carried out by submitting the transcripts of focus groups to the participants at the earliest time possible, in order to give them the opportunity to confirm that they have been accurately recorded. The analysis of the groups was shared with them and was used as the focus exercise for the second cycle focus groups. This I feel addresses respondent validation.

### **3.8 Introductory Explications of the Overarching Reflexive Stance**

Introduced earlier in the chapter, I will now expand upon my view of the nature of reflexivity in research, specifically in relation to this research. Finlay and Gough (2003) describe reflexivity as “... thoughtful, self-aware analysis of the intersubjective dynamics between the researcher and the researched” (p.ix). The same authors also expound that reflexivity necessitates crucial self-reflection on how the researcher’s “social

background, assumptions, positioning and behaviour impact on the research process.” (Finlay & Gough, 2003, p.ix). Therefore, some of the author’s background has to be filled in as the point of departure for an explication of the reflexive position assumed in this study.

Being one of the earliest occupational therapists to be trained in Malta, although not going as far as to declare that I am a pioneer of occupational therapy, I can confidently declare that I have been witness to some of the more critical stages of development of this profession locally. My relative veteran status has afforded me a wide-ranging practice in the field and over the years, I have acquired a profound cognisance of the enduring issues of the profession, with an awareness of the complex aetiology of these issues. I have also spearheaded the introduction of the undergraduate occupational therapy programme at the University of Malta and consider this as a key development in the consolidation of this profession. This factor relates me to most of the participants in the study as a contributor in their education, whether directly or indirectly. My relationship to this research is quite deep-seated and brings with it profound foreknowledge with its potential biases and, more significantly, a possible acceptance of intractable long-established professional norms and the status quo. This situation risked precipitating a case of “blocked insight” (Finlay, 2003b, p.111), with some far-reaching implications, especially for my analysis. I am therefore very conscious of the fact that in order to maintain a dialectical openness with my data, I have to adopt a reflexive stance. Indulging in purely confessional writing (Harper, 2003) which I have done thus far, does not constitute reflexive practice; it is at best a sound exposition of insight into my positioning as a researcher in the field. Some indications of how reflexivity occurs in my research practice would, at this point, be in order after briefly considering what represents reflexivity. What actually constitutes reflexivity seems to be contented and the practice of it challenging (Finlay, 2003a), whilst its relationship to reflection is obvious. Reflection is thinking about something “which is a process that is distant and takes place after an event”, whilst reflexivity “involves a more immediate, dynamic and continuing self-awareness” (Finlay & Gough p.ix); it has been suggested that reflection and reflexivity are concepts on a continuum (Finlay & Gough, 2003).

Therefore reflection is a good starting point for reflexive practice in research. In my effort to build in reflection and reflexivity, I have resorted to the taking of field notes during and after data collection. I also frequently involve my supervisors by sending them feedback after key data collection episodes and seek their opinion on my analysis. Specimens of these are reproduced in Appendix 1 and Appendix 2. This has given me the opportunity to constantly return to my perspectives on data with new challenges that allowed me to

develop or change insights. Resorting to conducting two focus groups in each setting has also been key to revisiting viewpoints through exploring personal responses and interpersonal dynamics (Finlay, 2003a).

My view is that reflexivity is not a quality which can be prescribed as an add-on to a research project. It should be a *constantly informing special awareness* the researcher has about every aspect of his/her research - which nominally includes his/her motivations and preconceptions - that is an over-arching and underpinning quality. This should be coupled to an openness to re-evaluate strongly held positions and the possibility of change and growth. I believe that I have been sufficiently open to adapt my approach to various aspects of this research and I responded to the requirements of generating significant data and later to frame it in the analysis, and subsequently the interpretation and discussion.

### **3.9 Summary and Conclusion**

In this account, I have outlined the building blocks of the methodology of this research. First, I illustrated the scope and purview of this investigation, next I proposed semantic clarifications of the concepts underlying the research question and objectives. The epistemological perspective was also clarified and linked to the choice of qualitative research approach. I then articulated how this informed my choice of data collection methods. I concluded this chapter by looking at quality issues around the concept of triangulation as it was applied in this case study and some introductory reflections on the adoption and development of a reflexive stance.

In the next chapter I will give a detailed account of the actual enactment of these theoretical proposals in the field as I set about and proceeded with the data collection. The choice to articulate my methodology effectively over three chapters might be considered as contentious or indulgent, but I feel that this was the best strategy to underscore the trustworthiness (Ballinger, 2006) of this research as it allowed for the careful recording of the development of my thinking around data collection and the concurrent and, eventually, final analysis of the data.

## Chapter 4 Details of Fieldwork Issues and Methods

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### 4.1 Introduction

The purpose of this chapter is to seek to recreate the real-life context and setting of this research, as well as illustrate the details of fieldwork and data collection methods. The intent is to ground the theoretical constructs outlined in my methodology chapter in the reality of the service sites and participants that form the ecosphere of this case study, and how the study evolved and progressed. This research, having much to do with a specific professional environment necessitates a strong element of scene setting, which will effectively be attempted here.

Ballinger (2006) suggests that a source of trustworthiness is 'thick description,' where extensive details are given about the context and the participants of the research and this is what is effectively depicted in this tract. This chapter also conveys an element of the reflexive dimension which has informed each phase of the data collection. The areas discussed include these four major sections: *detail concerning access to settings and participants, including access and ethical issues; data collection by means of focus groups; data collection by means of in-depth interviews; temporal and contextual issues surrounding the case.*

### 4.2 Details of Settings, Participants, Access, Recruitment & Ethical Aspects

#### 4.2.1 Choice of Participants and Sites; Initial Access to Research Environment

I start this account by clarifying my choice of participants and research sites. The research essentially needed to generate a snapshot of the profession of occupational therapy in Malta and also properly fulfil the requirements of a case study. To do this, I elected to study the experience of practitioners at different practice sites or services by making use of focus groups and interviews.

My awareness of the somewhat considerable disparities in service aims, means and delivery existing between the various public service sites, motivated me to adopt a data collection strategy that involved the majority of the main services. This I felt served as a

very representative cross section of the profession. My final selection included the following services:

1. Acute and hand rehabilitation service;
2. Mental health service;
3. Rehabilitation service;
4. Residential care service;
5. Paediatric service.

In an effort to preserve the anonymity of the research sites, I am using a descriptive term to identify the nature of practice, rather than the official national nomenclature or title for the service.

The different areas of practice on which I have focused represented the subunits of the case. It is for this reason that I have likened the structure of this study to the nested case study process (Thomas, 2011a) or the embedded case study (Yin, 2009). This implies a system of subunits fitting into the larger one and which gain integrity from the wider case, which is the occupational therapy profession (Thomas, 2011 a).

#### ***4.2.2 Participant Inclusion and Exclusion Criteria - Focus Groups***

A cogent rationale for the selection of the participants is essential to ensure that one of the fundamental sources of data in the study is fit for purpose. As a sampling frame, I devised nominal inclusion criteria in order to ensure that the participants taking part in the focus groups had the necessary background that would enable them to contribute rich and insightful experiential information about their area of practice. I therefore chose to include occupational therapy practitioners with at least a minimum of three years of clinical experience to participate in focus groups and in-depth interviews. This ensured that they had completed a two-year post-qualification practice rotation at the major service sites and, after being permanently posted, could count on at least a year of experience in a particular practice site. Participants who were excluded were those with less than a year of practice at their service site. The selection criteria for participants taking part in the interviews are discussed in section 4.4.2.

#### ***4.2.3 Establishing Nominal Characteristics of the Practice Sites in the Study***

I will now attempt to convey a basic description of the research milieu where this project was conducted, mainly looking at the sites and the participants.

Occupational therapy in Malta is provided principally by the Ministry for Health and is predominantly a healthcare concern. Although at the time of writing this report there were intimations of occupational therapy services being offered through other public service entities, such as education, the service remains firmly embedded in the health system and in the main is hospital-based. It was therefore by including these traditional major sites that I could research a detailed and authentic case study of the Maltese occupational therapy professional identity.

As was stated earlier, in order to preserve the anonymity of the sites and the participants, I will not be referring to the actual services by name, but will be identifying them by the type of services that these offer. An overview of these follows.

### **1. *Acute and Hand Rehabilitation Service***

The acute and hand rehabilitation occupational therapy services are located in the only general hospital on the island of Malta. This major medical institution caters for the whole range of medical and surgical specialities and occupational therapy fits within this provision. The principal therapeutic services are ward-based, but there are also very important outpatient hand rehabilitation and rheumatology services.

Short-stay admissions tend to predominate on the wards, and the emphasis of occupational therapy seems to lean towards early intervention and preparatory techniques (in preparation for occupational function), remediation of activities of daily living and the provision of aids and adaptations. Intervention at outpatients seems to be characterised by a predominance of physical modalities, exercise regimes, splinting, client advice and education.

### **2. *Mental Health Services***

Occupational therapy mental health services are based at the mental health hospital facility, which also offers services at several community psychiatric day centres and a short-stay admission unit based at the general hospital. Rehabilitation services are offered at all levels of the service. As described on the local website, health.gov.mt: "OT services are offered to young people and adults with psychiatric conditions, conduct disorders, intellectual disabilities, psycho-geriatrics and people with substance abuse" (Mental Health Hospital & Psychiatric Day Centres, n.d.). In this instance, services are both hospital and community-based. Practice seems to be patently occupation-based.

### **3. *Rehabilitation Services***

These services provide for extended stay admissions at a rehabilitation hospital, catering for diverse age groups and conditions, which include neurological, orthopaedic and general medical conditions. The practice environment is on a considerably smaller scale than that at the public general hospital and is characterised by the close working together of the different professionals involved in rehabilitation. Occupational therapy offers services both to inpatients and outpatients.

### **4. *Residential Services***

Residential occupational therapy services are based at a long-term care facility for an elderly population of clients. This is the largest facility of its kind on the island of Malta with a bed capacity of around 1,000. Services offered by the facility are principally ward-based, addressing a population of clients with various degrees of dependency. This can range from those who only require supervised independent living to those who are exclusively bed-bound.

### **5. *Paediatric Services***

The occupational therapy paediatric service is part of an interdisciplinary child assessment unit. A large part of what the occupational therapists do here is taken up by assessments. It is a strictly an outpatient-based service that is geographically and structurally closely allied to the rehabilitation hospital. The unit produces reports which are used for statementing purposes. It is also involved in the provision of individual therapy programmes and advises teachers, family members and professionals.

Table 4.1 illustrates the human resources available at each of the practice sites at the time that the research was carried out. Members of staff on rotation, staff returning to service after extended breaks and those recently transferred from another site were excluded from the focus groups, and were deemed as not having enough consistent exposure to the working conditions of the site. Occupational therapy members of staff acting as professional leads or Heads of Department were selected as key informants to take part in the interviews.

	HUMAN RESOURCE OUTLINE OF THE SERVICE SITES				
SERVICE SITE	NOTE 1*	NOTE 2	NOTE 3	NOTE 4	TOTAL
Acute Services	3	1	2	10	16
Mental Health Services	2		1	13	16
Rehabilitation Services	3		1	14	18
Residential Services	3	1	1	6	11
Paediatric Services	2		1	11	14
<b>LEGEND:</b>					
*NOTE 1	Members of Staff on Rotation				
NOTE 2	Staff Returning To Service or Transferred from Other Sites				
NOTE 3	Members of Staff in Administration (Professional leads or Heads of Department)				
NOTE 4	Members of Staff Eligible to Participate in Groups				

**Table 4.1: Human Resource Outline of the Service Sites.**

#### **4.2.4 Establishing Nominal Traits of the Participants**

It is beyond the scope of this study to give an outline of the professional background of each of the participants, simply because of the large number of practitioners involved. These ranged between a total of 38 in the first cluster of focus groups to 39 in the second; a grand total of 45 if the key informants are included (refer to Table 4.2). Having said that, it would much enhance the authenticity of this account if some basic information about the participants were to be given here.

Participants, with the exception of one, all qualified in Malta. They obtained their qualification mainly between the early 1990s to the mid-2000s, although a couple of the key informants who took part in the interviews had obtained their qualification in the late

1980s. A mix of educational backgrounds was evident; the majority had a B.Sc. as their basic qualification, while a number had a diploma qualification. An appreciable proportion also was in possession of a Master's degree, obtained either locally (not in occupational therapy) or in the UK. A number of the participants also had some experience practising abroad either as students when they had participated in the Erasmus exchange programme or as qualified practitioners taking part in the Leonardo EU staff mobility scheme.

#### **4.2.5 Participant Access**

Access to the practice sites had been sought through a first contact with the professional lead of occupational therapy services, whose preliminary approval paved the way for me to start contact with the heads of the department of the different services (Appendix 3). This process occurred in the early stages of the study, before the actual ethical approval was granted. After the ethical approval for the study was available (Appendices 4 & 5), contact was again made with the heads of department who furnished the lists of members of eligible staff. This method of access was more similar to a gatekeeper approach, cited by a number of authors (Webster, Lewis & Brown, 2014).

My position at the time as Course Leader and Head of Department gave me, I believe, not an inconsiderable advantage in my effort to seek out and recruit participants. This was due to the fact that most of the potential research subjects were either ex-students of course programmes which I had coordinated, or they had contact with me as students in one of the classes I taught, or they had undertaken fieldwork with me when I was a clinician. This included practically all the clinicians involved in the focus groups, as well as nearly all heads of service who participated in the interviews.

I am very grateful for the excellent cooperation that I met with throughout; although this was not without its anxieties owing to prevailing circumstances that had developed at the time of the data collection, which I shall outline at the end of the chapter. But all things considered, a potential hurdle that could have been posed by participant recruitment was, in practice, non-existent. Notwithstanding these considerations, my "special position" also had its potential downsides. Conducting research with a subject pool with whom I am so familiar and who may harbour deep feelings towards my persona - feelings borne out of the prolonged association with me as students, and which could range from respect in some or even deepest resentment in others – may throw some doubts about the authenticity and the naturalness of their externalisations and disclosures. Quite apart from these aspects there is my foreknowledge of the participants and the services

involved, and a level of pre-established expectations. Both those considerations necessitate a deeply reflexive attitude towards the data and its examination.

Brewer (2000) cites factors such as location of the research, sensitivity of the subject being researched, as well as the “nature of interactions between the researcher and researched” (p.127) as necessitating a “critical attitude towards the data” being generated. Reflexivity is a part of ensuring the legitimacy of the data (Brewer, 2000) and perhaps by extension, its validity. Specific reflexive tracts applicable to this research will be regularly articulated in the ensuing sections of this chapter. Some of the concerns about validity were addressed methodologically and a priori.

Creswell (2007) suggests caution when researching so close to one’s professional milieu or organisation and recommends “multiple strategies of validation” (p.122), in order to ensure that the account of the case is “accurate and insightful.” The design of this research offered ample strategies which contributed towards engendering authentic insights. Firstly, it involved a wide stratum of occupational therapy clinicians from the five sites mentioned earlier. This has included a sizable and representative sample across these specialisms. Secondly, the fact that two focus groups were conducted at each of the services involved, gave me more than ample space for validation and the sourcing of different perspectives. Another data source for this research was the use of interviews with key informants. The participation of all the heads of department contributed towards this end and helped to provide a different perspective on the issues of professional identity.

#### **4.2.6 Number of Potential Participants and Extent of Participant Response**

As has been stated earlier in this chapter, my inclusion criterion was clinicians with at least a year of practice history at the particular service site. This could be construed as a very unspecific criterion with a potential to attract a large number of participants possibly making the conduction of the focus groups unwieldy.

Krueger and Casey (2009) seem to advocate that groups for non-commercial purposes should be limited to between five to eight members, as groups which include 10 or more participants could prove difficult to control and may not allow participants the chance to contribute perspectives and insights. Bloor *et al.* (2001) suggest that it is a common method in focus group research to seek “over-recruitment” in case there is a limited turnout of participants. Although I was observing these points on recruitment, I was also conscious of the potential of the feelings of resentment that I may engender if, unwittingly through some ill-considered criteria for inclusion, excluded some of the established members of the profession. But I had to draw a line somewhere and decided to exclude

staff members on rotation and also those returning to service; basically staff who had been posted to the site for less than a year and therefore not part of the established workforce. I felt that inclusion of these would have weakened any argument that I could have made to support that my inclusion criteria were based on a carefully thought-out rationale. One factor which had reassured me that the groups would not be especially bulky was the fact that the Maltese occupational therapy workforce was relatively small and would not have yielded unmanageable numbers for the groups if one were to consider that a percentage of clinicians would not be interested in participating.

Table 4.2 gives a basic impression of the extent of the participation of staff in the groups. Generally, I achieved a good level of participation across the different services settings. Although I can only speculate about the reason for this positive turnout, my strong feeling is that professional identity in occupational therapy is an issue which has profound resonance with the Maltese workforce. As can be appreciated from the tabulation, there were instances when the size of the group was rather challenging, specifically in the second group at the rehabilitation service and the second group at the paediatric facility. Impressions of the groups will be given in the ensuing sections.

Service Site	No. of Eligible Members of Staff	Members of Staff in First Group	Members of Staff in Second Group
Acute Services	10	10	7
Mental Health Services	13	7	3
Rehabilitation Services	14	9	12
Residential Services	6	5	5
Paediatric Services	11	8	11
<b>Totals</b>	<b>54</b>	<b>39</b>	<b>38</b>

**Table 4.2: Number of eligible members of staff and participation in focus groups.**

#### **4.2.7 Ethical Approval and Recruitment**

Ethical approval for this research was granted by the Research Ethics Committee of the School of Health Care Sciences at Cardiff University where I was registered for my doctoral degree, and by the University Research Ethics Committee of the University of Malta, where I hold my post.

The process of eliciting permission for this study was elaborate, especially applying for the local REC approval, as this necessitated that I obtained permission from the data protection officers of the five practice sites. I also had to negotiate access to the participants from the professional lead of occupational therapy services and five heads of department who effectively acted as gatekeepers. I have adopted a process of seeking informed consent from the subjects 'in stages.' After I obtained the list of emails of eligible participants, I proceeded to send out the briefing material and consent forms via email. Next, I asked permission from the respective heads of department to attend one of the weekly staff meetings where I gave a presentation to continue to explain the purpose of the research, what participation would entail and the value it would have for the profession and the benefits that participants might gain from taking part. Most of the eligible participants submitted their consent form during the meeting; others tendered theirs at the venues of the focus group. A copy of the participant information sheet and the consent form can be found in Appendices 6 & 7 respectively.

Some of the limitations of the process of informed consent described in the previous chapter are being specifically applied here: eligible staff in each of the sites have taken part in two focus groups which allowed for a potentially wide ranging discussion to develop around the topics of professionalisation and professional identity. This inherently carries with it the possibility of issues developing which could not be completely predicted at the time of inviting the participants. Although it has to be clarified that throughout the data collection, the discussions generated in both the groups and the interviews had not veered into specific exposition of treatment of clients and work conditions, but were circumscribed to the discussion of the topics of professional identity, as experienced personally by the participants or in relation to other professions. This was very much close to the premise of the ethical 'pledge' that I had expressed in my official ethical applications and therefore, in practice it was not a source of great concern. This could be attributed to the fact that the focus group and interview guide were constructed around definitions of professional identity, which may have contributed to delimit discussion.

The fact that I have carried out member checks and shared my analysis with the participants, has given them the opportunity to confirm that they have been fairly and authentically represented. Anonymising the practice sites involved in the study also has its limitations within the Maltese setting, as all these sites are unique and will inevitably be recognisable from a report notwithstanding efforts to preserve anonymity.

The occupational therapy service sector in Malta is quite small and the allocation of personnel in the workforce is generally also quite well known. This, again, to some extent weakens strategies adopted to anonymise participants. Any major research in Malta with a small workforce will have to face these challenges, so the current study should be within the 'safety ethical net' achievable given the prevailing conditions. I have discussed these points with participants and they have not been unduly concerned with this issue.

It is significant to note that the participants had previously taken part in focus groups and interviews discussing issues concerning professional identity and professionalisation. These are fairly abstract concepts and there was no evidence of psychologically untoward consequences precipitated by their discussion, although strongly held positions and emotionally loaded reactions could have been engendered. It is therefore reasonable to conclude that these do not constitute any risk of harm, but are part of normal conversation. Therefore, subjects were not being exposed to any inappropriate risks.

This section has overviewed details concerning characteristics of the sites and participants, as well as the processes involved in accessing the subjects and obtaining ethical approval. The ensuing section will consider aspects of data collection through the focus groups, highlighting some of the crucial decisions and processes adopted, together with the rationales which have underpinned these choices.

### **4.3 Processes of Data Collection: The Focus Groups**

#### ***4.3.1 Some Considerations on the Use of Focus Groups in Organisations***

The use of focus groups in this research was similar to those described by Krueger and Casey (2009), although I believe that these authors had a different organisational environment in mind and were making their considerations with a rather different cultural mind-set. Their overtly cautionary tone gives the impression that they were thinking of a private concern where competition between members of staff and respect for the organisation seems to be the order of the day. This could be quite different from the situation in a public health profession, where staff on a permanent posting arrangement may be less cautious when talking about their organisation and issues of competition are of a rather minor concern. According to these authors, focus groups in organisations can prove challenging since these may not be conducive to encouraging colleagues to be honest and accessible about their interests. With hindsight, I feel confident in declaring emphatically that this was not the case in this study, as will be evidenced later

in the analysis. Staff members have not been at a loss to express their interests in the subject, as well as voicing their concerns. Although there was considerable variation across settings, my impression, borne out by the transcripts, is that focus groups have been an excellent choice to tap into professional identity issues.

The focus groups consisted of members of staff who at the time were practising clinicians assigned with identical responsibilities and none of whom occupied staff administration positions. This ensured that there were no hierarchical concerns or a “power differential” (Krueger & Casey, 2009, p186) which could have inhibited or put participants under duress. Working with what could be considered as pre-existing groups may have caused some challenges with deciphering some of the shared ‘group speak.’ My previous experience as a clinician and also manager of an occupational therapy service working with staff groups helped me to overcome these semantic barriers which I occasionally experienced in the analysis. But, I also feel that I had the additional advantage of holding two focus groups at each site and this afforded me ample opportunity to clarify linguistic ambiguities that this group speak may have generated by simply asking participants to explain what they meant. I was also careful not to rely exclusively on these and my interpretations, and cross-checked such instances with key informants during the interviews.

In contrast to Krueger and Casey’s cautionary stance on the value and use of pre-existing groups, others have found positive points to make on established groups which find clear analogies with this research. For example, Kitzinger (cited in Bloor *et al.*, 2001) feels that working with pre-existing groups can provide the social context where “ideas and decisions are made” (p.22).

Bloor *et al.* (2001) also note the practical advantages of using pre-existing groups and this has proven to be very much the case with this research: it was relatively clear-cut how to best organise the groups given that most participants were located at a specific work site (with the exception of Mental Health). Generally this may have also contributed to relatively contained attrition rates, as I was always on the lookout to organise the groups at the most opportune times, such as after a staff meeting.

Farquhar and Das (1999) suggest that focus groups with pre-existing groups can facilitate the disclosure of sensitive information particularly that which is felt stigmatising. The authors maintain that this is the case because focus groups entail disclosure, not just to the researcher but also to group members and, in the case of sensitive issues this can be much facilitated if the participant pool is from the same social membership group.

Although it can be considered a bit of a stretch to consider professional identity as a highly sensitive issue similar to what the authors had in mind, the social mechanisms in operation could very well apply for this research and could have facilitated frank and uninhibited externalisations from the participants.

One major drawback is the 'taken for granted' or 'obvious' factor which can be an inherent characteristic of a focus group carried out with a pre-existing group of colleagues (Morgan, 1997). This has the potential of leaving out valuable insights and information and it is a factor which I have been very mindful of throughout my data collection and analysis. I shall be dwelling on this point later as it has been a major influence on the progress of this research, notably progress to the second set of groups.

Another not insubstantial source of concern was confidentiality. As I have alluded to previously under ethical considerations, within the Maltese practice environment each setting is unique and identifiable and by extension, the identity of the practitioners associated with it can quite easily be identified, especially through the citations used to illustrate results and analysis. This was a concern especially at the beginning of the project, when I was envisioning separate analytical tracts for each practice site. But as my data collection progressed and I discussed my plans with my supervisors, I gradually moved to an analytic strategy that is represented through the emergence of overarching themes that blend the perceptions of participants across sites. This minimises the risks that quotations from the groups can be ascribed to a particular practice site and, by extension, the participants working at those sites.

### ***4.3.2 The Enactment and Conduction of the Groups***

The focus group strategy adopted consisted of an initial five groups carried out at five major occupational therapy practice sites in Malta. This first set of groups was transcribed and analysed; details of this analysis will be considered later in this tract. Subsequently, another series of groups was undertaken at the same sites and with the same participants, with the intention of seeking further clarification of issues which had been generated by the first group discussions.

#### ***4.3.2.1 Designing the Focus Groups – Basic Underlying Concepts***

The major influence underpinning the design of the groups was specifically the research objectives of the project, as translated into practice by my reading about focus group preparation and principles from the major literature sources. It would be well beyond the scope of this particular section to describe the ontological underpinnings of the aims of

this research, which have been comprehensively discussed in the literature review chapter, but I will reiterate that the theoretical points of departure were conceptualisations around social science of professions. I was principally looking into eliciting discussion around these four major areas in relation to the occupational therapy profession: *the articulation of professional identity; development of professional identity; uniqueness of professional identity; professionalisation / professional status.*

At the foreground of my thinking were also operational definitions of professional identity and professionalisation. These helped to focus my inquiry to basic essential concepts that were a prevalent influence during the focus group inquiry, slightly less so during the interviews. The definition of professional identity was adapted from discourse that originated from Kielhofner (2004) and is exemplified as follows:

*“Professional identity is the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity.”*

In the case of professionalisation, the concept is both ill-defined and circumscribes a vast array of discourse from social science literature. I have opted for an adaptation from Witz (1992), which I have articulated as follows:

*“Professionalisation is the process which an occupational group undertakes to consolidate its status in society and becomes recognised as a member of the established range of socially identified professions.”*

The term ‘recognised’ in the above definition makes the connection with identity. I feel that there is an inextricable, obvious but perhaps difficult to articulate linkage between the two. As I suggested in the introduction chapter, professionalisation was more a foundational and very influential concept, but ultimately the evidence generated for this thesis was around professional identity.

My pursuit to devise these two operational definitions was on account of the fact that I wanted to ground the focus group discussion around concepts which the participants can readily identify as well as identify with. These definitions were presented to the participants and used as the basic focus group discussion triggers in the first round of focus groups. I felt that trying to instigate a discussion simply by presenting the terms ‘professional identity’ and ‘professionalisation,’ without providing some nominal definitions could have potentially stalled the groups as the participants would have been faced with two clearly abstract and ‘dry’ terms. A possible downside to this was that

conceptualisations around the basic issues of this research were somewhat outlined *a priori* for the participants as these were semantically circumscribed around these definitions.

Starting from significantly established theoretical positions with respect to the area of study - this was after all one of the premises for selecting a qualitative case study methodology – had also prompted me to adopt a more structured approach for the groups. This I tended to align with Morgan's (1997) recommendations for a structured group with a high level of moderator involvement. Although I have to clarify that throughout the most part of the conduction of the groups, I balanced the underpinning agenda of the data collection with a more facilitatory role, since I wanted to elicit interactions and group norms (Bloor *et al.*, 2001), of which, I believe, shared professional identity is one. Therefore, the definitions and objectives of the research that formed the agenda of the inquiry were merely the starting points for the group discussion.

#### 4.3.2.2 Number of Groups

The guiding assumption which has underlined the choice of the number of initial groups has been quite amply discussed, and that has basically been the requirement to deliver a faithful and comprehensive picture of the occupational therapy professional environment in Malta. This has resulted in an initial batch of five groups - one for each of the selected service sites. The rationale for reconvening all of these five groups was principally an effort to clarify ambiguities and possibly follow up on areas which had not been discussed in the first group (Bloor *et al.*, 2001).

Morgan (1997) maintains that holding just one group could be a source of confounding data since it could prove difficult to ascertain whether group discussion content was the result of group dynamics or represents authentic substantive data. Conducting two groups in each site therefore afforded opportunity to determine whether certain data could have been the result of vagaries of setting or chance. Although the issue of data saturation is another determinant of how many groups need to be conducted, in this case, since the design was around the tenets of case study, I did not consider it a *sine qua non*, validation being principally ascribed to the inherent qualities of triangulation that this research design was set out to do. A limitation on the number of focus groups possible was also occasioned by the time limits involved, potential logistical challenges and possible participant exhaustion which could have occurred if more than two groups per site were attempted.

#### 4.3.2.3 Location and Timing of the Groups

All 10 focus groups, with just one exception, were held at the service sites. The only group not held on site was the very first one involving the acute practice service, which was conducted in the Faculty of Health Sciences Boardroom. In reality, this did not constitute any inconvenience to the participants because the Faculty premises are located on the grounds of the public general hospital, effectively upstairs from the occupational therapy department in question. The Faculty Boardroom just happened to be available at that time and was an excellent setting if, perhaps, a slightly formal one in terms of seating arrangements.

As a policy I did my utmost in order to accommodate the participants and generally speaking, I could always count on good locations where to hold the focus groups with instances of minimal to moderate environmental intrusion. Although I offered to take the initiative of finding space for the group sessions by inquiring with administration of each setting, the participants were very supportive and most of the time they identified and booked the rooms for the groups. Most of the times we used small conference rooms or staff meeting rooms. I am confident that these were conducive to the conduction of group sessions. Groups were held towards the end of the working day and this may have contributed to the, generally, high participant turnout.

#### 4.3.2.4 Practical Execution of the Groups - Preparation

The practical guidelines given by Krueger and Casey (2009) were invaluable and I have developed my focus group procedures based on the detailed information which these authors provide. The enactment of the groups has necessitated quite profound mental preparation. A morning or afternoon was always set aside prior to the scheduled group, where I could revise the group guidelines, the questioning style, the stages of the group session, as well as a quick re-familiarisation with the broad aims and objectives of the research.

As Krueger and Casey (2009) succinctly put it, the moderator cannot simply be an “empty vessel” (p.90) recording the comments of the participants. Through my preparation I have sought to develop the skills of “listening and thinking” (p.90). This was pivotal in ensuring that I was receptive of the direction that the group discussion was going and this also made me conscious of whether the main areas of the inquiry had been covered.

#### 4.3.2.5 Procedure of the Execution of the Groups

I opted for a more or less standard way of organising and conducting the groups. This I had fully mapped out and articulated on paper for the first focus groups. I always preceded the actual session by an informal chat accompanied by refreshments. I made it a point to ensure that some choice sweet snacks were in good supply to help 'energise' the discussion and make the proceedings generally more palatable. I hate to think that this acted as an incentive for the participants to take part in the second groups, but perhaps it was the case!

After the refreshments, I read through the set of ground rules I had prepared for the participants to follow, which I had adopted from Krueger and Casey (2009) and these were as follows:

1. This is intended to be a discussion and so please do not wait to be invited to participate.
2. There are no right or wrong answers and everyone's perspective is of interest and important.
3. There may be different points of view or experiences in this group, but please feel free to say what you think, and to agree or disagree with other participants.
4. Please, at all costs, do not talk at the same time as it would very difficult to transcribe the group.

These tended to invite the development of a rather expectant, charged and quite formal atmosphere, which I tried to dispel as best as I could. Unfortunately my relationship with the participants as former course leader may not have helped in this regard. I can report that generally the groups became much less formal as the discussion developed and I made sure that all participants were involved and prompted to contribute.

Following the review of the ground rules, I briefly introduced the research and then launched into the focusing group exercise. Bloor *et al.* (2001) suggest that a focusing exercise need not take the form of a question. In fact, I asked the participants to reflect on the operational definitions described earlier. These were presented to each on two A4 printed sheets. They were then invited to talk about their experience of professional identity as occupational therapists, which acted as the topic opener. This helped to set the tone of the group and initiate the discussion. The session was then developed

around four key questions (please refer to Appendix 8 for a copy of the focus group guide tool):

- How do you express (articulate) your professional identity as occupational therapists?
- What factors do you feel have contributed to the development of your professional identity?
- How is your professional identity unique / specific / distinct?
- How do you see the status of the occupational therapy profession in Malta?

The language used during the group meetings was another factor which merits discussion here. Maltese professionals are notoriously bilingual shifting continuously from the Maltese language to English within the space of a sentence. I was conscious of this and encouraged participants to use whichever language style they preferred. They also had the option of using just the Maltese if they preferred, although I was always using English during my interactions with them. With the knowledge that the profession is taught in the English language, using English language text books of either US or UK origin, and with the knowledge that all documentation is carried out in English, I have to confess some profound misgivings about hearing articulations on professional identity and professional issues in Maltese. But I felt I did not have a choice and it would have been rather inappropriate, too dictatorial and certainly not naturalistic to insist that English was used exclusively. But the use of Maltese to express concepts for which there are no equivalent or proper Maltese terms, has, on infrequent occasions, presented some challenges and conundrums in the analysis.

#### 4.3.2.6 Recording and Transcription of the Focus Groups

The best method of capturing the group discussion is by audio recording (Morgan, 1997). Although I had little control about where the groups would be held, I made sure that I could rely on the best equipment to audio record the group meetings. Two small but very powerful digital recorders were always on hand and this ensured that I had a crystal clear record of the group and a back-up device in case of malfunction.

At the beginning of the groups, the participants were asked to introduce themselves and also talk about their work, so that the transcriptionist could count on some extended passages of speech where the participant could be clearly identified. Occasionally, I

would call out a participant by name during the group for the sake of helping the transcriptionist. Although I was mindful of the fact that this might have made some participants rather self-conscious, the fact that there was a high level of trust and that this was a group of colleagues, I felt reassured that any feelings of awkwardness were amply mitigated. It is a well-nigh impossible or self-defeating a task to be the moderator and the researcher without any assistance, and attempt to take down notes during a group consisting of ten highly participative members, but I did take some notes of points I wanted to elaborate upon at opportune times during a group. But it was a truly challenging task. This is one strong justification for having a detailed transcript created for each of the group sessions, which is what I relied upon for the research.

Gibbs (2007) suggests that in certain situations, the researcher can opt for a draft record of what people have said or even resort to use a gist transcription. Krueger and Casey (2009) mention the possibility of working with abridged transcripts of focus groups, but point out that these would have to be produced by someone who has a profound understanding of the purpose of the study. This research was concerned with developing an understanding of the professional world of the participants based on a “systematic analysis” of data (Bloor *et al.*, 2001, p. 42). This could only have been achieved by using the full transcripts. Considering the scale of the data collection that was involved, the paucity of my typing skills and the fact that I was doing research on a part-time basis, I simply could not conceive of doing the transcripts myself and I had therefore enlisted the assistance of a professional transcriber. This has delayed the time I could embark with the analysis to a certain degree, but it was a compromise that was unavoidable.

### **4.3.3 Analysis of the First Focus Groups**

#### 4.3.3.1 Pre-Analysis Reflections.

Dealing with focus group data is effectively managing a potentially enormous body of information that needs to be analysed in a systematic, consistent and verifiable manner (Krueger & Casey, 2009). Although I had previous experience analysing interview data for my Master's degree, working with groups presented a challenge in an altogether different order of magnitude. Furthermore, the fact that I was investigating an environment with which I was very familiar, both in its superficial presenting attributes as well as its less explicit underlying intricacies, necessitated a profound act of reflexivity on my part in order for me to become attuned to the implications of my position. But more than reflexivity, I had to overcome a potentially blocking perception engendered by having to investigate the fabric of my normal surround – the reality that I, more or less,

deal with on a day to day basis, where ideas, beliefs and processes are taken as a given and unquestioned. Given, taken for granted notions and normality, although repositories of so many levels of reality and meaning, are not immediately amenable to yielding a deeper understanding by virtue of the fact that these constitute one's backdrop and permanent frame of reference. I believe that this has been the case in the initial phase of the data collection, most specifically the *very first group*. This condition may have been compounded by the fact that I was not doing the transcriptions and had to wait for a while before these were available. The necessary analytical markers finally emerged as I made myself familiar with the content of the transcripts reproducing in detail the discussion in the groups and also as a result of debriefing by my supervisors. But this situation somewhat altered my data collection plan.

My initial plan was to conduct a group related to a particular service site, analyse it and proceed to carry out the second group based on the analysis. But because the initial analysis process was proving to be protracted, I was risking stalling the data collection. I therefore decided to continue with the whole sequence of first groups. I feel that this does not affect the quality of the data collection, after all the sites had been considered as subunits of the whole case and conducting the first wave of groups without an intervening analysis contributed to viewing them on 'equal footing'.

#### 4.3.3.2 The Logic and Mechanics of the Analysis

The analysis and interpretation of data in this project were based on the convergence of three sources of 'raw material': supervisor debriefing, field notes and verbatim transcription of the focus groups. I tend to identify two phases of analysis in this research. A first 'rough and ready' phase that enabled me to carry out a preliminary analysis before undertaking the second cluster of focus groups and this is what is described in this chapter. The second and what I consider to be the definitive analysis, involved all the data sets and constitutes the real watershed event of this research. That is described in the next chapter and I consider it a phase that although had started during the fieldwork, but was a fairly dramatic phase of realisation which I effected after a process of considerable familiarisation with, reflection on, handling of and reduction of the data.

Krueger and Casey (2009) claim that the presence of the analyst in the groups gives a sense of the "energy, passion, emotion that doesn't come through the transcripts" (p.124). Having conducted the groups myself, I can count on the advantage that the authors mention and I have often recorded this in my field notes and conveyed it in peer debriefings. Nevertheless, I cannot pretend that the bulk of my analysis, as alluded to in

the previous paragraph, is not based on the transcripts. Frankland and Bloor (1999) claim that not relying on transcription runs the risk of forsaking the main benefit of groups which is the “richness and complexity of the responses of group members” (p.144), which is obviously best captured by the transcripts. Relying on field notes and peer debriefing could result in selective attention and recollection of certain data and the possible neglect and exclusion of other significant ones (Frankland & Bloor, 1999).

Subscribing to an explicitly stated analytical strategy was a considerable source of reflection and tension for me, brought about by a number of factors. And this is also why I refer to a ‘rough and ready’ strategy during the first phase. The case study methodology, as articulated by its main proponents does not come with unequivocal specifications for the analysis. No doubt this is down to the fact that it allows for a flexible use of methods. But close scrutiny of the authors’ writings does yield some ostensibly irreconcilable positions. Simons (2009) appears to harbour strong misgivings about the use of grounded theory in case study research – this has been discussed elsewhere. On the other hand Thomas (2011a) sustains that the use of the constant comparative method is the “basic method of interpretative inquiry” (p.171) in case study. Gibbs (2007) cites the constant comparative method as one interpretative method in grounded theory, which would, by extension, put Thomas in a rather conflicting position with Simons’ views. I also have to confess an initial reluctance to adopt a wholesale coding strategy for the focus groups, a position strongly motivated by voluminous reading around case studies and focus group literature and what I noticed in these sources as a prevalent tendency not to spell out a specific analytical-interpretative stance. I was envisioning a way of analysing and interpreting the groups without resorting to fracturing the transcripts into codes as I thought that this would divorce me from the immediacy and authenticity of the groups. I was also reluctant to create what I felt could be aberrant abstractions about a world I knew and understood so well.

In my analysis of the first focus group I found the indexing system devised by Bloor *et al.* (2001) perfectly fit for my purposes, but I felt that the analytical induction and logical analysis which the same authors prescribe for the analysis of groups rather uncongenial. Eventually, I was using a system of coding and memo writing, a process absolutely analogous to the constant comparison method. This will be discussed in more detail in the next chapter when the second phase of the analysis is illustrated. At this point, it would be significant to clarify some terms of reference and some of the mechanics involved in the analysis.

Gibbs (2007) defines coding as the “process of identifying passages that exemplify thematic ideas and give them a label” (p.31). Memos are described by the same author as “analytic thoughts about codes [that] provide clarifications and direction during coding” (p.31). Writing tentative or provisional memos has really contributed to unblocking my perspectives and aided me to progress with the accumulation of insights from the data of the groups. The analysis of a group entailed, nominally, familiarisation by a number of cycles of reading and memo writing on the electronic documents. Field notes, supervisor debriefing and reflection was also crucial in the development of the explanatory memos. On average, transcripts were reduced to around 50% of their original length, by a process that condensed them to just the coded passages and accompanying memos. The thematic analysis would eventually yield an index of codes supported by citations from the participants’ speech and accompanied by tentative explanatory memos.

#### ***4.3.4 Reflexive Impressions Accompanying First Tranche of Focus Groups.***

I feel that I can state with considerable confidence that the first wave of groups generated an abundance of information. The bulk of this data I can look upon with a researcher’s dispassionate detachment. I could also see it being externalised with only the most nominal stimulus on my part as transmitted through the apposite focus group tools that I used. There is much information that I do not see myself embedded in or which bears any reference to my presence. But there was also a fair amount of ‘stuff’ which, on first encounter, was rather disturbing and dispiriting, having to do with the state of development and influence of the profession of occupational therapy in Malta in certain areas. For someone who is so passionate about the profession this was occasionally rather demoralising. It was counterbalanced by more positive and encouraging findings from other quarters, and this has served to alleviate a sense of ‘precariat’ or tenuous professional work, which was occasionally conveyed. I feel that it is premature to reveal these aspects of the findings at this stage without having a foretaste of the whole picture, but from a reflexive standpoint the information I have discussed here has considerable value in portraying some of the concerns that I faced during my fieldwork and initial analysis.

Another issue that emerged during the focus groups was discourse around factors influencing the development of professional identity. This was one of the focus group questions and the response it generated from the participants and my reaction to this response, especially merits consideration from a reflexive standpoint. This issue frequently brought with it references to the course programme and undergraduate training at the university. These were veiled and sometimes quite direct references.

My natural inclination was to clarify and get involved in the argumentations developing. I have to admit that I had to apply strong inhibitory 'brakes' not to get involved and unwittingly generate data extraneous to the participants' experience. There were moments when I could not completely subvert my natural reactive inclinations to supply an answer. In the more reflective, deliberate pace and isolated psychological mind-set of the analysis, I can report that I was free from these constraining issues. The analysis is a process less assailed by difficult-to-guard and deep-seated psychological reactions which could occur during fieldwork interaction.

#### ***4.3.5 Progressing to the Second Set of Focus Groups***

Key to my progress to the second series of focus groups was my sense of confidence in and completion of a basic analysis of the first groups. It was only in this way that I felt that I was 'adequately armed' with the necessary foreknowledge to fashion effective focus group triggers for the second groups. The cognitive step involved in my progression to the second groups is inextricably linked to the issues which were discussed earlier under *Pre-analysis Reflections* and *The Logic and Mechanics of the Analysis*, especially my experience with the analysis of the very first group which I had conducted at the acute hospital. Furthermore, I had found planning for the follow-up group at the acute hospital a bit of a challenge because the first group had consistently given me the impression that it was very comprehensive in terms of content, as well as my understanding of it. I therefore had to overcome this strong sense of completion. But after I had been through the first analysis and much reflection, I felt that I had developed enough insights to allow me to undertake the second group with confidence and based on a considered rationale. I eventually decided to enact the second group at this site based around a tripartite inquiry, which effectively became a template for all the second set of groups. This tripartite approach can be described as follows: in the first part of the follow up group, I reviewed the salient themes that had emerged from the first focus group; next I explored professionalisation issues, which I felt were not addressed specifically in the first group; finally I returned to the issue of professional identity, but anchoring it around the concept of occupation by means of a focus exercise. A detailed record of this is recorded in Appendix 9. Specifically, the template adopted flexibly for the follow-up group at the acute setting can be found in Appendix 10.

##### ***4.3.5.1 Thematic Areas Explored in the Second Focus Groups***

Although I believe it would be premature at this point to reveal the first phase and somewhat inconclusive intimations of analysis, derived from the initial coding and memo-writing, I also feel that it is rather important to record some of the areas that were the

impelling concepts driving the second wave of focus groups. Looking at some of the themes also gives an initial flavour of the findings of the study and the issues characterising the sites. I have briefly overviewed some of the themes associated with each practice sites that I sought to explore further in Appendix 11.

#### ***4.3.6 Summary of Discussion on Fieldwork Issues Related to Focus Groups***

The foregoing sections have overviewed key facts about the putting into practice of the data collection method using focus groups. The account also included reflexive articulations specifically related to the analysis, the process of developing insights to progress to the second set of groups, as well as about instances related to the fieldwork. The following section details the rationale and implementation of the second major data collection method of this project, which was the use of in-depth interviewing.

### **4.4 Processes of Data Collection: In-depth Interviews**

#### ***4.4.1 Significance of the Use of Interviews in this Study***

The interviews were planned to be used as a data collection method from the outset as part of the case study methodology, which had been adopted as the founding framework of this research. The interviews were not part of a strategy of theoretical sampling (Charmaz, 2011). They were intended as a means of reinforcing the strength and validity of the data collected from the focus groups and served to introduce alternative and corroborative perspectives in the study as a means of triangulation. The facets of triangulation have been amply discussed in the methodology chapter, suffice to reiterate here that it is one of the strategies associated with case study method (Thomas, 2011a).

Braun and Clarke (2013) claim that triangulation is a way of capturing the many “voices” and “truths” (p.186) related to a phenomenon, rather than accessing the right results. Referring to the challenges of triangulation, Stake (1995) argues that there are many views which need to be illustrated in a qualitative inquiry and, although establishing beyond argument the right one is not possible, there is an ethical obligation to limit the misinterpretation of cases. And this is the main contribution of triangulation. Interviews in this study were the principal point of triangulation, complementing the rich and multifarious perspectives derived from the focus groups and continuing to refine the scope of interpretation.

#### **4.4.2 Selection and Number of Interviewees**

A total of seven interviews were planned and carried out with senior occupational therapists associated with administration and management in occupational therapy and whom I judged could act as key informants because they could play a fundamental role in this case study by contributing data from a slightly different angle on the subject and also help to clarify the findings derived from the focus groups. These informants could count on a wealth of experience and at the time occupied an altogether different role than that of the practitioners involved in the groups. The majority were Heads of Department of the service sites. Although eventually only four of these Departmental Heads were interviewed, as I could not enlist the participation of one service administrator. Instead, I elected to interview another member of staff who was previously a Head of a Service site and was then occupying a principally educative and administrative role. Also interviewed were the professional lead of occupational therapy and the Director of Allied Health Professions within the Ministry of Health, who happened to be an occupational therapist at the time when this research was carried out. All these participants could call upon more than twenty years' experience in occupational therapy, and the majority were in possession of a postgraduate qualification up to the level of Master's. The omission here of more specific professional biographical details is deliberate. It is an effort to, as far as possible, preserve the anonymity of the participants within the small setting of the Maltese occupational therapy practice environment. It is hoped that this short account is enough to convey a sense of the role occupied by the interviewees and their relationship with the participants who were involved in the groups. More detailed information would nearly automatically disclose the identity of the participants to anyone nominally familiar with occupational therapy in Malta.

##### 4.4.2.1 Developing the Structure of the Interview Guide

The main underpinning theoretical influence on the interviews was that of the active interview, as articulated by Holstein and Gubrium (1995). The authors develop the idea of the active interview as a form of interpretative practice. This steers away from the idea that the interviewee is merely a repository of information to be simply accessed by the researcher. The active interview is a formal or planned situation where the interviewer activates the participant's interpretative capabilities, which must be "stimulated and cultivated" (Holstein & Gubrium, 1995, p.17) by the experienced and strategically prepared interviewer. Obviously, this philosophy had to be somewhat tempered by the exigencies of the study, specifically in the way that the interview guide was developed.

As essential principles to create the interview guide, I was looking at Kvale (2007) who translates the ideal position of Holstein and Gubrium into the reality of practice. Kvale (2007) describes thematic and dynamic dimensions of the interview questions and a more or less tightly scripted interview guide. The thematic dimension of the questions I developed was informed by various requirements, the most basic of which were the research objectives. But the interviews, coming at a stage in the research after the analysis of the first batch of focus groups, also had to serve the purpose of further developing the investigation around the thematic areas which had emerged from the analysis. The interviews also signified the end of the data collection and I felt compelled to encompass all the 'lose ends' of the study, as far as this was technically possible. This could have been bit of a tall order for the interview guide to sustain. But the fact that I was going to have unfettered access to seasoned occupational therapists in leadership roles presented me with a prime occasion to generate significant data and I was driven to make the best possible use of this by devising what I considered as the most appropriate instrument for the circumstances.

A diagrammatic impression of the basic structure of the interview is given in Figure 4.1. The rationale for the choice of the areas is given in the ensuing text. It has to be appreciated that this scheme was not followed rigidly, but served as the basic template. A specimen interview schedule can be found in Appendix 12.



**Figure 4.1: The basic structure of the interview.**

The point of departure for the design of the interview guide was similar to that of the focus groups. I was still convinced of the utility of using operational definitions on professional identity to drive discussion during the interviews, as I had done in the focus groups.

Through hindsight, reflection and discussion with peers, I became conscious that much of my thinking during the conduction of the groups was dominated by the concept of professional knowledge as this relates to professional identity. My attention was also being drawn to the issue of professional values underpinning identity of occupational therapists, which I had not focussed on specifically in the groups. I, therefore, introduced another definition of professional identity that made specific reference to values, derived from Slay and Smith (2011, p.86): "Professional identity is defined as one's professional self-concept based on attributes, beliefs, values, motives, and experiences". I felt that this contributed to add another significant dimension to the investigation.

Choosing which of the thematic material that had emerged from the analysis to present to the interviewees for further discussion posed a considerable dilemma. It would have been simply impossible to go over all the findings, so I had to prioritise which should merit further investigation. It could be argued that I would be prone to my particular biases and predilections about the subject when choosing the themes to discuss, but I felt that a cut-off point had to be identified and I was sufficiently familiar with the subject to be in a reasonably good position to determine what was most important for the study. The themes selected were more or less used consistently across the seven interviews, although on-going reflection and consultation of field notes prompted me to fine tune the guides as the interviews with different participants ensued.

In planning the interview guide, I have to report that I had to overcome the impression that the participants, by virtue of their role and experience in the field, were experts on the issues which were being investigated and attuned to all the theoretical nuances of the subject. If I made this assumption I would have been at risk of presenting them with propositions for discussion that would have been far too technical or academic and this could lead to a situation where I stump them into silence and stall the interview.

Kvale (2007) speaks of a dynamic type of questioning that facilitates interaction and flow. This should avoid academic language and transform researcher requirements into more practical terms. I was mindful of this and made an effort to translate my inquiry into accessible interview questions and prompts. Two examples of these are given in Table 4.3.

<i>Operational Definition</i>	<i>Introductory Explanation</i>	<i>Interview Questions</i>
<p><b><i>Professional identity has been defined as a perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity</i></b></p> <p><b><i>(Kielhofner, 2004).</i></b></p>	<p>If we look at this definition we can see that professional identity is a quality that gives a sense of identity to the individual members of the profession – perhaps an internalised professional identity.</p> <p>But it also identifies them as members of a profession, as a collective, a group to the public.</p>	<p>What are your views on the professional identity of occupational therapy?</p> <p>How do you define occupational therapy or describe yourself as an occupational therapist?</p> <p>This definition also refers to a perspective that binds members of a profession. What do you think is the perspective that binds occupational therapists?</p> <p>Is this a perspective that is shared by occupational therapists across the different specialities? (Why isn't it shared by all occupational therapists?)</p>
<p><b><i>Professional identity is defined as one's professional self-concept based on attributes, beliefs, values, motives, and experiences</i></b></p> <p><b><i>(Slay &amp; Smith, 2011)</i></b></p>	<p>This definition seems to be focused on the idea of self-concept.</p>	<p>What are your thoughts on occupational therapists' sense of professional self-concept?</p> <p>Can you look back on your work with clients in the field and think/talk about of the values, beliefs and attributes that have accompanied your practice as an occupational therapist?</p> <p>Can you think of an episode or episodes where you feel you really functioned as an occupational therapist?</p>

**Table 4.3: Examples of the use of operational definitions in the interviews.**

#### 4.4.2.2 Initial Generic Impressions of the Interviews

As I will demonstrate later in this tract, there was a number of organisational issues unfolding that had created some tensions between the Department of Occupational Therapy at the University and the service sector due to an ongoing trade union issue that coincided with my final stint of data collection. I therefore approached the conduction of the interviews with a sense of trepidation as these happened to be scheduled at a time when the issue was still in progress, albeit heading towards some sort of resolution. It was also after I had the experience of carrying out the focus groups, which for me had constituted a whole new genre of qualitative data and which I had found to be quite challenging on a number of counts. I therefore scheduled my first interview with an ex-colleague of mine with whom I knew I would feel completely at ease and anticipated a manageable situation, and perhaps to come away with a positive experience.

In fact, the interviewee seemed to connect very naturally with the prompts that I was giving from the research guide. The interview was generally free flowing with some instances where I had to do some back tracking to ensure focus as there was a tendency towards the expansive and the development of arguments which were not always completely relevant to the study. But generally, the flow of information was natural and I was disinclined to step in to ensure that all my points were covered. A major reservation that I had about the research guide before I actually used it was that it would be too comprehensive and too rigidly scripted. These impressions were completely dispelled by the first interview, since the topic areas proved to have considerable logical flow and I could blend and move through different points with ease. I felt I was really doing qualitative research: generating rich information and some really powerful utterances from the participant. This was quite a different experience from the rather wide-spanning but occasionally superficial quality of the focus groups. With so many different perspectives bearing down on the discussion within a group, it was sometimes difficult to sustain flow and topic development intelligibility across so many participants.

### **4.5 Temporal and Contextual Issues Surrounding the Case**

For a study that has generated such a major body of data collected over an extended period of time, I consider it entirely pertinent to establish a narrative that gives an idea of the time-spans involved, parallel professional events that could have contributed to the perspectives of the participants and conditional factors that have impacted the data collection. An overview of these factors continues to lend veracity and authenticity to the case as well as the interpretation. Stake (1995) claims that “the uniqueness of individual cases and contexts [is] important to understanding.” (p.39).

According to Simons (2009), one of the strengths of case study research is to “enable the experience of complexity of programmes and policies” (p.23) and that “through closely describing, documenting and interpreting events in ‘real life’ settings” (p.23), case study research can contribute towards understanding of critical issues. Therefore, supplementing this write-up with a description of the context of the study is more than adequately supported by the literature. This also contributes a dynamic dimension to the outlines of the settings given earlier in this chapter.

#### **4.5.1 Time Spans and Factors Affecting Duration of Data Collection**

Various issues influenced the rate that I could undertake my data collection. As a consequence, the time span involved in the execution of the groups has been somewhat extended. The reader’s attention is drawn to Table 4.4.

<b>Data Collection Method</b>	<b>Time Period Involved</b>
<b>Phase One - Focus Groups</b>	February 2014 – December 2014
<b>Phase Two - Focus Groups</b>	December 2014 – February 2016
<b>In-Depth Interviews</b>	May 2016 - July 2016

**Table 4.4: Time span overview of the data collection.**

The reasons behind this seemingly protracted data collection stem from two main extenuations. The first had to do with my emerging cognitive and practical skills of coping with the inordinate amount of data that were generated by the focus groups; this has been amply discussed earlier and relates to data handling and analysis. The second major mitigating influence was the fact that I was undertaking the research on a part-time basis, while occupying the position of academic Head of Department at the University. The various and frequently onerous demands of my post have impacted on efforts to collect and analyse data. One notable development in this regard occurred at the beginning of 2015 when the Department was tasked to undertake a major academic audit. This was essentially a small-scale research project and since I had the knowledge and the vested interest to most effectively represent the Department, there was no way I could have comprehensively delegated this task.

Another major hindrance which I experienced was in the form of an industrial action/union directives that occupational therapy fieldwork education staff in clinics were following in their demand for remuneration for clinical work with students. This occurred

sporadically in the second semester of 2014/2015, as well as the whole of the following academic year (2015/2016). This was a constant source of distraction requiring my almost daily involvement in high-level meetings and official correspondence. I was in the unenviable position of having to manage this tension between the University and the service sector, as well as engaging with the very staff involved in the union dispute for the purpose of continuing with my data collection. This was a rather stressful and demanding time, but did not affect the response of potential participants in the research.

#### **4.6 Conclusion**

This chapter has spanned a wide arc of information that has ranged from descriptions, rationales and formulations concerning the sites, participants and the data collection methods involved in this research. The account has also included a narrative dimension, characterised by a methodical unpacking of how this research evolved and was contextualised, in an attempt to lend to the case being studied an appreciable grounding in the concrete physical and professional environment. This was coupled to reflexive aspects of the lived experience of the researcher as an active participant in the inquiry, both as a seeker of information and interpreter.

The next chapter is comparatively brief, but its length belies the importance that it plays in this thesis. It outlines the second and final phase of the analysis of the data spanning across the data sets. It is a chapter which constitutes the aspect of 'discovery' of this research and illustrates the final analysis process with annotation and definition the themes constructed.

## Chapter 5 Analysis of the Data

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### 5.1 A Note on the Analysis - Introduction

The challenges and tensions that I experienced with adopting a systematic and authentic method for analysing my data have been amply discussed elsewhere. Analysis featured from the earliest stage of my data collection, as it was a necessary step to enable me to undertake the second cycle focus groups. However, this did not constitute a definitive analytical method that I felt would allow me to systematically and conclusively represent my results, as well as respecting the theoretical tenets of qualitative case study methodology. I now here outline how I have arrived at the approach I adopted when organising the vital findings of this case study, which was constructed out of participants' discourses, using thematic analysis.

### 5.2 Rationale for the Use of Thematic Analysis

As a starting point for considering what method to adopt in order to undertake the final and definitive analysis of the data, I reflected on several of the key writers' articulations about analysis of data in case studies. My assumption was that this would equip me with a considered and appropriate method compatible with case study. Discourse on analysis of case studies is summarised in the ensuing discussion.

Proponents of the case study methodology have emphasised the importance of giving a voice to the participants and ensuring the authenticity of the case findings (Simons, 2009; Thomas, 2011a). However, these authors do not seem to tender any specific analytical approach that should be applied in case studies and this could be by virtue of the fact that case study methodology allows for the use of a range of different methods, each potentially requiring correspondingly diverse strategies for analysis.

According to Simons (2009), case study research poses particular issues in the area of analysis and interpretation. She feels that these are very much dependent on the experience and skills of the researcher. It is also not possible to specify guidelines that could be widely applicable across different cases because each case presents very specific characteristics and contexts. The author draws attention to the fact that methods

of analysis are sometimes brought to bear on case study which are more appropriate to other forms of research. She seems to harbour misgivings on the use of classic grounded theory, which she attributes to Strauss and Glaser (Simons, 2009, p.125), as an analytical strategy as this "is a step too far from the immediacy and the 'lived experience' of people in cases" (p125).

Broadly similar points are made by Thomas (2011a), who also emphasises the importance of adopting holistic analysis which reflects the nature of case study research. He views case study as a form of interpretative inquiry which is not concerned with "fracturing the social world ... into variables" (p.171) but strives to understand the meaning that individuals construct from their experience of the social world. He suggests that the basic method of analysis in case study is the constant comparative method. This involves cycles of reading and rereading of the data for the purpose of identifying and annotating themes. Constructs are then drawn out which summarise and organise the data. The process then moves to a more interpretative stance, where connections are made between the identified themes by process of "mapping." This paves the way to the emergence of meanings and explanations of the constructed reality being studied.

In their indications on analysis of case studies, Merriam and Tisdell (2016) seem to suggest possible schemes in the analysis of cases depending on whether these are considered as single or multiple case studies. These authors consider the "procedures for deriving meaning from qualitative data ..." (p.233), as applicable to single case studies. In multiple case studies, the authors specify the need to conduct a within-case analysis and then a cross-case analysis. Although I consider that these suggestions are useful, especially in the way that data analysis can be organised, I think that "procedures for deriving meaning from qualitative data ..." is too generic and quite open to interpretation and far from prescriptive.

Although I have found these articulations rich with food for thought about the implications, possibilities and qualities of data analysis in case studies, I also feel that, generally speaking, these offer less than conclusive, clear or firm indications about what to actually adopt as an analytical strategy. In order not to remain stranded in the process of producing my results, I had to consider the adoption of a recognised, explicated, practicable and congenial method of analysis. Ultimately, my reasoning was starting to be dominated by the more practical question of finding a method-appropriate form of analysis that broadly fitted or was congruent with the case study methodology, i.e., basically an analysis that could be applied to focus group data and interview data, but bearing in mind some of the considerations noted above.

These were the considerations I had in mind when I turned my attention to Braun and Clarke's thematic analysis and which I ultimately selected to analyse the case study data. The final analysis of this case study that cuts across and overarches all the data sets involved, followed the principles of thematic analysis, as developed by Braun and Clarke (2006, 2012, 2013). Thematic analysis is a method that can be applied flexibly with a number of research methods and has been considered as independent of theory and epistemology, unlike other forms of analysis, such as grounded theory, which are associated with specific theoretical frameworks (Braun & Clarke, 2006). This very much resonates with the consideration that were made by Simons, discussed earlier.

Thematic analysis can be used in both patently inductive, as well as principally deductive approaches to analysis of data (Braun & Clarke, 2012). The rationale of thematic analysis, whilst extolling a systematic approach towards a data analysis, also highlights the importance of depth and the consideration of the more tacit aspects of the data (Joffe, 2012). I think this adaptability has contributed to my being able to unlock the meanings inhabiting the discourses of the participants.

As I have discussed in previous tracts, my very close association with the field being studied initially acted as a barrier, inhibiting me from evolving the necessary insights that were underpinning the tensions that occupational therapy practitioners experienced with their professional identity. And this, I believe, was for the very simple reason that I was dealing with 'the normal' – the prevailing surround or standard term of reference of my professional environment that had imbued me with a 'so what?' frame of mind. Adopting a flexible approach in the use of thematic analysis that oscillated between using theory to develop analytical insights and listening and valorising the often dramatic utterances of the various clinicians involved without preconception, was therefore instrumental at this stage of the research.

### **5.3 Procedural and Reflexive Aspects of this Thematic Analysis**

The analysis of this case study closely followed the six phases of thematic analysis described by Braun and Clarke (2006, 2012). These phases are:

1. Familiarisation;
2. Coding;
3. Searching for themes;
4. Reviewing themes;
5. Defining and naming themes;
6. Producing the report.

This account takes my analysis up to Stage 5 (Defining and Naming Themes). The reporting and the discussion of the themes will follow in the ensuing chapters. Thematic analysis requires the obvious very considerable reflection at each of its stages, as well as the persistent engagement with the raw data. This allows for the consistent cognitive processing that enables the recognition of patterns of meaning – both overt and latent (Joffe, 2012) that could eventually coalesce into ‘themes.’ I feel that crucial to usher the final analysis of the data, were Phases 3 (Searching for Themes) and 4 (Reviewing Themes); Phases 1 and 2, although of fundamental importance, consist mainly of ‘legwork’. Some of the questions that I was constantly asking myself as I impelled the analysis at these crucial stages, were:

- What constitutes a theme?
- Should my themes be factually constituted, or more conceptually fashioned?
- Do potential themes faithfully represent the participants across the settings and the data sets?

An overriding dilemma was to strike the right balance between themes as conceptual configurations and themes as inclusive factual containers, encompassing as much information of saliency as possible. Another important influence that was foreshadowing my search for patterns in the transcripts was the issue of the frequency of themes throughout the data sets, versus their relevance to address the research question, or ‘keyness’ which is the ability to address issues related to the research question (Braun & Clarke, 2006).

Although spending extended periods of protected time with my coded transcripts was crucial to the recognition of patterns in the data, an important aid was the use of flow charts and mind maps that helped to give a visual perspective to the ragged mental territory that developed around my processing of the data. By way of an example, the first mind map has been reproduced in Figure 5.1. Figures 5.2 and 5.3 represent evolving attempts at constructing themes from the data codes.

Figure 5.4 represents a relatively advanced attempt to pin down a set of themes for this case study. Further reflection upon the codes in the light of the research question and objectives, enabled me to reduce the thematic map to that reproduced in Figure 5.5. A constant organisational criterion which was brought to bear on this penultimate thematic map, was the Research Question ‘*How is Professional Identity Articulated and Constructed within the Practice Environment of Occupational Therapy in Malta?*’ Specifically, the two concepts which it carries, namely ‘construction’ and ‘articulation.’

The conclusion of Phase 4 of the thematic analysis arrived after I had decided to organise the thematic material around two principal themes that reflected the research question quite faithfully. At this stage I felt convinced that these themes were amply supported by the data, and that these represented reasonably explicit and demarcated areas in my findings.

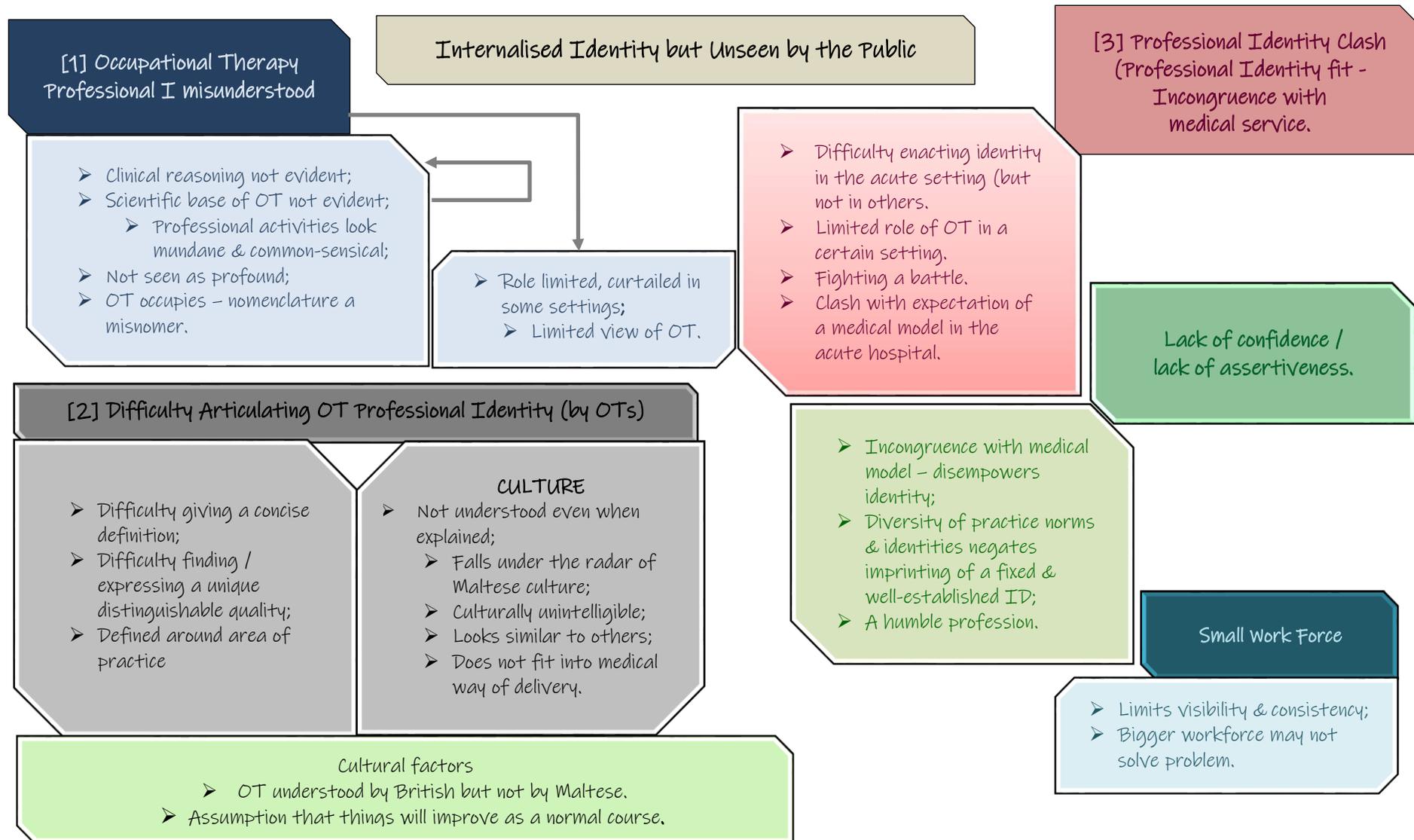


Figure 5.1: An example of one of the first handwritten mind maps compiling data codes.

Main Themes in Light of Study Objectives  
& Research Question

[1] Occupational Therapy Misunderstood (Perception of the Public)

[2] Difficulty Articulating OT Professional Identity (Articulate)

[3A] Suggested Main Themes from Study Objectives

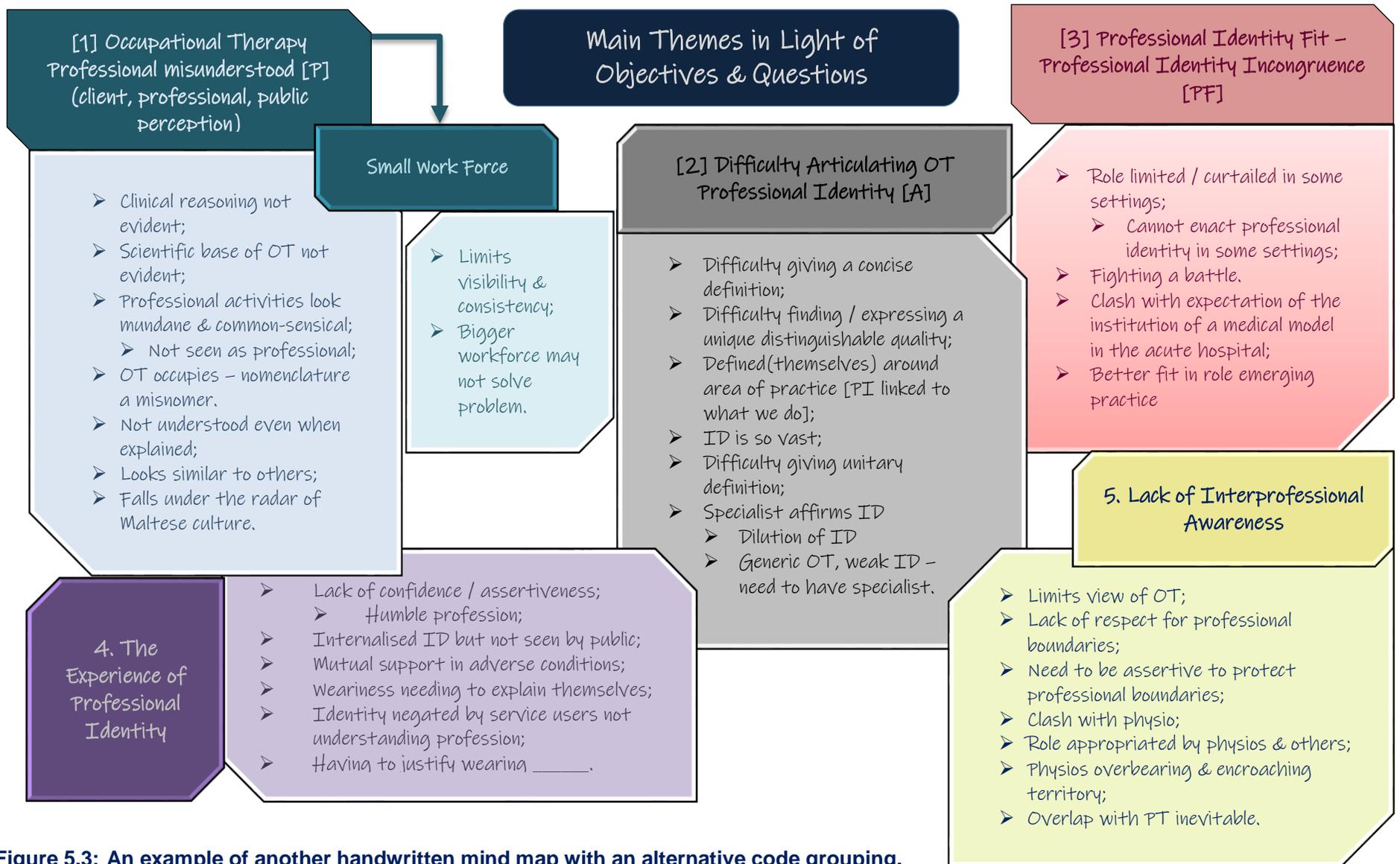
From Objectives:

- Articulation [A];
- Experience [E];
- Professional Identity Uniqueness;
  - Difficulty separating this;
- Public Recognition / Perception - including of clients and other professionals [P].

[3B] Emerged Themes.

- Professional Identity Fit [PH] with medical model.
- Interprofessional Awareness [IP]

Figure 5.2: An early handwritten mind map outlining evolving attempts at coalescing main themes from coded data.



**Figure 5.3: An example of another handwritten mind map with an alternative code grouping.**



Figure 5.4: An early, but relatively advanced, 'cleaned-up' attempt to pin down a set of themes  
 Source: Adapted from Braun and Clarke, 2006 (interstitial codes and tentative subthemes are not shown).

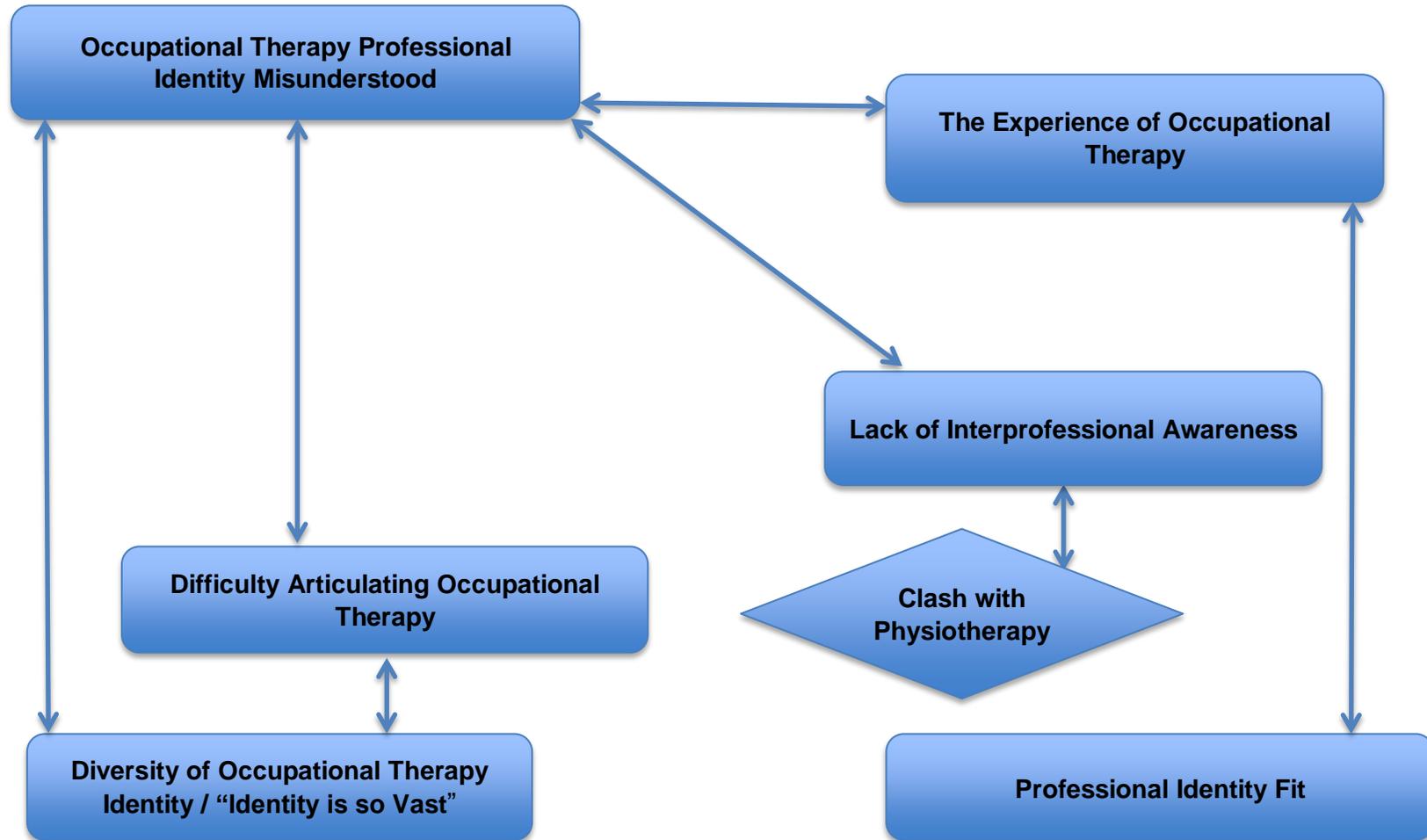


Figure 5.5: Reduced Thematic Map taking account of the research question and research objectives

Source: Adapted from Braun and Clarke, 2006 (interstitial codes and tentative subthemes are not shown).

#### **5.4 The Final Thematic Map**

Being, on the one hand, faced with a sense of duty to faithfully and comprehensively represent my participants, as well as wanting to be reassured that my findings have the requisite level of rigour and that these constitute an organic synthesis, the temptation was to draw out the analysis over an inordinately lengthy timespan.

At one point, I felt that my efforts were turning into a Sisyphean task. Thematic analysis is an inherently recursive process (Braun & Clarke, 2013a) and if one is not wary, this naturally exacerbates a tendency to continue processing data with no end in sight, in order to appease one's pursuit for quality and a moral 'compact' with the subjects inherent in qualitative research.

After regularly going back to the coding, the data abstracts and how these support the significant themes (and a lot of soul searching!), I devised the thematic maps shown in Figure 5.6 and Figure 5.7, feeling sufficiently reassured that this was a robust and consistent representation of the case.

The two principal themes that I have constructed and the attendant constellation of subthemes are a natural development that reflect how my data collection progressed and was being conceptually propelled. I am convinced that these best represent the wide-ranging, semantically, conceptually and factually challenging, innumerable articulations of the participants.

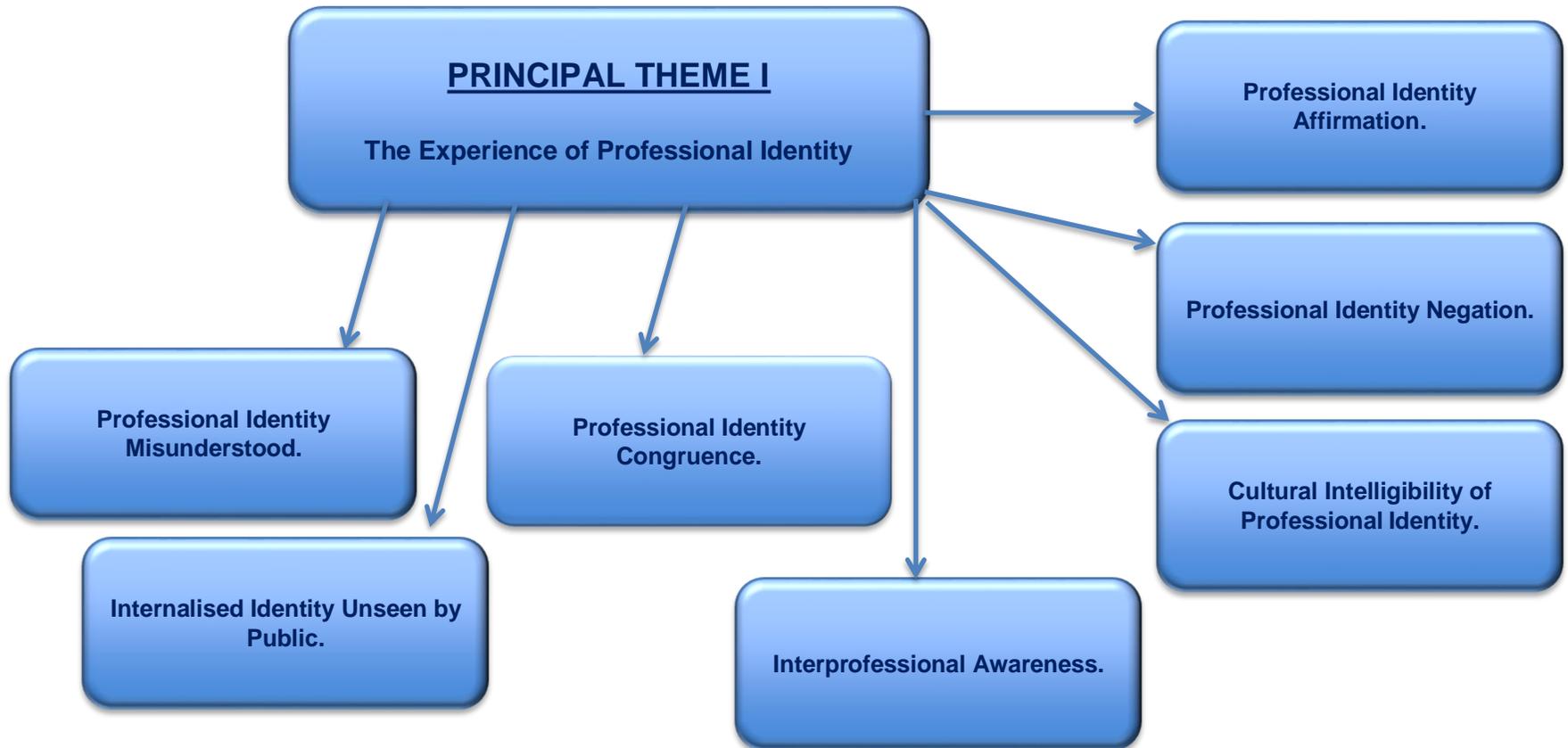


Figure 5.6: Final Thematic Map, the First Principle Theme and its Constellation of Subthemes.  
Source: Adapted from Braun and Clarke, 2006.

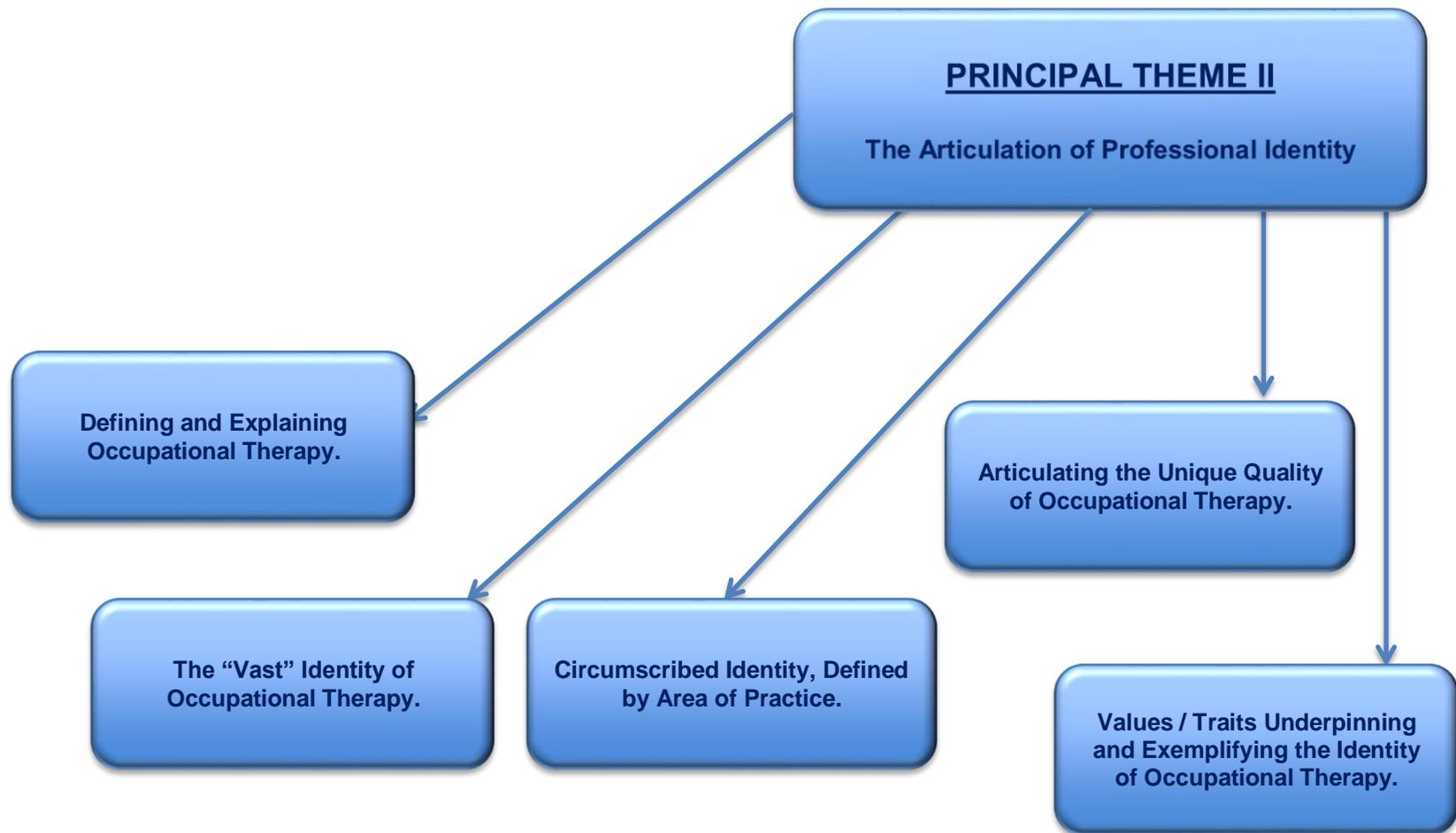


Figure 5.7: Final Thematic Map, the Second Principle Theme and its Constellation of Subthemes.  
Source: Adapted from Braun and Clarke, 2006.

## **5.5 Outlining and Defining the Themes**

The final stage of this brief account comprises Phase 5 of the thematic analysis that includes the definition of the principal themes and the relative subthemes depicted in Figures 5.6 and 5.7.

According to Braun and Clarke (2013b), a crucial part of the final analysis is the ability to define themes. The process of defining themes contributes to reducing themes and subthemes to relatively essential outlines captured in a few sentences that help to convey “focus, scope and purpose” (p.249). The definition of the themes should portray the dominant patterns and characteristics in the data that satisfy the research questions (Braun & Clarke, 2013b).

## **5.6 Labels and Definitions of the Principal Themes and their Subthemes**

The following section details the titles and the definitions of the themes of this case study. It also considered their allied subthemes in greater detail.

### ***5.6.1 Principal Theme 1: The Experience of Professional Identity***

This theme encompasses a gamut of perspectives of the participants related to their experience of professional identity constructs within their practice environment. It exemplifies and explains profound feelings engendered when professional identity is challenged, negated, eroded and also affirmed in the course of these clinicians’ engagement with the overt and tacit features of the immediate and wider professional environment. Such features include the main human players in the environment, comprising professionals and service users. I should note that other ‘contextual’ or ‘structural’ environmental features include the latent forces and tensions exerted by the philosophies of the service settings and the wider national culture of Malta. The various subthemes of Principal Theme 1 are discussed in greater detail in the following sub-sections.

#### **5.6.1.1 Professional Identity Misunderstood.**

This subtheme portrays the participants’ feelings of being misconstrued as professionals. It includes narratives relating to how occupational therapy work is considered mundane and unprofessional. Participants feel that the complexity that underlies the rationale of their work is not evident to the public. They also feel that their role is curtailed both figuratively - in the way that it is viewed and considered - and prescriptively – in the way that referrals are made to them in certain service settings. Participants claim that this

tendency to be misunderstood is further compounded by their small workforce; this limits professional visibility, consistency of services and reinforcement of their image to the public.

#### 5.6.1.2 *Internalised Identity Unseen by Public.*

Participants professed to feeling as proper professionals and occupational therapists, but their professional persona remained unseen and not appreciated by the public. Key informants tendered explanations for this phenomenon, which ranged from the fact that occupational therapists use everyday activities which might not look 'professional' and the use, by some occupational therapists, of clinical tools common to other professionals, making the identity of occupational therapists indistinguishable from others.

#### 5.6.1.3 *Professional Identity Congruence.*

This subtheme considers the fit or lack of fit between professional identity and the service settings. Participants report a clash between their ethos as occupational therapists and the underlying service philosophy of the setting. This could be ascribed to the medical model imperatives prevalent in the more traditional service sites. Participants felt limited as this incongruence between their identity and the service setting prevented them from enacting their professional identity.

#### 5.6.1.4 *Interprofessional Awareness.*

This outlines the participants' concerns about the lack of awareness by health professionals, of the roles of the different health disciplines, starting at educational level within the university, with the attendant lack of respect and equal regard of co-workers during practice. The participants related the lack of respect of professional boundaries demonstrated by certain players (mostly physiotherapists), appropriation of certain professional functions by other professionals who might believe that certain roles are easily taken over, but who lack the necessary knowledge and training to fully inhabit and effect such roles. Instances of and explanations for the occurrence of overlap with other professionals in certain settings are also discussed.

#### 5.6.1.5 *Cultural Intelligibility of Professional Identity.*

This describes how participants compare their experiences working with British and Maltese clients, claiming that the former seem more attuned and appreciative of what occupational therapists are offering. British clients seem to put more stock into being enabled to carry out their self-care independently as they recover in hospital.

In contrast, Maltese service users do not seem to expect that they have to participate to work towards personal self-efficacy while they are admitted in hospital. They associate therapy with physiotherapy and expect therapy to be done to them in the form of exercise and seem to assume that improvements in their health will translate naturally and automatically into improved occupational and personal competence. This mind set contributes to nullify the role of the occupational therapist in certain settings.

#### 5.6.1.6 Professional Identity Negation.

This subtheme relates to how participants experienced a denial of their professional identity when they were required to repeatedly explain their role to service users and other professionals. Some have used the word “justify” i.e. having to justify their roles, as if they had to make a case for their existence in certain settings. This was a source of strain and wear, and perhaps burnout.

#### 5.6.1.7 Professional Identity Affirmation.

This subtheme outlines how certain dramatic and profound success stories, especially in rehabilitation, help to reinforce the professional identity of practitioners. Across most of the practice settings, participants also claim that specialisation, which constitutes the moving away from generic practice to working with a narrow range of client groups and conditions, strengthens their professional identity. The fact that the influx of referrals is consistent, notwithstanding the apparent limited visibility and knowledge of occupational therapy, also helps to sustain professional identity.

### **5.6.2 Principal Theme 2: The Articulation of Professional Identity.**

The focus of this theme is the way that participants manifest their professional identity through their articulations about it. This constitutes reflections on and images of their professional selves and is a function of the formed and internalised occupational therapy identity that the participants carry around with them. It manifests in how they define themselves as occupational therapists; how they characterise their service as well as their articulation of the unique quality that distinguishes their profession. The theme also studies the values that participants thought underpinned their profession, which constitute fundamental qualities of their professional identity. The subthemes of Principal Theme 2 are discussed further in the following sub-sections.

#### 5.6.2.1 Defining and Explaining Occupational Therapy.

Participants across settings do not appear to have a shorthand method of defining their field. They give extensive explanations about what they do, but they themselves seem challenged when attempting to produce a concise, succinct and incisive definition to represent occupational therapy.

#### 5.6.2.2 The Vast Identity of Occupational Therapy.

This subtheme characterises the challenge and inherent contradiction of trying to capture the meaning of occupational therapy in a simple definition when the field is so wide spanning.

#### 5.6.2.3 Circumscribed Identity Defined by the Area of Practice.

This subtheme centres on the peculiar and perhaps characteristic way some participants profess to define occupational therapy. Instead of characterising occupational therapy around an overarching and unitary quality that spans across the array of practice areas, these participants feel more confident explaining occupational therapy around what they do in their particular niche of practice.

Examples included explaining occupational therapy around the field of hand rehabilitation, or rheumatology services. Although this *modus operandi* is inadequate to give sense to the role of the profession of occupational therapy in other practice areas, such as mental health and paediatric services, yet is considered perfectly fit for purpose even though it only throws light on a narrow range of practices.

#### 5.6.2.4 Articulating the Unique Quality of Occupational Therapy.

This sub-theme outlines how participants convey the unique quality of occupational therapy. A number of participants have associated their professional identity with the unique quality or contribution that it brings to the health field. Although it is widely recognised that occupation 'grounds and centres' (American Occupational Therapy Association, 2002) the profession of occupational therapy, only a minority of participants have cited this as characterising their field; instead most mentioned a range of constructs such as holism, function and client-centredness, as distinguishing their field. These identified qualities, some participants recognised, are shared with other professionals.

#### 5.6.2.5: Values Underpinning and Exemplifying the identity of Occupational Therapy.

This subsumes what participants have externalised about the values that underpin their professional identity. Some have mentioned altruism, and a general people-centred orientation, while others have also cited loftier values such as advocacy for the clients that they serve. Some have also likened the profession of occupational therapy to a vocation.

## **5.7 Conclusion**

This short account served to outline and explain the method of analysis applied to this case study. It also annotated definitions for the two principal themes and their attendant subthemes. This account is a critical 'staging post' to launch the next three chapters of the dissertation, which will basically comprise Phase 6 of the thematic analysis: Producing the report.

The first two pieces will consist of a detailed representation of the themes and subthemes, substantiated by relevant extracts from the data. These will be followed by a comprehensive chapter that discusses and interprets the findings, framing them in major or central explanations developed from conceptual discourse and other empirical studies.

## **Chapter 6 Reporting of the Themes: Theme I**

### **The Experience of Professional Identity**

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#### **6.1 Introduction**

This tract develops from the thematic analysis process described in the previous chapter, where the rationale of the analysis was discussed. That account culminated in the definition of the themes and attendant subthemes. The process of my deriving the final thematic material for this case study involved the constant comparison of the coded data sets emanating from the various sources, together with the foreshadowing influence of the research question and objectives. This resulted in the clarification of two main themes:

- The Experience of Professional Identity;
- The Articulation of Professional Identity.

This account constitutes the beginning of Phase 6 of the thematic analysis process, as described by Braun and Clarke, i.e. the reporting of the thematic material. The first principal theme, The Experience of Professional Identity, will be discussed here.

#### **6.2 Reflexive Points on the Interpretation**

At this point, I feel it is very pertinent to explicate my strongly held position with regards to the process of the analysis and the following interpretation. The practice of thematising the participants' interlocutions from focus groups and interviews, inevitably creates an organic synthesis of relatively manageable simplicity from the amorphous, but intelligible, complexity of experienced and co-constructed reality of the participants. I also realise that the themes and their relative stemming subthemes are deeply mutually embedded and nest within a complex web of relationships (perhaps causal influences), which the process of thematising will have simplified or refocused by the interposition of research-devised artefacts. The analytical process is a necessary and unavoidable prerequisite in order to produce a fordable and useful research product that can induct a research audience into the many levels of complexity of the investigated case.

Bearing these 'inexorable limitations' in mind, I have strived to conceptualise distinct thematic areas in order to throw differently angled light sources on the complex reality of the case, thus revealing different facets of detail, but also preserving verisimilitude notwithstanding the disaggregation that is necessary with coding and thematising. I have also tried to preserve the relational aspects between the subthemes by developing them as mutually reinforcing units contributing to the theme structure to which they form part. In this regard, my thinking was very much influenced by the analogy that Braun and Clarke (2013a) have created, likening the creation of themes to patchwork in the crafting of a quilt.

Each of the subthemes constitutes a microcosm that is subjected to an involution as part of the process of the interpretation. This contributes toward reconstituting wholeness to the case by inductive aggregation of the perceptions and reflections produced by the participants. I have also included instances of deductive reasoning in this interpretation, but only when this is the result of the participants' interchanges in focus groups. These are not presented as proving causal relationships or being representative of trends, but are reported as highlights or emphases in the data, that prompted further specific reflection.

The use of the word 'narrative' in this context, specifically as it appears in the title of the next section and subsequently, merits clarification as its meaning can be equivocal considering the wide and divergent use of this term in qualitative research. I use the term 'narrative' in the spirit that Braun and Clarke (2006) use it to describe the processes involved in Phase 6 of the thematic analysis. This chapter, as I have described earlier, is in effect the first part of Phase 6 - the reporting of the themes. The authors recommend that reporting of data should go well beyond providing extracts from transcripts but embed these extracts in an *analytic narrative* that convincingly illustrates the story that the researcher is conveying and that this sites the data in the wider picture of the research. Narrative that accompanies data is important in order to create coherence and internal consistency for the data extracts (Braun & Clarke, 2006). With these recommendations and characterisations in mind, I consider it quite pertinent to use the term narrative in the setting of reporting thematic analysis as it signifies a process of embedding and contextualising the data extracts that substantiate themes and subthemes.

### **6.3 Narrative of Principal Theme I: The Experience of Professional Identity.**

The principal theme 'The Experience of Professional Identity' is inextricably linked to the issue of public recognition of the identity of occupational therapy and the tension that this

creates for the practitioners. These concerns principally stem from the fact that occupational therapists feel that they are misunderstood and underappreciated.

The following focus group exchange is emblematic of this existential mind-set:

*P5: ...what makes our professional identity is what the lay person knows and thinks of occupational therapy as a profession. ... lay people, the people outside the hospital, the non-staff, the people who need our services are the people who have the major role in making our professional identity. As much as they know, will make our professional identity. The staff and the relevance of our profession to the other staff is also a major part, but the people being served by us have quite an important role.*

*P7: ... I agree with you but I have some reactions about that. ... I still find myself having to explain my role as an occupational therapist every day, every day; I have to define what occupational therapy is and that is frustrating to be honest, I don't like that. It is one thing graduating after a month and you are still happy to define who you are ... as an occupational therapist but it is another thing, that after sixteen years of working as an occupational therapist, you always have to redefine what occupational therapy is. So ... that is the way it should be - that people should know, the person in the street should know what occupational therapy is. But I wouldn't leave it just like that. Moreover, I think that sometimes you have to even keep on, not just explaining what our professional identity is with the lay person, with the service users, but also with, with other professions and sometimes even with consultants.*

This exchange, I feel, best sets the scene for the ensuing review of thematic material allied to this first principal theme. The first participant in the above extract highlights the dependency relationship that exists between professional identity and the public recognition of it, while the second participant's interjection articulates the tensions of inhabiting a misunderstood professional identity.

The various facets of the experience of professional identity have been charted in the following seven subthemes:

1. Professional Identity Misunderstood;
2. Internalised Identity Unseen by the Public;
3. Professional Identity Congruence;
4. Interprofessional Awareness;
5. Cultural Intelligibility of Professional Identity;
6. Professional Identity Negation;
7. Professional Identity Affirmation.

### **6.3.1 Note on the Use of Extracts from the Data Sets**

Some reflection on the data extracts used to substantiate my interpretations would be in order before I launch into the discussion of the subthemes. The majority of the focus groups and interviews were held in English, but the participants were at liberty to use Maltese if they felt so inclined and a minority had opted to do so. Maltese professionals – indeed a whole stratum of the Maltese population – tend to shift rapidly between Maltese and English during informal conversation. Also, technical words and professional terminology is in English and this will be used during Maltese conversation. When transcribed, the rapid shifting between Maltese and English gives rise to a rather tentative grey area of expression – a sort of ‘hunting’ for the right word from the English or Maltese vocabulary - entirely intelligible to a Maltese speaker, but arguably lacking the organising concision that English usage imparts. This has made translation quite challenging for me on two counts. First I had to make sure that the import of the extract is transmitted unequivocally. I also wanted to preserve some flavour of the original text that comes from a more literal translation, but being mindful that a more idiomatic translation is required for a British audience.

Since all participants were Maltese, the use of the English language might lack uniform or standard usage, which one would expect from British speakers. I have resisted, as far as possible, retouching passages in order to make these more idiomatic, but in certain ‘extreme’ cases some sort of slight intervention was unavoidable to improve readability. These researcher-applied modifications are recorded in text to ensure transparency, as follows:

- Text quoted verbatim from the data sources is italicised.
- Non-italicised text in curved brackets represents clarifications inserted by the researcher.
- Italicised text enclosed in square brackets is either text that has been translated from Maltese or that which has been amended slightly to improve idiom or syntax.
- Text enclosed in square brackets, followed by an asterisk indicates extensive translation.

The participants have been anonymised by the use of a code in place of their name. Codes starting with a 'P' denote a participant from a focus group; codes starting with a letter 'K' indicate a key informant quoted from an interview.

### **6.3.2 Note on the Content and Structure of the Subthemes**

In discussing and interpreting the thematic material in this tract, I have very closely followed the definitions I created in the preceding chapter. These definitions are useful territorial maps to guide the reader through the involutions that the subthemes go through in each of the ensuing subsections of this discussion. I have therefore avoided, in most instances, giving extensive introductions to the subthemes in order not to repeat the theme definitions here, although I have included lead-in passages at the beginning of sections and short conclusions, as a way of ensuring cohesion and coherence, and signposting this rather extensive tract; as well as keeping in view the underpinning rationales that supported my thinking.

## **6.4 Interpretative Review of the Subthemes**

The subsequent sections carry details of the interpretation of each subtheme supported by extracts from the data in relation to the first Principle Theme namely, The Experience of Professional Identity.

### **6.4.1 Professional Identity Misunderstood**

Crucial in the experience of professional identity for occupational therapists seems to be the fact that they are not only misunderstood, but also underestimated with the wealth of their professional knowledge and knowhow remaining unappreciated. This happens both in their interactions with service-users and other professionals. This situation seems to hamper them from realising their full potential as health professionals:

*P9: ... in my opinion, I think our professional identity relies completely on the public's perspective of what we do. We have been hampered by this ... by this notion for many, many, many years because we feel that what we can offer, and we know we have the knowledge of, is most of the time ehm, misunderstood, not utilised to its full potential by the public who should be receiving our service ... but also, which is even more serious in our opinion after all these years from ... colleagues of other professions. They have difficulty ... knowing ... what we can offer, what our professional contribution might be, so we feel that we always struggle to make a dent in the whole ... healthcare service.*

*P11: ... although we continuously strive to be the advocates of our own profession, because it is us who have to advocate our profession, the perspectives of the other team members really hinders our performance.*

The clinical reasoning of occupational therapists is not appreciated or understood and for the most part, remains a latent factor. The following quotation makes good use of an English saying to illustrate this:

*P9: After these couple of minutes of discussions, I think I am still convinced that the best logo I have ever heard of occupational therapy is 'more than meets the eye' because that is everything for us. We always have to explain and explain and justify what we are doing.*

*P11: We can do much more but somehow or other they do not understand the rationale underpinning our professional ...*

*P7: We have been taught in our courses that there is a scientific base to occupational therapy. And it seems that we can see it because we know, we have been taught and inserted in it, but other professions seem to not to be able to see that, which is again ... frustrating.*

These statements, I think really epitomise the issue of occupational therapy professional reasoning and doing, which are not manifest to the public and to other professionals, with the result that profession is underestimated. An additional extract illustrates the extent of analytical thinking in action that occurs when an occupational therapist might seem to others to be working with the mundane:

*P13: ... because sometimes our interventions from an outside perspective, they look very normal. Like, for example, a carer can watch a person to dress up but when an occupational therapist is ... watching or assessing a person dressing up, there are so many things going down the line, there is task analysis, all the components. Everything is [...] under scrutiny. To an outside person that thinking is ... ridiculous.*

It is difficult for an outside observer to appreciate the clinical reasoning of occupational therapists that is based on the analysis of a range of factors, which could nominally incorporate the physiological, psychological and environmental that impact on occupations. The fact that occupational therapists are perceived to be dealing with the common place seems to underrepresent their worth as professionals and their contribution taken as common sense or “taken for granted” as this quotation puts it:

*P15: The fact that we deliver through activities, I think that both from the patients and from other staff, some things are taken for granted. ... So, things are taken for granted because, so to speak, it is common sense and the thinking behind it, is not perceived by either the patient or other staff.*

Another important point that is made in the above quotation is characterised by the notion of “the way we deliver through activities” – occupational therapists’ approach of encouraging or inviting their clients to participate, rather than “doing to” the client. This

might be perceived as outlandish in a care environment, where the expectations are that “interventions” are “done to” the client. It could constitute another perception that requires the public to make an adjustment for occupational therapists, not normally expected of professionals.

Some have reported other professionals appearing as if they are “rubbing salt into the wound,” perhaps as a result of these professionals being exposed to the use of crafts by occupational therapists in a medical environment:

*P11: (Quoting an incident when another professional visited the service) “Ah, you do four years at University to do this, to do that?” ... They (crafts) are misinterpreted “Ah yes! [that is what I call work!]”\* ... “It’s play ... [that is what I call work! You come to play with the patients, I wish I could had taken your course programme!]”\**

In certain settings there still prevails an association between occupational therapy and crafts, especially in long-term institutional care facilities for the elderly and in mental health facilities. This was quite evident at the time of this research and is exemplified in the following extracts:

*P17: Because historically, treatment modalities, such as crafts have been used, sometimes I feel we are still burdened with the image that we are entertainers, we are babysitters ... We are ... asked to occupy ...*

*P19: [And we are still being underestimated, as if we are still associated with crafts ... “Listen, you’re basically crafts”]\**

*P11: The media we use, the tools we use - they are misinterpreted.*

I have to note that by the time the second focus group was conducted at the residential services, crafts were no longer in use.

There is another aspect to the way that occupational therapists are estimated by other professionals that moves from being a mere perception to actualising a role or identity restriction. This happens when the services of occupational therapists are prescribed when a referral is made:

*P21: But sometimes even the way you get referrals or the way [that] you get feedback from nurses. For example, we have a particular patient at this point in time who is quite dependent ... because she can’t do much. It is not because she doesn’t want to do anything. Her physical abilities right now are very limited. Our method of referral was for a bathing assessment and what is written in the handover book is still ‘bathing assessment pending’ ... and I explained why I did not go for a bathing assessment in the first place*

*because there are many more components that I need to work on before I do that. But ... for some reason, the perception of the nurses and other healthcare professionals still remains - OT equals bathing, OT equals toileting and that is a continuous challenge that we have to face.*

There is the possibility that occupational therapy can be restrictively identified with bathing assessments and referrals reflect this. The full range of skills and services offered by occupational therapists are not captured by the activity of 'bathing.' This view of occupational therapy is a restricted one that is ingrained and limited to the sphere of activities of daily living in certain settings, such as acute and rehabilitation services. Analogous scenarios are reported in the paediatric service, highlighting how occupational therapists are at risk of being viewed as the purveyors of activities of daily living concerns by other professionals and also parents:

*P23: Yes, I think, I think it depends on how you are perceived by the parents ... and also how you are perceived by other professionals. ... for example if you are in a case conference [or] if you are in a team meeting and the only feedback that they are going to ask from you is about a limited section of your work, of what you do, then that is ... how shall I put it? That is ... A barrier yes because ... you feel that other professionals mainly are just seeing a little part of what we are doing and that our profession is not all about, for example, ADLs only. It is an important part but that is not the only thing.*

A generally identical tone is conveyed by the following quotation from a participant who also works in the paediatric field:

*P25: ... sometimes you get referrals and you understand that the professional knows bits and pieces of your services and not your background knowledge etc. For example, they refer specifically to something. Let's say they refer for an alert programme and so they are deciding that the child needs that programme. If you are referred to a doctor, you'll refer to a general investigation, you don't tell them "I am referring this child ... For antibiotics" let's say or "antihistamines." So in those cases I think they lower your status ... if you feel that you are not –your work is not like promoted let's say bits and pieces of it, basically.*

I believe that the way that referrals are made could be a by-product, or could bespeak a lack of professional autonomy accorded to occupational therapists, since the referring agency is not leaving the care of the client referred to the acumen of the therapist, but instead asks specifically what it wants done. The reason for this could also be more benign - merely a matter of lack of mutual professional awareness and not ominous domineering. But in any case, it could speak volumes on professional status of occupational therapists, but could also be symptomatic of interprofessional conditions that other disciplines (not just occupational therapists) endure.

Some participants have associated the inadequate understanding of occupational therapy to the fact that the workforce is small and this has led to limited visibility. It was as if occupational therapists could not make inroads in certain services as they did not have the necessary human resources:

*P17: And the numbers are against us and obviously there is one OT to I don't know how many nurses.*

*P27: I don't want to sound pessimistic, however, I think that, unfortunately, here at wards level our professional identity, at least in certain wards and with certain professional people, especially with the medical doctors ... our professional identity is almost [non] existent, and why? I think the main problem is patients to staff ratio ... our situation [has] improved lately but ... We are still not enough. So, I think that is the problem here at (name of service omitted). Why is the role of the physiotherapist so defined?*

*P29: And I believe that the root of this problem is that we are not constantly in [the] same ward. If I would be constantly in the same ward, I would have control of these patients who are retraining in their activities. But even though I give a written and a verbal handover, I cannot control what the nurses do or review regularly. I am not even reviewing my patients regularly, let alone ...*

*K6: No, it isn't (occupational therapy not recognised at the acute setting) [and the cause is the lack of staff]. The lack of staff is a problem for our identity. In fact, you see other professions ... [... which have a strong identity like the nurses and others.] ... [The numbers, the numbers affect.]\**

Although these are very convincing points, they are somewhat negated by contrasting views tendered by other participants. The way that occupational therapists conduct their work – liaising, consulting with staff, empowering clients – could still be considered problematic where the imperatives of the acute hospital care mentality prevail. The following quotation suggests that occupational therapists might still experience intelligibility issues because of the way that they function and having the necessary human resources would not change that perception:

*P17: For sure, I agree, but I still think that even if we had more regular attendance in the wards if we had the numbers that we need, there would still be the resentment that we don't carry out the tasks all the time ourselves that we delegate to them.*

One key informant suggested that with their approach, which perhaps contrasts with hospital care or the medical model approach, occupational therapists would actually not have to rely on large staff numbers and are better equipped to operate in novel service settings:

*K3: However, being very large in numbers does not necessarily mean that the contribution is better. I think if we are selective in what we do, very specific in what we do, then we can be [the] [ones] providing the service in a different way to our approach. It doesn't have to be a one-on-one. It can be ... a consultative approach or it could be educational in schools, for example that you could teach the teachers, the LSAs (learning support assistants), the heads of school and then you the ... from that knowledge they can implement certain, certain interventions with the children, for example in schools. So, within a day centre doing educational talks, for example.*

This subtheme has overarched a number of reflections of participants that highlight how and in which context the identity of occupational therapists is misunderstood, together with some of the attendant nuances. This is a composite theme with a wide trajectory; it underpins most of subthemes that follow.

#### **6.4.2 Internalised Identity, Unseen by the Public**

This subtheme is closely associated with the previous one and develops some of the nuances therein. It begs development as a separate theme as it crystallises a profound existential perception that exemplifies a condition of professional invisibility and its consequent potential professional depersonalisation and perhaps, pressures to conform to a particular identity.

The extracts depicted below portray the deep irony of being the bearer of an internalised professional identity, the product of an educational and training process, as well as being legally sanctioned, and yet this remains unseen and unacknowledged by the public:

*P7: But as regards to what you said about our identity within us as a profession, I believe that has progressed a lot. I have seen a change, a big change, and yes I believe that we ... as occupational therapists know what our role is and we are quite proud [of] it and that is why we are so frustrated. That is because our role is not seen ...*

*P7: Thank you, so yes, I like ... this first part of the definition, I totally agree with that, [in other words] "professional identity can be defined as the perspective that binds members of a profession together." I believe that that exists in occupational therapy in our profession and at (name of hospital omitted), yes, we know what occupational therapy is, we know what our role is and I believe we are very much proud of [it]. But, as much as we are unable to ... come out, there is that amount of frustration, because we cannot be seen as we see ourselves.*

The following three participants, express similar sentiments, perhaps in a less dramatic fashion. One also notes a common and quite pivotal point which recurs: the issue of pride invested in professional identity. It represents the deep personal investment that

the practitioners associate with their professional identity, which is not reinforced or acknowledged by outside players:

*P8: So personally, yes we feel that we have our own profession and we know our identity but it is portraying it to others, which is hardest.*

*P10: Even though some people might find it difficult to understand what we do. However, I think, intrinsically as [...] occupational therapist[s] we do have an identity. We know our identity and most of us are proud of this identity [...] even though other people might find it difficult to understand what our role really is.*

*P13: Yes, yes. I think that as a ... on a personal level, we know what we do and we have that professional identity. The thing is how others are seeing us, is the problem.*

The following extracts contribute another perspective on or explanation to this phenomenon, namely that occupational therapists seem to practise using tools derived from a biomedical or 'biomechanical' frame of reference (the external manifestation), but retain an internal (or internalised) focus on function or independence:

*P7: ... It is true that sometimes we seem to be looking ... just at components, ... but there is a whole perspective, as you know and as we all know when we address a patient, we think in terms of function of independence. So that process is still ongoing in our minds. So, it is true that from the outside we are seen as just being component therapists but, but we don't just ... especially from the hand therapy point of view, within ... occupational therapy, we are not just being biomedical.*

But for an external observer, the internalised principles of occupational therapists are not manifested, and all that remains visible is a practitioner using tools common to other professional groups. This notion is captured as follows:

*P7: Because my role as an OT has been so reduced to an extent that, that it's like the system, I feel, imposes upon you to be like a pseudo physiotherapist.*

*P25: And many of them won't understand, even during the assessment ... what OT is. Perhaps after seeing them for a while [?] Because even, for example, they associate you with the use of, let's say threading, we explain why we use that, etc., but then they see the speech therapist use it ...*

Such occurrences could be an additional source contributing to professional invisibility. Occupying professional roles similar to and using tools common to other professionals allied to the health field could render occupational therapists less distinct and make them less visible and understandable to the public. These findings from the focus groups were

tendered to key informants for their consideration and the possible clarifications that they could posit. The explanation given by one key informant (below) outlines how the use of activities might be misconstrued by the other professionals, and this denies occupational therapists' professional visibility or status:

*K4: ... I can understand that, because if I am working with a person, for example, I am practising the recognition of money and somebody passes by ... and sees me showing this person false, false money cards, they would think that I am playing with the person. I mean, at a glance, if one doesn't explain what they are doing and what is the scope, yes, we could be seen or interpreted as if we are doing activities to pass the time. Perhaps that is what the other therapists were referring to. That they would be doing [...] recommending an activity with a scope and [...] others would be interpreting the scope of that activity in a different way. So that would be depleting them from their identity [...]*

A further reflection by the same key informant renders a more comprehensive explanation, which highlights the way that occupational therapy practitioners might feel inhibited about their tools which appear to have less professional legitimacy when confronted with the 'proper' equipment predominant in the medical environment. This is almost anomalous to a 'crisis of faith:'

*K4: Another thing which comes to mind is if for example you see a physiotherapist with a goniometer or a doctor with a stethoscope that would give a more professional appearance, ... so if one introduces a puzzle to a person with an intellectual disability, for example, or sequence cards, the professional might not feel that much proud of their own tools to work with. And I think the crisis might be there. If I am not convinced that what I am presenting is the right thing and is therapeutic for the person, I might choose to do something else to appear more professional.*

A similar explanation is offered by another key informant, who also introduces the element of assertion – occupational therapists need to be assertive and perhaps less self-conscious or embarrassed with respect to the use of their legitimate tools when confronted by the medical environment:

*K5: This, in my opinion, happens a lot with younger therapists. Because they still haven't got their identity grounded and I suppose what they mean inside is that, "I want to do occupational performance through occupations, but the doctor is going to look down on me - that is not professional - the nurse is going to look down on me." But, unless you are truly convinced of who you are [...], you cannot portray it and if you truly believe you are an occupational therapist, then you would portray that. And you have to be assertive. [I], I don't let anybody tell me anything different about occupational therapy.*

The issue of occupational therapists needing to be more assertive and also portraying – perhaps ‘actively portraying’ their role so that it is visible - is also made by another key informant who gives this view:

*K3: Do you know who I can blame that on? The individual. I can only say ... I am not saying to blame but I think the person responsible, the OT has to portray the image as an occupational therapist. If we are hiding in the shadows of other professionals, yes then we are not seen as OTs. If in a ward round, in a conference we don't represent ourselves and our contribution, then yes. If we allow other professionals to dominate us, then yes, it is our fault. If we don't overcome our own insecurities, our personal insecurities. Or if we are self-limiting ... we don't seek to grow as a profession, we don't seek to advance, we don't seek to develop. If we are not seeking [...] to ameliorate ourselves, then we are insecure.*

This prompts the questions: Why do occupational therapists have to ‘actively’ go out of their way, as it were to portray the image of occupational therapy? Why does it not come naturally as it does for other professionals?

Can this pressure “to portray themselves” lead them to stray from their identity in an effort to avoid resorting to the use of activities in certain settings and conform to a medical model image of presentation? The following extracts suggests such a scenario:

*K4: That is of concern for me, about professional identity not being proud of one's own tools and background to practise them throughout the professional life and as one goes along, one will start adopting bits and pieces and skills and tools of other professionals and that would sort of dilute the professional identity.*

*P12: I think that this problem has come, has been coming for so long. Because we always ... we [have] always been in favour of the biomechanical approach. And it made us look similar to the physiotherapists in such a way that we nowadays cannot define ourselves in a different way. ... Somehow, we seem to want to be like physiotherapists.*

The fact that occupational therapists in certain settings use means and tools common to other professionals in order to portray scientific credibility, could actually be rendering them indistinguishable and “invisible”, and impacting their validity.

This subtheme has highlighted a key phenomenon that affects the identity of occupational therapists – the lack of visibility of an internalised identity. Explanations for this, which were constructed on discourses from key informants, included the fact that occupational therapists might use activities which might not live up to the expectations of professional practice in a medical environment and the use of methods of intervention common to other professionals. This is closely related to the next subtheme that

encompasses issues of identity congruence which occur in some service sites of the profession in Malta.

#### **6.4.3 Professional Identity Congruence**

This subtheme portrays the tensions that occupational therapists have reported about enacting their identities in certain practice settings. The origin of this could be a mismatch between the tenets of occupational therapy and the predominant demagogues of the medical and institutional settings where occupational therapists operate. This reality could also be the source of pressure that practitioners experience to 'align' their identity, alluded to in the previous subtheme and possibly subvert their ethos.

The difficulty that occupational therapists experience to enact their identity, is characterised in the following extracts. In the first one, the participant articulates how, within the acute medical environment, the professional role of occupational therapists is limited because the acute medical setting is artificial and removed from the actual context of the client's life:

*P12: We work in an environment which is acute, where we cannot practise, where we cannot assess the level of independence of the patient because the patient is not within his own environment. We are working in an acute environment, which does not belong to the patient. So our role, it is obvious, that our role is lost because we are only associated ... the only functional activities we can assess on the ward are the bathing, the dressing and toileting. So we are [reduced to taking] the patient to the toilet, to dress and bathe.*

The issue of professional identity incongruence is demonstrated succinctly in this focus group interchange:

*P12: Sometimes it happens that you have your own professional identity but it does not correspond to what you are actually doing now ... You know what you want to do or what you should be doing but you are not doing it now because you cannot [...]*

*P27: But either you [...] cannot do it because of the system or because you do not have time [to] do it. Or because we are very inconsistent with our intervention with patients at ward level, basically because of lack of staff.*

The last quotation also reintroduces the issue of inconsistent presence on the wards because of limited staff resources, rather than apportioning the blame wholesale on the mismatch between the identity of occupational therapy and the acute setting environment. But the reflection on staff resources is quite eloquently and dramatically dispelled by the following utterance, which, although recognises the issue of staff

numbers, firmly apportion blame on the philosophy of the hospital for lack of implementation of occupational therapy:

*P7: ... the occupational therapy process is a rehabilitation process so in the acute setting, there is a place for occupational therapy [but] if we want to implement the whole process of occupational therapy [that] cannot be implemented to some extent in the acute phase. So it is very deep, the occupational therapy process, ... it is client-centred and we look at the quality of life, we look at the function, but within the acute setting, it is very limited. Also, because the philosophy of the hospital just does not want to implement that, it does not require that, so you are fine, you are doing medically [well] so you can go home.*

The issue of incongruity between identity and setting, I feel is quite incisively made by this excellent analogy given by one of the participants in a focus group:

*P13: It is like playing football in a basketball pitch.*

Another strand of this subtheme unpicks aspects from a slightly different angle: the clash between the ethos of occupational therapy and the environment within institutional settings that some participants have reported. Practitioners relate something akin to hostility from ward staff, when they attempted to introduce activities that are intended to make clients function more independently and that are quite apart from the institutional expectations. This narrative is represented in this manner:

*P14: In fact, I was ... when I was in one of the male wards, I was actually hated because I was the one who invents work. Because I instructed ... liaised with them regarding positioning, regarding splint wear.*

*P9: Because you rocked their boat, dear.*

The last quotation also gives the impression that occupational therapy goes against the grain of some institutions. This is further illustrated in the next quotations that demonstrate that the professional roles that occupational therapists assume, as consultants or educators do not fit with a custodial mode of care at an institutional setting:

*P16: "Because the occupational therapist comes here, orders, leaves and we have to follow her orders." That is how they see us.*

*P11: The system in which we work, [...] we do not fit in the system so we are seen as the ones who come and prescribe and then leave.*

*P9: Rules and regulations which we try to adapt to, to free up ... for the client's benefits but unfortunately the system is clipping our wings.*

The uphill task faced by occupational therapists working in an institution, is persuasively elucidated by this participant:

*P11: The thing is [that] when you are in an institution there are a set of regulations, you know, [baths] have to be ready by 09:00 o'clock then from 09:00 until 11:00 "we can take our break," I am [referring to] the ward staff, and then there is [lunch] time, nappy changing so there is a set of regulations. If we are truly patient-centred or client-centred ..... in fact, we as OTs are, the system would work differently. However, we are institution-centred, regulation-centred, bed number-centred, not patient-centred. So on the ward, you know, the NO (nursing officer in charge) or whoever is in charge they will tell you, "Listen don't come after nine to do the bathing, don't come at 12:00 to do the feeding" because you know that they have to be ready by this certain point in time.*

The narrative arc of this theme has subsumed two principal elements that encompass aspects of professional identity congruence for occupational therapists. The first is about the enactment of professional identity which is inhibited in some settings, perhaps most especially in an acute setting. The second is about a clash of the ethos of occupational therapy with institutional modes of care. Both these scenarios present different aspects of the lack of a fit between professional identity and the tacit service philosophies, and a possible resulting curtailment of professional identity.

#### **6.4.4 Interprofessional Awareness**

This subtheme covers additional important influences on professional identity that occupational therapists ascribe to their immediate professional surroundings, and is very much closely related to the previous themes. It spans concerns voiced by occupational therapists about a lack of awareness by other professionals of their role, and how this could lead to appropriation, albeit unintended or unthoughtfully undertaken, of the occupational therapists' professional space.

I have constructed the basic intimations of this theme around the reflections of the participants concerning the awareness about their identity by other professionals in the multidisciplinary team. Basically, it was felt that professionals needed to be educated about the role of occupational therapy:

*P14: We work with speech therapists and we work with physiotherapists and I think that the referrals we get from these people, they understand what we do. But nurses, doctors, carers, care assistants, they don't ... sometimes they don't even have the slightest idea of what we do and it is unfortunate [in] this day and age that these professions ... they haven't been taught what our role is with the patients.*

Practitioners have reported that they are involved in the education of junior staff on the role of occupational therapy through in-service education, but senior staff mentality may be resistant to change and this affects the whole professional set-up of certain professions, e.g. nurses, contributing to the status quo and the perpetuation of misconceptions:

*P9: But it is difficult, yes and unfortunately we are [increasingly being] expected ... because I do these sessions to train the carers and the student nurses, rather than the staff at higher levels. So that we think [that there] is a gap that should be filled very seriously because it has ramifications throughout these other professionals' working life and then it affects, it impacts ours ... All their (referring to junior staff) enthusiasm towards us, after they have acquired knowledge of how we can help is lost because they don't have any support from the ones above them and obviously they, rightly so, will look up to those immediately above them for support.*

Practitioners have called for the education of professionals at preparatory level to address issues of interprofessional awareness:

*P9: And I am talking about the doctors, I am talking about the nurses and mostly those professions which are taught at University which should have a lot more input on what other, not just ours but we are obviously ... what other professionals can contribute. And they should be nurtured into respecting other professionals. Respect is a big issue, because if you respect, you will seek advice and support ... So what I thought in the back of my mind that it will get better because people will come to work here knowing what we do, is not really the fact so there is still an issue about the training outside and how well prepared other professions are vis a vis the role of others so I think that is a big issue.*

*P14: I think at the educational level, for example, doctors and nurses they should have proper education, "Listen ... this profession does this, this profession does this. You will have to work with them in the future so be prepared that you are going to meet this person who does this and you have to refer to them regarding this, this and this."*

I now move the narrative of this subtheme away from the educational issues discussed so far to construct further insights into interprofessional awareness which emerge from the more immediate day-to-day relationships of occupational therapists with other professionals in their area of practice. The following extract expresses how interprofessional respect and awareness contributes towards mutual recognition of identities and good teamwork, which even trickles down to service users:

*P18: I think it is also because of the team approach. It depends ... on which team you are working with, the individuals. Because there are teams which acknowledge your role and ask your opinion on things, ..., and appreciate your work but then there might be other teams which don't appreciate much and that makes a big impact on whether the patients will be aware that you exist in the ward and your role because we don't work alone, we have to work*

*in a team. For example, you might have seen a patient in the morning and then the nurse would go and say, "Ah, the occupational therapist has seen you this morning." And the patient would become more aware "OK, she is not the physio, she is an OT."*

A considerably more pointed consideration of interprofessional practice is constituted by the grey area of overlap with other professionals, most specifically physiotherapists:

*P20 ... I think physiotherapists, we have a lot of challenges with physiotherapists due to ... we have these grey areas between us and our professional identity is somehow challenged in that way.*

Other participants explain views of quite patent disrespect for boundaries, where other practitioners unceremoniously just take over areas which are not within their purview. This is manifested in team meetings where feedback concerning certain specific aspects of the client's condition seem to be pre-emptively taken over by other team members who seem to overlook occupational therapy. This seems to exert pressure on occupational therapists to assert themselves:

*P22: I agree with (name omitted). I mean, there are lots of, even where we work we find it a lot in our ward that you always have to, ... be there first or say your role first because there is always someone else who will try and say what you have been doing for the past few weeks, themselves. ... But we have a lot of team members [who] feel that they can do our job and say our job, of what we have been doing, so you always feel you have to fight for your right as an OT here ... you have to push yourself in, to be ... heard.*

*P20: The problem here in Malta they don't respect boundaries. That is what I see. Other professions sometimes they ... I hear them myself saying something which we need to say ... I mean, it's ridiculous sometimes. I mean, even physiotherapists do these things ...*

The discussion on working with physiotherapy is frequently dramatic and quite far removed from the relatively tame initial iterations about interprofessional awareness considered in the forgoing, with participants using loaded conflict terms such as "battle." These terms bespeak of pivotal existential tensions present in certain settings between occupational therapists and physiotherapists, perhaps stemming from the fact that the latter can call upon a considerably sizable work force which the former cannot muster:

*P13: I also think of it in a way that for us having to face the reality of the ward is a challenge in terms of numbers, as (name omitted) was saying. If I had to compare for example, the medical team we are just three compared to, I think they are about eighteen, eighteen (physiotherapists) ... so if you had to compare numbers, they would outweigh us ... by far. It is like we are fighting a battle.*

*P22: Exactly, you always have to ... it is as if you always have a battle.*

*P22: I think it is because, as a profession, we are so ... new in the area compared to physiotherapy which has been in Malta longer ... they are such a strong profession and they have ..., a lot more staff ... you always have a battle to have a patient at one time.*

*P24: I think the perspective is different from the wards versus outpatients. For example, I know what (name omitted) means when she says that you have to fight and it is the truth.*

*P24: But I think, we have to fight for our identity but it is not easy, I think.*

Reflections on these statements beg the question: why should two different professionals be fighting for the same professional turf? Considering they are (or should be) offering distinct contributions, they shouldn't be at loggerheads, as each would occupy different domains of practice. Possible answers point us towards various routes to ponder on the issue of interprofessional working.

So far impressionistic characterisations have been offered on this issue. The following developments of this subtheme offer a more objective and concrete illustration of the implications of interprofessional working; what could perhaps be termed the 'perils or pitfalls' of interprofessional working. Occupational therapists perceived a threat to their identity originating from the appropriation of certain of their professional functions by, but not only, physiotherapists:

*K4: Working in collaboration, I believe, helps. However, there were times when working in collaboration was a way of teaching another member of staff, another profession one's own skills. For example, when occupational therapists and physiotherapists do combined home visits and the physiotherapist ... would be exposed to what the occupational therapist is [recommending] ... In that way, the physiotherapist would also be learning how the occupational therapist would give advice about adaptations and there could be occasions where they meet other service users who require adaptations and they would be the ones to recommend adaptations without consulting the occupational therapist. So, working in collaboration helps perhaps to identify [the role of the OT] but the occupational therapists need to be more assertive.*

*P20: But now they [have] got used to what we recommend and why we recommend it and they sometimes say it before we say it. "Yes, yes I agree with you." Physiotherapists say it before we say it and we have to say, "Yes, yes, I agree, you should, you should install a grab rail here."*

Participant K4 suggests that, when faced with these situations, occupational therapists need to be assertive to overcome issues of overlap and perhaps create a stronger voice and role, and making themselves more indispensable to the multidisciplinary health

team. The larger population of physiotherapists compounds the situation of professional appropriation, as they move into areas of professional practice that seemingly should be delimited to occupational therapists, if it were not for lack of necessary resources:

*K4: Another thing which comes to mind is the numbers. There are [many] more physiotherapists in a particular site than occupational therapists so if there is a demand for a service but there is the lack of resources for it, others might take up that role.*

Participants have also suggested that this appropriation occurs as a result of the fact that occupational therapy activities may appear to be based on logical judgement pragmatics, perhaps even common sensical, or spanning the commonplace:

*P26: [And unfortunately sometimes I feel what happens is that, because we see patients holistically, we look at many areas ... other professionals might think that we deal with aspects that are not "that" professional; do you understand my point? They see it as if they can do it themselves.]\**

*P28: [It's as if he thinks that he can do the stuff that we do, but then he gets stuck; because for them the process looks straightforward. For example, a person needs to learn how to get to work on his own. That's supposed to be elementary. But the individual still experiences problems; something must be wrong, "So now I have to refer to the OT".]\**

*P22: ... when the nurse does a bathing with a patient, even if they think [that] they can do the bathing assessment, in reality, they haven't done the bathing assessment. So, just telling the patient to wash themselves but then helping them three quarters of the way when in actual fact the patient could have done from A to Z by themselves, that isn't a bathing assessment. They may think they have done it, that they didn't need us to do it but, in reality, they don't see what we see and they are not trained to see it.*

*P30: Early Intervention Teachers assess the children before us because we have a waiting list and they see them much more frequently, they see them on a weekly basis. So they see more the ... for example, in toilet training, generally they tend to give their advice which is not with a background, but just hearsay.*

These discourses also suggest that, although other professionals can appropriate the rightful professional responsibilities of occupational therapist, they cannot fully affect them or actualise them, since they are unable to bring to bear the analysis, the insights and the clinical reasoning of occupational therapists, which are the results of professional training. So, this appropriation is possibly misplaced and misguided, depriving service users from specific professional services. It could also be symptomatic of a *modus operandi* prevalent in Malta in interprofessional working as the following extract from a key informant demonstrates:

*K2: But the battle is that they have impinged on a lot of our areas without maybe knowing ... them having the training. These areas are like the home visits, recommending aides and adaptations. We hear of many patients even privately, they won't refer to an OT. They would carry out the physio and they would recommend aides and adaptations for the patient. Home visits and doing measurements and how (words not clear) steps. Like they have learnt on the, on the job, you know, the recommendations that, that we give. So, aides and adaptations, home visits.*

This subtheme has spanned both the origins and implications of interprofessional awareness and practice amongst health professionals, specifically the impact of this on the identity and practice of occupational therapists. The concluding reflections demonstrate the serious import that certain of these practices might have. These indicate that occupational therapist could have to assume a more assertive stance with regards to their practice, not only to mind their interests as a profession, but also to safeguard important health issues of the service users.

#### **6.4.5 Cultural Intelligibility of Professional Identity**

While the previous subthemes have expounded on the influences on professional identity originating from and confined to the immediate professional surround, this subtheme looks at factors that, possibly, originate from the wider social world of the participants – Maltese culture. In this section, the refracting influence that Maltese culture exerts on the professional identity of occupational therapists is considered.

This influence can be discerned along three semantic strands: the idea that for Maltese clients, the nature of occupational therapy is unintelligible even when this is explained to them; the disempowered Maltese clients, reliant on a medical model style of healthcare and unreceptive to the tenets of occupational therapy; a comparison between the experience of working with British and Maltese service users, that seem to confirm the participants' perceptions about the local culture not being 'fertile' ground for occupational therapy.

Participants relate numerous incidents where the nature of occupational therapy remained unintelligible for service users even when it is explained. It is as if occupational therapy 'falls below the Maltese radar' or is recorded as a different health profession that fits in better with the service users' pre-set idea of a health worker.

The following extracts characterise this idea:

*P22: ... even when you explain to a patient "I am an occupational therapist, I am going to work on these things, this is my job." You will still hear them*

*saying to their relatives, “Oh, I am with the physio.” Or “Oh I am with the nurse.” And you think, “I have just spent all that time explaining what I do, and you still don’t see it as important.” Because to us, to me personally, if I hear someone say, “Oh I am the physio” and I am an OT, it’s offensive to me because I know I work hard as an OT, but I am not being recognised as an OT. Because they see everyone as either a nurse or because physiotherapy is so much in demand here, they see everyone as a physio.*

*P7: ... I mean, from what I can see and [maybe] what (name omitted) can see as well, is that we are mostly being seen [as] physiotherapists and what is more, is that our purposeful activities, the things that we do with our patients are not understood in the sense of giving a functional activity or an occupational activity, but they are just understood as being some play, sort of thing, [you are playing with plasticine]. So you are just doing an activity which is not related to the long term goal of achieving function and independence ... Yes I find myself, even if I have explained, people don’t understand. People don’t understand, they just don’t understand.*

*P21: ... We encounter this difficulty even on the wards. While with nurses, physios and doctors, somehow our role has become ... well known and identified when it comes to patients, even though we explain before we start a session, we introduce ourselves and what we are going to do, they still sometimes do not link how this is going to be helpful. For them, once we mention the word ‘therapy’ so we are physios and they sometimes make it clear that they had already walked that day so we don’t, we shouldn’t give them any, anything that causes more effort so ...*

This is as if in colloquial terms, parlance and the vision of what is a 'therapist' for Maltese clients is reduced to the physiotherapist and health worker a nurse. This apparently goes beyond being merely a label applied to the therapist recipient of the epithet, but also to the actions expected of that therapist. Occupational therapists' efforts to enable their clients to regain better performance in occupations and in personal self-efficacy are not appreciated or given precedence. Instead, service users assume that as their physical condition improves this would proportionately result in improvements in occupational performance. The following extracts exemplify this idea:

*P13: For example, for some people it is crucial for them to walk again, but [...] they don’t see it as important to start, for example, dressing up themselves independently. For them, it will be, it comes automatically “Once I am better, I would start doing this.” For them, it is not valued that you need to practise or learn a new technique to start doing it over again, I mean, for them, these are things I have been doing for years ... when physically I am better I will start doing them automatically.*

*P31: They will think that once they will improve their mobility, they will be able to cope ... with all their ADLs.*

*P22: “Ah because that would automatically come. Once I can walk ...”*

For Maltese service users, therapy is equated with exercise and occupational therapists have reported challenges shifting their intervention from preparatory methods, which can be perceived as exercise, to actual occupations. Exercise seems to be understood or valued as therapy, but not functional activities:

*P22: Because we use the activity, they think, "Oh..." so after you have spent like an hour doing a bathing, dressing toileting assessment, you've done grooming and everything and they think. "So you are not going to do exercises on my arm?" And you think, "I have just spent an hour and a half with you." But that was not important to them, because they don't see that as therapy. Even though you explain it.*

*P8: But then the patients, you work with them just transferring and strengthening and ... they expect you to continue that ... So, when you move into function, they still expect you to do upper extremity strengthening, while from my point of view, "You are fine, you can transfer." ... So to shift from the components ... from the performance components to the areas ... sometimes it is a bit of a challenge.*

The participants also equated the difficulty that Maltese service users have with certain of the practice tenets of occupational therapy, with the disempowered attitude assumed by clients in a hospital or medical environment. This can vary between an apparent disinclination to take an active role in rehabilitation, to hesitant decision-making on the part of the client when occupational therapists adopt a client-centred approach in their interventions. It is as if the practitioners have to cope with a culture of passivity in the face of expectations about medicine and cure that makes it difficult for clients to engage with the methods and outlook of occupational therapy. Exemplars of this are delineated in the following citations:

*P30: And I think there is also a cultural barrier because ... parents often come here for us to give them solutions. They cannot understand that occupational therapy is daily life. Their occupation is [what] they do every day. So they expect to come here and we work with the child or whatever and they don't do anything at home, for example, so you don't get people who are following the programme because they just get them here ... Yes, but Maltese culture has it that if you go to a doctor, he will cure you so, if you [go] to an occupational therapist she will do the work, not the parents.*

*P23.: You know, certain parents ... you see certain kids like, who might ... that [who] would improve like if parents work on certain skills but then they would prefer to go to ... someone else because that is their way of thinking how their child is going to get better and seek additional private help ...*

*P25: ... in general, the Maltese system disempowers the client so it really takes a lot of energy to empower a parent ... I think it is general across all professionals in Malta ... I think the parent then doesn't feel confident enough to help her child.*

*K6 [But the Maltese culture, you go to the client: "Aren't you the one who knows?" The Maltese person wants you to come up with the solution for him, do you know how it is? "You tell me what I need. You tell me what is good for me." It is not the patient himself who tells you, "Listen" what [he would like] to achieve and even his int... [word 'intention' not finished]... do you know how it is? Slowly, things are changing but still with a certain age group, even if you suggest certain things ... We, Maltese, for example, as much as possible, we seem to want to remain dependent, do you know how it is? Even this thing about independence, if you want to enhance and encourage independence, do you know how it is? ... I don't know, maybe it is due to Malta's geographical size ...? That we can still help each other out. One family.]\**

Participants seem to confirm the refracting influence of Maltese culture on their professional identity, when they compare the local mentality of service users with that of foreign clients. Such comparisons are demonstrated in the following extracts:

*P4: And another one I think is the culture ... If I compare my work with someone who is British or [a] foreigner mainly English people and Maltese people, there is ... it is a different story. When I work, let's say, I am giving an example of an English person, I am at ease. I feel that I am doing my work and they give me feedback ... that I am doing the right thing. But when I am with a Maltese person it is something big. OT is something very different [to] the norm ... Or vague.*

*P13: I mean sometimes we feel the difference when we have a foreign client. For example, a patient ... from the UK, foreign patients, they have a different perspective on these things ...*

*K6: ... You notice when you have certain foreign patients, you enjoy working with them. Because they really appreciate what you are trying to do and what you are trying to achieve with them.] And you can discuss things and you can, [...] make them participate in decision-making, in their treatment programme.*

The following key informant notes possible "obstacles" in the Maltese society for occupational therapy that might clash with its aims:

*K2: But the older generation, not so much like in a place like India or something like that, but the older people do feel, "If I am dependent now, like why should I suddenly become independent?" Not lazy but ..., "[I have worked all my life!]" ... "[Now] it is my time to relax." "[No, my daughter does everything for me]" So, there is this ... they won't return to independence. We do have these obstacles. You are trying to get the patient [to become] independent, to dress alone or whatever and you have the daughter cooking for her. The daughter, she has either moved in with the daughter or the son. Or they have got them a carer and the patient is not bothering to dress and wash alone. I always remember I had a case once at (name of institution omitted). There was a relatively healthy Maltese person who wouldn't do anything. Everyone was doing everything for her and changing her and dressing. And she was actually quite independent, she could actually peg up clothes. And there was this English lady who was there on a temporary*

*like respite period. She had a massive stroke and she didn't regain use of her dominant side and she wanted to go home independent and she wanted to carry out all ... she was there till she carried out all the adaptations. I was seeing this British mentality.*

The practice of occupational therapy in the United Kingdom and further afield, also seems to constitute a sort of idealised state for some participants where their professional efforts are appreciated and perhaps their identity realised:

*P22: ... in Malta as a profession, OT isn't [...] seen as important or as known as much as physiotherapy, whereas if you work abroad, for instance in England, they ... OT is very important to the other team members but even to patients because they know what they do ...*

*P18: I was going to say something small from my experience working in England. When I used to work there, I used to feel empowered, much more than in a hospital here ... in a Maltese setting.*

*P26: ... basically I had an experience in Kenya ... There I was working in a hospital with no occupational therapists, but staff knew exactly what our role was about ...*

This subtheme has overarched concepts related to the perceived influence of the Maltese culture on the professional identity of occupational therapists. This outline brings to a close my review of the thematic material which has highlighted the various influences on professional identity that the participants have reported to experience. I consider the ensuing two subthemes as providing conceptualisations on the effect of these many influences on the professional identity of the practitioners.

#### **6.4.6 Professional Identity Negation**

This subtheme explicates participants' feelings engendered by the lack of reinforcement of their professional identity, effectively as a result of a number of influences – or the sum of influences - considered in the foregoing thematic material. These multiple forces essentially cause a negation of professional identity for occupational therapists in some settings. Underpinning the causative effects of this negation is the oft-discussed misunderstanding of professional identity and incongruence with setting expectations. But participants also use more forceful terms to describe their condition: the need to *justify*. Practitioners also talk about weariness and the sapping of their emotional energy as a result of working in an environment which is averse to their professional identity.

Examples of the most dramatic manifestation of the negation of professional identity occur in instances when the participants use the word “justify,” as if they have to make a

case for their work in the process of explaining themselves to other professionals and even service users. The following extract from the data is illustrative of this:

*P7: You justify your role with a nurse. You justify your role with a doctor or with a consultant. You justify your role with other professions. And I'll expect to justify my role with patients, I mean, I can do that. But to justify your role day in, day out with the same people you work every day, this is something ... it's frustrating and sometimes you feel ... you get weary of doing that.*

In the next extract a participant was relating an incident during her work on a ward where she had to go through a time-consuming and emotionally draining interprofessional encounter with another health worker, where she had to explain her intervention; she again uses the word "justify":

*P13: It took me all the afternoon, you know? And when I relate it back, it is still emotional for me because it was in a very specialised environment, I had to justify it with the NO (nursing officer in charge) of the ward. So, then these things take out a lot of energy ...*

The point of departure for the next quotation, is the notion that occupational therapy scientific reasoning is not displayed to the public and that this meant that the clinician had to go out of her way to make a convincing explanation for what she is doing:

*P21: I think that the most frustrating part of it all rather than explaining it for the first time is when you have to explain over and over again to the same person then, ... some patients if I go for the initial assessment and I explain, I accept that, but if I go the day after and I still have to explain who I am and what I am going to do, then I think that is a bit too much and it can be quite frustrating.*

Faced with situations where their identity is regularly not acknowledged and where they need to justify it could set up a situation which is akin to a negative feedback mechanism. This could have a dispersing effect on identity. This impression is illustrated by the following data extracts:

*P13: So maybe the perception of them does impact upon our professional identity because, of course, when you are faced with this attitude over and over again by our clients you start, you start, feeling "[What] am I doing ...? What am I doing wrong?" I mean, you start blaming yourself. "Maybe am I doing something wrong for this to happen?"*

*P10: And if you keep getting these messages. It does affect our self-esteem as professionals so I think, we really should work hard on ourselves, on our own identity, on our own characters.*

*P21: That is why I mentioned, sometimes, low self-esteem or low self-confidence affects the professional identity.*

Most of the extracts used to represent this subtheme also often carry descriptions which demonstrate underlying personal or psychological factors associated with professional identity issues: self-esteem, self-confidence, energy, feeling weary etc. Although practitioners have professed to have an internalised identity, professional conflicts with resulting identity negation and dispersal, seem to impact on the personal psychological domain, as the next quotation highlights:

*P4. ..., it seems that it is the situation that challenges your identity, not because I don't believe [in] who I am and what I do. But if we weren't human beings maybe, we wouldn't feel like that, but an episode like (name omitted) [related] which happens even to us, to me, personally, I mean, it challenges even your ego, your thoughts, I mean you reflect. "Why is this happening?" .... And I think we give too much, as well. It gives away too much of our positive energy.*

Further evidence of the psychologically straining effects that professional identity negation might have for some practitioners is given in the following extracts:

*P9: The struggle ends up tiring us a lot. The struggle of always trying to stamp our feet to get what is rightfully ours is tiring.*

*P14: So it rubs on you but eventually then I tell myself that "I have clinical reasoning, I know what I am doing. I have some experience now because I am getting older in the profession."*

The last quotation introduces an element of a countering of doubts with resort to knowledge and "clinical reasoning" being presented as a sort of defence mechanism or a 'justification for professional existence'. The notion of a defence mechanism is also evidenced by instances where mutual support is cited as playing a role in contributing to practitioners' "survival" in their practice. Examples of this are as follows:

*P29: And, if we didn't have each other, to support each other, we would not survive.*

*P9: We never give up because in this facility we do support each other a lot and we derive strength for each other and each other's experiences and I think that is the plain truth, we find solace in what we discuss.*

*P14: ... in our department I am saying, ... we share stories of patients, we share expertise, we have seniors who teach us all the time and even during our break time, sometimes we have to stop ourselves because we share all the time. "Listen, with that patient, I did that." "Listen, with this patient, I don't*

*know what I am going to do.” “Do this, try this, try...” ... I think in our department that’s what keeps us alive. That is what keeps our identity alive.*

*P16: It helps to keep our frustration at a minimum.*

*P17: We support each other.*

I conclude my review of this subtheme by quoting a rather dramatic utterance, which is obviously not representative of the state of affairs within the profession, but that expresses the most severe and deleterious outcome of professional identity negation possible: the idea that professional settings are inhibiting the full enactment of professional ethos. This dissatisfaction is of such an extent that it motivates this practitioner to consider leaving her profession:

*P7: In fact, that is one of the reasons, if I may say, that I plan to someday leave because I am not abiding by my own professional identity. I am just doing something that the system is imposing upon me and I don’t agree with that.*

In this subtheme I have strived to illustrate the net consequence of the various forces that act to challenge the practitioners’ professional identity. These influences could have personal attritional effects because of instances where professional identity is repeatedly not legitimised.

Staff occupying professional environments with these persistent professionally challenging influences could sustain signs of burnout, as evidenced by certain terminology that is used in discourse associated with this subtheme.

#### **6.4.7 Professional Identity Affirmation**

This subtheme captures conceptualisations that effectively add up to professional identity affirming influences. The first important dimension of this subtheme concerns perceptions and reflections that seem to satisfy the practitioners’ need for professional gratification that result from successes with clients and positive feedback from clients. Another affirming influence has a more patently objective quantifiable basis and is the influx of referrals notwithstanding the perceived limited understanding and visibility of the profession of occupational therapy within certain practice environments. The fact that the participants recognise that their professional identity, as occupational therapists, is stronger in some settings than in others, is a source of affirmation and this is also highlighted. The final strand to be considered in this subtheme concerns the participants’

reflections on a particular prospective development within the profession that could strengthen their professional identity - this is the specialisation of services.

The experience of positive outcomes with clients is a strong affirming force that could be considered as instituting a virtuous feedback mechanism, diametrically dissimilar to that discussed in the previous subtheme. The following passages from the data eloquently illustrate this in different settings and with diverse client groups:

*K2: I had a spinal cord patient ... he was seventeen, eighteen. Years and years ago. When we were still at [name of institution omitted]. [...] Very depressed, overweight. ... He was at a BBQ with friends at night, they were running around in [Maltese Resort Town] and they dived into the pool which was empty and he ended up tetraplegic. He could move slightly his hands, but you know? It was very, very little movement and I had given him this adaptation. Nobody had ... he was still waiting I think to go to [Overseas Rehabilitation Facility]. He had been there for about two years he hadn't been doing much and I had just qualified. It was my first placement, I was sent to [name of institution omitted]. Trying to, sort of, use my OT knowledge "What can I do for this person?" You know? And I remember giving him this adaptation, going through the catalogues and this adaptation could take a biro, it could take a toothbrush.*

*It was ... fantastic because it was at the beginning of my career, at a time where I was going round ... "Occupational therapists, look at independence. Look at this." And people ... I faced many times consultants going, "Oh, are you going to get your basket?" Looking at the OT of the '60s from the UK or whatever and I used to have to ... blush a thousand colours and in front of a whole group of orthopaedic surgeons and students. So I did pass through these ... embarrassing moments but I remember it was, it was a very good experience. There have been others. There have been patients who ... I used to work mainly with stroke patients and I did home visits or recommending stair lifts or things for the bathroom but patients when they actually, ... affirm what you are doing means something and tell you, ["Thank God for you!"]*

*K1: Yes, but they vary because our practice is not just with a particular group of patients. It is a variety of conditions, so I can't tell one example that it is only function that I managed to do. Sometimes, it is just going on a home visit for a patient who is bed-bound and you give them some ideas. Maybe to use a Dysem net, a wedge cushion, a pressure relief mattress and that would be a goal achieved with that patient. ... it varies. For example, if we have a learning disabled child who has dyspraxia or dyslexia, doing the access arrangement test and [giving] them the report that they need; we are going to support them that they need extra time, that is also a satisfaction within my occupational therapy career because eventually some of them, they come and tell you, the parents or the patient comes and tells you, "[name omitted], I made it, I got my Maths O' Level. I am now doing my Master's. I am now doing my ..." ... "I am going to pursue another ... University course." So, these are the satisfactions that help me professionally to continue to focus on the patients and that keeps me motivated to remain an occupational therapist ...*

*P14: Yes but I think, I do feel [like] an OT, but I think the support I have from my colleagues and the patients. For me, the patients are the biggest reward for me for being an OT. It's what keeps me on track, to be honest, I mean what we do with the patients and sometimes their comments, you know they ... For example, when I used to work in a mental health setting, they used to tell me things that they didn't tell the doctor or the nurses. Even here, for example, sometimes they tell us ... "No-one has the time for ... to stop and listen and talk to me." ... we give quality time to our clients and I think that is why our role is important. But it is not always appreciated but at least the fact that the patient appreciates it, I think that is what keeps us going.*

*P13: ... it was the initial contact and the patient has dementia in early stages and we were ready and when we were coming out, the patient on the opposite side of the bed called us and he said, "Come, come please". And we said, "Do you need anything? Maybe a glass of water?" "No, no, no, I just want to say 'well done' for the way you spoke to the patient. If I was instead of him, I would want someone like you to talk to me like that." And that it is a very simple comment but it made me reflect on what did I do different (what I had done differently) to so many other people that went (who had gone) to that patient and to the way they (had) communicated with him. And we were discussing it with my colleague why did the other patient, he was hearing of course what we were saying and I mean, what made him tell us that?*

The consistent influx of referrals that participants have reported indicates that occupational therapy services are sought after and in demand. This constitutes 'quantitative' information that affirms professional identity for practitioners, in the face of the adversities they report. Instances of this consideration were reported as follows:

*P7: Yes, yes but then interestingly we are getting a lot more referrals than we used to have. So some kind of acknowledgement ... [exists]. It might not be exactly the precise thing that we would like it to be but I have noticed [in other words] along the years that referrals have increased. Now, if I have a vague idea of what occupational therapy is and I believe that this therapist can help me, I keep on referring even though I don't know the exact role.*

*P12: I have seen a very vast improvement in eight years that I have been working here. I remember the first time I went to [name of institution omitted], we literally were shopping for referrals during the first days. So, no-one knew, we had to go and organise seminars to nurses and staff what occupational therapy meant. Nowadays, they all call and give us referrals. So there was a vast improvement.*

The following extracts, apart from further substantiating the evidence for the increased demand for occupational therapy services, also highlight how the profession is moving into non-traditional sectors and also the private sector, without the support of the public service:

*P2: But in reality, I mean, we started the course in the 1990s, \* when nobody knew what OT [was] and even the demand on our services were quite low*

*compared to now. ..., even the OT course started to open every ... year rather than every two years. Why? Because the demand is increasing and each year, when the OTs are qualified they are recruited because the need, more demand is ... and there are people now who are working full-time privately as OTs which means there is even a way that people can improve their career working privately.*

\* Researcher's Note: The first occupational therapy course programme to be offered in Malta was actually in 1984; this participant is referring to the first programme offered by the University of Malta.

*P18: But I think, people are becoming more aware of OT. They are, because as [name omitted] said, people are requesting more our services even not just in hospitals, in the community so they must know what OT is and ... how we might be beneficial for them.*

Participants reflected on the fact that the professional identity of occupational therapy could be more strongly established in certain settings, than in others. This is another affirming influence, as it allows the participants to adduce that certain professional environments allow them to thrive. The reflections originate from key informants, with a bird's eye view of the profession rather than from the practitioners, who might be more immersed in their practice environment and not sensitised to the practice realities of other services. The following extracts underscore this point:

*K2: I think it varies according to the different areas. ... Not with all areas, so ... I think they are quite strong say, in oncology, or say they are quite established maybe in mental health ... where the main allied professional in mental health is the occupational therapist. But in certain pockets, maybe more in acute care where they feel a bit like the underdog or maybe they don't feel so, ... in control. I feel that their professional identity can be sometimes a bit wishy washy, sort of overlapping with other, other professions. Having said that, it has improved. There was a time we ... actually had to go out and market and advertise our, our identity.*

The following key informant, whilst again confirming the differences between settings, continues to analyse and discern certain causative factors linked to the history of occupational therapy in Malta, which might have led to this state of affairs:

*K6: ... For example, you can see that certain OTs in certain settings ... they have a certain identity, [word not completed] professional identity. While others, in other settings, maybe the identity is a little bit more, it's weaker because I think it all depends on the way people project themselves as OTs, for sure ... For example [in] psychiatry I think it is very strong. Paediatrics, it is gaining a lot of momentum ... Rehabilitation also.*

Researcher's note: In the following translated passage that interviewee illustrates areas where occupational therapy struggles to assert its identity.

*K6: [In acute we are still struggling a little bit, but obviously due to the nature of the setup, the nature of the work, the lack of ... all these things that I*

*mentioned earlier; [also in the] community I think, in areas where there are fewer OTs. That is why I link it a lot to the numbers [of staff] and even the history of our profession. Because for example, the OT profession has a long history in psychiatry.] \**

A similar reflection is tendered by the following key informant, who highlights the fact that occupational therapy practice in mental health has a distinctive and perhaps stronger identity which might be free from overlap with other professions, something which has been cited as a problematic factor in other service sites:

*K4: For example, I have worked a lot in mental health so I can see a great distinction between the role of the occupational therapist [when compared] with the other professions, the allied health professions. In fact, in my opinion, in the mental health setting the occupational therapist has a very specific identity [...] because there rarely is an overlap between the roles and skills in comparison to the other professions ... Although there were various developments in our roles in the way we have developed in the sense between working solely in the hospital and [now] we have developed even the community services, but there still is a very, very specific role to the occupational therapist in comparison to the other ... professions.*

Participants have consistently expressed their views about the importance of specialisation, as a process which strengthens and affirms, or asserts their identity as occupational therapists:

*P18: I personally think that we would benefit as a profession, we would benefit from having areas of specialisation ... I would personally wish to have more areas of specialisation in all the hospital settings, even in, at [name of service omitted], there is the [hand service] which is very specialised, but and there are also the community services at [name of community service omitted] but then why do you just have one OT at [name of community service omitted]?*

*P24: I think this tension wouldn't be there if we were more specialised in our areas, I think ... as [name omitted] said ...*

*K2: ... professionals, when they go into specialisation and when they ... find their footing in certain areas, do they feel that they have a professional identity, otherwise people, many of the professionals feel sort of that they are jack of all trades master of none or they feel [that] they don't have as much status in a multi-disciplinary team.*

The last data extract introduces the idea that, in the absence of specialisation, the professional might lack status at an interprofessional level. This again is reflected in the following passage, which also mentions the issue of appropriation of the generic role of occupational therapists by other professionals:

*K6: ... I think that specialisation, it is a must for us now ... Specialisation [word not completed]. That people, that OTs have to specialise in certain areas, become really specialised, really well trained and ... [because if we will remain too] generic, people are going to take up our role so ...*

The specialisation that these key informants refer to could in fact be a surrogate concept for specific professional knowhow or knowledge which they consider as being absent in the generic role of occupational therapists in certain settings. A generic role or identity, is possibly seen as not strongly distinctive, and which requires the 'iron cladding' of specialisation to render it impervious to appropriation.

The following quotations suggest 'pros and cons' to specialisation. Although recognising its advantages in strengthening their roles, practitioners also recognised that specialisation could possibly contribute to distance occupational therapists from their distinctive characteristics and even limit their area of concern:

*P32: Lately, even in our profession, we have been pushed for specialisation in different areas, like it is in my case and [name omitted] case in the hand therapy. And I believe, although to a certain extent I believe that it is good to have people specialising in areas, in different areas, I believe that [we] will lose more our professional identity.*

*P7: It is true that we are headed towards specialisation and that is another disadvantage. An advantage because you can show up your role as, in occupational therapy, in that particular area but ... from my point of view, you tend to be seen as a sort of or pseudo physiotherapist or a hand therapist, or for example in paediatrics, you will be seen just as an activity therapist who is just doing some activities.*

This subtheme has encompassed a range of influences that were perceived by the participants to affirm, strengthen or assert their professional identity. These influences included intense success stories in rehabilitation; the increasing demand for and diversification of occupational therapy services; the realisation that certain settings are more congenial to the occupational therapy profession than others; and strength through specialisation. The final dimension of this subtheme – specialisation - was considered problematic and not all seem to be convinced of its merits in strengthening professional identity.

## **6.5 Conclusion**

In this chapter, I have produced an interpretative review of the thematic areas emanating from the first Principal Theme that I have identified for this case study: The Experience of Professional Identity. This theme ties in with the fourth objective of this research which was: *To explore Maltese occupational therapists' perceptions or experience of the extent*

*to which other health professionals and clients recognise the nature of occupational therapy in Malta.*

Aspects of this theme were mapped in seven closely related but separate subthemes. In order to preserve verisimilitude to and ensure an authentic explanation of the constructed experience of the participants, as well as introducing a logical explanatory thread, I have positioned the subthemes in quasi-hierarchical order. Therefore, the review starts by looking at the basic underpinning tension of the experience of professional identity, represented by the idea that occupational therapy is not understood, or misunderstood. A number of subthemes develop perspectives and levels of this concept. The last two subthemes focus on the effect of various influences on professional identity that could have negating and affirming outcomes for occupational therapy practitioners in Malta.

In the next chapter, I will review the second Principal Theme that I have assembled from the data of this research: The Articulation of Professional Identity.

## **Chapter 7 Reporting of the Themes: Theme II**

### **The Articulation of Professional Identity**

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#### **7.1 Introduction**

This chapter covers the second part of the narrative of the results of this case study and overviews the second Principal Theme: The Articulation of Professional Identity. This will effectively conclude the representation of the data of this case study, and comes before locating the findings in the extant literature, in order to frame the research within an explanatory theoretical lens and position it in relation to previous studies, and discourse carried out in the same or allied areas. In order to ensure consistency and clarity, the format of the previous chapter will be broadly followed.

#### **7.2 Reflexive Points of Departure**

The reader might wonder why the starting point of the research findings did not begin with the articulation of identity and then move to examine the experience of it, instead of the reverse order given in this account. I had initially approached my research very much with this assumption in mind, i.e. principally looking at articulations around the concept of professional identity. But I had to change my perspective, perhaps the hard way, from the very start of my data collection. At that stage, my idea of professional identity was that this is the sum total of knowledge, training and know-how that the practitioner carries and brings to bear on clinical situations, in order to address a health need that contributes to the well-being of service users. Professional identity issues, I thought, could be linked principally to feelings of competence and thence to a level of preparedness. I was considering practitioners as 'units' that carry around this identity and I could tap into it and basically, look at its strengths and shortcomings with respect to the demands of the practice field; a mere function of competence. And also at the construction of this identity as this is related to the educational process. As an educator, my idea was to use these findings to improve student preparation by mainly looking at what missing clinical knowledge needs to be included in the degree programme. I had no idea that I was on course to unlock a veritable Pandora's Box of perceptions with entirely different origins and with completely unexpected implications.

After I conducted my first focus group, I was immediately inundated with the practitioners' discourses on the experience of their identity as it interfaces with the external world of their professional environment, along dimensions dominated by issues of intelligibility and self-consciousness about their means and tools. Their concern about public recognition and approval was overwhelming and caught me unawares.

I tried initially, and possibly misguidedly, to persist with propping my initial assumptions and tap directly into the concept of professional identity I had in mind, but eventually, came to terms with the way that my data was being generated and was eventually able to recalibrate and readjust my outlook. And this is basically the reason why I started my review of the findings from the 'experience' of professional identity, rather than the 'articulation' of it. I believe that the former construct occupies a more important space of meaning and thence thematic territory.

I believe that I have compelling evidence to suggest that in the psyche of Maltese practitioners, public recognition matters quite a lot and merits careful scrutiny and development as a specific theme area. It also seems to predominate over other considerations related to identity. In order to manage a glimpse into the workings of the practitioners' internal professional identity, I was limited to do this in an indirect way, by inviting the participants to reflect on themselves as professionals and to express articulations on what they offer. Several strands of discourse that I will be developing in this chapter will evidence this.

### **7.3 Narrative of Principal Theme II: The Articulation of Professional Identity**

The fundamental finding which is at the core of this theme, is the difficulty or even anxiety encompassing an explanation for or definition of occupational therapy seems to occasion in them, and this is ascribed to the fact that there is no simple way to offer such a definition. The following quotations give a flavour of this dilemma:

*P22: It is so vast, what we do, that you start off with like this general term of what OT is and then you end up saying: "But we also work in mental health, doing this and we also work in paediatrics, doing this and we work at the (an independent living centre) doing that" so you have so many things that we do, that to just explain it in like a few sentences is so difficult: you start the ball rolling about what OT is and you keep going, sort of.*

*P2: Even the definition of OT in itself is so long and complex and it involves cultural, environment ...*

In the following extract, the issue of the challenge of explaining occupational therapy is also highlighted, but the quotation also reveals the level of deep irony and drama that is associated with a basic personal identity tenet for occupational therapists, which is the ability to articulate their profession, essentially what they do for a living:

*P7: No, it is not challenging, [laughter] ... it is a crisis. For me personally, because every time a person asks me, "What do you do for a living?" I say "I am just ..., I am a therapist." I don't say I am an occupational therapist. ... maybe I am the most pessimistic person here in this room but, but I just say "I am a therapist." Full stop and don't ask me more questions about that. Because every time that I say that I [m an] occupational therapist, they, I have to explain what occupational therapy is and they don't understand and that is frustrating.*

This excerpt also touches upon the intelligibility issues of occupational therapy and articulating what it is – a conflation of the two pivotal issues which this research is untangling. This is also a demonstration of the inextricable linkage of certain concepts and, effectively codes (and their undeniable interchangeability), in the semantic matrix surrounding professional identity. This might, inevitably, lead to an occasional harking back to the previous theme.

## **7.4 Review of the Subthemes**

The dimensions or manifestations of the articulation of professional identity will be represented in the following five subthemes:

- Defining and Explaining Occupational Therapy;
- The Vast Identity of Occupational Therapy;
- Circumscribed Identity Defined by the Area of Practice;
- Articulating the Unique Quality of Occupational Therapy;
- Values/Traits Underpinning and Exemplifying the Identity of Occupational Therapy.

### **7.4.1 Defining and Explaining Occupational Therapy**

Fundamental to practitioners delivering a service in a multidisciplinary/interprofessional environment, is their ability to describe themselves to others, such as other professionals or service users. This could also be important in the education of students. This subtheme captures how this fundamental skill of describing their work does not seem to be firmly established in occupational therapy practitioners, for a number of reasons. For example, participants are faced with the challenge of providing a definition of their profession, when it is very multifaceted and they seem self-conscious of the fact that the

public will not understand it. Therefore, they tend to modify their definition or explanation to adapt it to the audience that they face. For these many reasons, they do not have a standard definition of occupational therapy. This seems to give rise to latitude in the characterisations and definitions of the profession that they articulate.

The following excerpts suggest the difficulty that occupational therapists experience with articulating a definition for occupational therapy, in some cases even after years of practice:

*P24: When I think about it, I ... when we try to explain to patients what we do, it is always a bit difficult ... So, when I ... when I looked at it I said, "Mmm, difficult to explain ... I find it difficult to explain to somebody, even now after seven years, what we do. ... That's when I think about it, that's what comes to mind, how difficult it is to explain what we do.*

*K3: ... So, people find it difficult, even I find it difficult after working all these years to define OT and the less experienced therapists will find it a little bit more difficult I think, than the more experienced people ok?*

*P28: Personally, I think, that this causes a lot of frustration for me. Because unfortunately I feel that we still face a lot of difficulty to be understood.*

*K2: It has come ... well it is something that has evolved so, obviously ... I think I have spent most of my career explaining what occupational therapy is from ... having done a course in the '80s which was basically the second course in Malta, it was always, ... promoting what we do from a very young age. What we do, what we can offer and I feel we do have a lot to offer so maybe it didn't come naturally, but I taught myself how to do it and I think we can teach our ... we need to drum it into our students and our staff ...*

*P18: And sometimes it is confusing for us, as well, because if we have been working for the past five years in ... with geriatrics or young patients. And then people just come and ask you "What can I do for paediatrics?" Sometimes even for us, they get ... you know, we are caught [unawares?] Because you are not that much into the [paediatric field] ...*

These quotations are all particularly striking as they highlight that defining occupational therapy does not come naturally but possess some difficulty or it evolves overtime. It is as if it is an acquired and deliberate skill and involves coping with a range of possible ways of looking at the profession. The final extract highlights how the practice of occupational therapy across different specialties can even confuse occupational therapists themselves, compounding the issue of attempting to define occupational therapy.

Attempts to explain or define occupational therapy range from the tentative to the comprehensive. There seems to be an absence of a spontaneous, on the spot utterance

or a readily available statement that tenders a definition. Instead, respondents seem to go through a process of assembling an explanation in the absence of a firmly established or standard way of explaining the profession. Some participants attempt to enhance their definition by giving examples of practice, as can be appreciated from the following excerpt:

*K3: ... I would define OT as a profession that helps the individual reach their goals ... in various aspects of daily life, including personal care, work and leisure. In order to be a more active participant within society or to improve his quality of life. That is how I would define OT.*

*K3: You might give an example, for example, of a stroke patient ... who was well and suddenly his whole life has changed. How can the occupational therapist help him? ... How is he going to manage his personal care, self-care? How is he going to manage the daily chores of getting in and out of bed, of ... functional transfers? How is he going to engage in community activities? How is his home environment, the outdoor environment going to affect him and how occupational therapy can contribute in overcoming these difficulties and then obviously at a later stage, looking more also at other community skills, like driving, like going out to work, participating in leisure and social activities. ... And also the educational aspect that we contribute towards ...*

The next definition is developed around the concept of occupation, but could be construed as rather different to the previous description of the profession, as it introduces new concepts, such as occupational justice. I feel that both these definitions are quite articulate, but carry dissimilar terminologies, which might give the impression of a different professional physiognomy:

*K4: ... I think the best way to define occupational therapy is to look at the interests and skills of the individual, we try to help the individual be as independent as possible ... the occupational therapist helps the person to learn and achieve new skills and abilities, so that the patient feels ... engaged and it is also related to occupational justice. If a person has a lot of skills, but hasn't got the opportunity to practise those skills, that is [a] form of occupational injustice. So, one of the main roles of the OT is to ... help the person be engaged in purposeful and meaningful activities so that he feels empowered and able to function in a good quality of life ....*

Some participants report that they eschew giving a definition or perhaps avoid explaining “directly,” but demonstrate what occupational therapy is by doing:

*P33: [I work it out through assessment, because you try to explain but, but get a blank stare. When you conduct the assessment, perhaps when you discuss how their condition was before and how they find themselves now; and then you tell them: “I will be the person who will be assisting you to regain those skills you had before, and we'll take it from there.” Then it's: “Ah, alright!”]\**

Although such a strategy appears to work for this practitioner, it could be said that this way of explaining a profession lacks a semantic or linguistic distinction or qualification, about professional identity that can be conveyed to an interlocutor. This could be a notable omission in a professional environment. Other participants have tendered arguably more tentative examples of an explanation or definition, such as the following:

*K6: I explain it like ... We are trained in ... assessing and working and helping patients holistically ... to identify their needs after an injury, after an illness, after a disease. Identify their holistic needs. Like their physical, psychological, emotional, social, occupational needs and try, together with the patient [to] help them to regain their ... or recover from their ... the problems caused by their illness.*

*K1: Basically, I would tell him that I will, I will focus on his daily needs that will ... that these will focus on the personal and the domestic ADLs however we go into other aspects. If the patient is at a working age, we can see the type of work, we can do specific assessments. If he is still driving, we can give advice on that. If he is a full-time wheelchair user, we can go into that aspect but most of all, I would emphasise during my definition that it is what the patient wants us to work on, what [his issues are], what are the problems [that] he is facing now.*

*P35: [I try to explain that during the patient's stay in hospital, we will try to help on skills associated with roles, such as the role of a mother, or the role of a housewife. Perhaps helping in ... re-establishing contact with the workplace; perhaps after discharge, he will have a more tranquil life and integrate with the community.]\**

Although these definitions do capture the quality of occupational therapy and are offered by seasoned practitioners, these demonstrate the pitfalls that clinicians face with explaining occupational therapy, <sup>1</sup>exemplified by the fact that there is not a readily available definition or a shorthand way of explaining the nature of occupational therapy.

The matter of intelligibility – being understood, or a fear of not being understood - also seems to impinge on the way that therapists explain themselves, and this adds a further dimension to the range of possibilities: the explanation has to be modified or ‘pitched’ according to the audience for which it is intended:

*P9: And in fact, to latch on to what P11 is saying, that is one of the nicer things in our profession that we are so varied that even the explanation we can customise to who our audience is. And it takes a lot of personal knowledge and confidence ... And insight to be able to customise your response. It's not a recipe.*

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<sup>1</sup> Extensive text passages enclosed in square brackets followed by an asterisk, [ ]\*, have been translated from the Maltese language

This last extract seems to imply that representing the profession depends on the particular articulation abilities of the individual practitioner requiring “a lot of knowledge and confidence.” It is questionable, perhaps, whether these abilities are readily available for students and newly qualified practitioners. Further substantiations of the adaptation and fine-tuning that occupational therapists make of their definition is shown in these examples:

*K3: It is complex. It is not, not everybody ... of the same intellectual level [laughter] might understand it immediately. Sometimes, you have to change that definition to make it more practical, in practical terms.*

*P13: I have changed, I mean, I have moved to the medical wards after a year away from the profession. And I have seen ..., I am in a completely different set-up, a completely different environment. The clients which [who] I see are elderly so I mean, it is even more challenging to explain to an elderly client what we actually do but there again, you cannot ... put everyone in one box you have people who are receptive to what we do and you have people who are not receptive, no matter how strong and how willing and how ... eager you are to explain. So ... up till now, I have not stopped. ... it is still ... a challenge to explain what we do but I never surrender ...*

*K5: I would give examples of daily life. I think examples carry us through, they make us more professional and you are talking in the language of the lay person ... Now, if it is a professional, I would go into ‘occupations,’ ‘daily living’ and more sophisticated terminology but basically, I would explain what we really do through examples.*

In this subtheme, I have captured some of the nuances associated with the articulation of professional identity, around the idea of defining and explaining occupational therapy. These nuances range from a tension or pressure that practitioners profess to experience when finding a definition; the range of definitions possible from the highly articulate to the tentative; explanations which transcend the transmission of a definition and rely on doing or giving examples; and the adaptations that are necessary to overcome intelligibility challenges.

These reflections demonstrate the range of semantic and linguistic standards prevalent across sites of the profession in Malta. This subtheme hints at a number of concepts on the articulation of professional identity by occupational therapists, which will be developed and interpreted in the ensuing themes.

#### **7.4.2 The Vast Identity of Occupational Therapy**

This subtheme illustrates another factor or dimension of the challenge that occupational therapists experience when they are required to define or explain the nature of occupational therapy, and this is their wide-spanning professional territory. The task of offering a succinct definition of the profession appears to be made daunting when practitioners are faced with the multifarious “vast” domain of occupational therapy. The following two extracts illustrate this quite eloquently:

*P7: But I believe that occupational therapy, its definition is so vast. I remember my first definition, I mean, reading it on a book, I don't remember which book, it had fourteen lines. So we look at quality of life, holistic approach, we look at the psychological aspects and many other things, many, many other things and it is not related to one area. So our role as occupational [therapists] is so unique that we have to find a lot of words to define it and that in itself ... is good. ... our philosophy of care is so beautiful and yet ... unfortunately because our definition as OTs, is very vast, skills, independence, function, quality of life, being client-centred and all those definitions which we all know, so vast.*

*K3: It is not easy finding a definition for OT because it is so vast. It is difficult to touch on all the aspects and all the areas.*

*P14: That's the problem because our profession is so vast and it touches so many people that it ... It is not easy. That's the first thing I open with.*

The difficulty articulating what occupational therapy is, in my opinion, very well captured by the sentence from the extract depicted above; “*So our role as occupational [therapists] is so unique that we have to find a lot of words to define it ...*”

A potential audience who could be the recipient of the definition of occupational therapy, such as students and service users, may bring with them their own knowledge of what occupational therapy is, but this knowledge is not reinforced or confirmed by the different realities, images and explanations offered to clarify the various “missions” of occupational therapy in its diverse settings. This phenomenon, a by-product of the “vast” territory of occupational therapy - occupational therapists doing very different things in different settings (first citation below) - could be another manifestation of the intelligibility issues that occupational therapists face which has been amply discussed in the previous chapter. It could also pose another challenge for practitioners in the profession seeking to articulate the nature of practice. I have chosen the following quotation in my survey of data extracts as I feel that the point is illustrated in an incisive and rather humorous manner:

*P31: We do have a lot of roles that might confuse a person. For example, once I was seeing an elderly lady and she came here for arthritis and then she told me, "I don't know, my niece is being referred for OT, as well, she is naughty."*

In the above citation the participant explains how a service user finds it difficult to understand the nature or reconcile the different 'natures' of occupational therapy. These 'natures' are the occupational therapy treatment of her arthritis, and her previous experience of the profession when her niece was referred to a paediatric service because of a possible behavioural or perhaps an attention deficit hyperactivity disorder. This underscores the ostensible absence of commonalities across the practice areas of occupational therapy and which undermine the possible imprinting of a single characterising image of the profession to external observers. The following quotations continue to illustrate this phenomenon:

*P22: I had an experience recently where I was speaking to a teacher and this teacher said ... "Where do you work, what do you do?" And I said that I was an OT and they explained to me. "Oh so, where do you work?" I was explaining that I worked in a ward and they said, "So you teach your patients how to write and how to ...?" They were linking it to how the paediatric OTs work and I was like, "No, it is not the same ... I check all of their ADLs and I go through how they used to work and if they used to drive." And they, they just had the blank look on their faces, they couldn't link how I was an OT and they had seen the OTs working [in] the school, how we were linked as a profession because they were two different areas.*

*P2: Even when we have students, for example, first years, here and they have been to a different place and they have seen OTs working in a different way. So when they come here, they are surprised that we do, for example, some things that in other hospitals they don't do. Because they don't realise that our role is so vast and different. It is different from working with paediatrics and then I am here working with geriatrics. Our role, our input with the patient is completely different. For example, even to explain to my friends that I work in [name of service omitted] and I do certain amount of things and then they tell me "But you also work with Housing we don't have patients in the Housing." So, they don't know the link, they don't know how to link the OT as a person that ... we have so many different roles, they think, "Ok you do passive movements, you do follow up ADLs." "But then what do you do with children?"*

*P12: I think that the reason is that the physiotherapy principals never change. Our profession is so vast, that [with] every rotation it is like starting from scratch. If I go to, let's say at [name of service omitted]. If I go with [her]\*, for example, not [her]\* because at least she is in orthopaedics. If I go to a neuro medical ward and then they send me down to the hands. If someone doesn't tell me, I might not realise that both of them are OTs because the things that we do are totally different.*

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\* Name of practitioner omitted and replaced by the pronoun 'her.'

Not having a unitary definition of occupational therapy and faced with so many different facets of the profession, practitioners seem to move to a default position of talking about their specific area of practice. This is demonstrated in the following citation:

*P18: And I also find that according to the setting and the context that I am [in], I explain occupational therapy. Our professional identity is very vast.*

This subtheme has illustrated the challenge that practitioners face to encompass the nature of occupational therapy when this is so wide-ranging and varied. It also demonstrated that some foreknowledge of occupational therapy by the service stakeholders, such as students and service users, is not reinforced by articulations of practitioners in different service settings. The diversity of occupational therapy seems to lend itself to being articulated according to the practice setting. This aspect will be further developed in the next section.

#### **7.4.3 Circumscribed Identity Defined by the Area of Practice**

Instead of tendering a generic and overarching definition for the profession of occupational therapy, participants seemed more comfortable explaining what they did in their particular area of practice. This could be a type of coping strategy that provides them with a simplified way of describing their profession that circumvents the challenge of encompassing the complexity and the vast territory of occupational therapy, as outlined in the previous subtheme. It is as if the practitioners manage to produce a definition by referring to what they do in their speciality; although this could be indicative of deeply inculcated views on identity. In fact, participants portray how this way of describing occupational therapy seems to emerge naturally as a consequence of how their roles have developed over time in specific service sites.

The following quotations come from two practitioners working in highly specialised areas of rheumatology and hand rehabilitation and illustrate this reality:

*P5: Nowadays ... what I feel safer doing and I feel more confident doing, is explaining what I am doing now as an occupational therapist. So, what I say is I work with rheumatology clients, people who have arthritis, because that is the lay term and phrase to use and I clearly explain that I help them get more independent, with getting their hand function ... better and recommend any other equipment which makes their life more functional, practical, easier - quality of life.*

*P32: Probably P7 will agree with me on this. In our case, I feel that the shift that we need to do from what we are as occupational therapists to hand therapists. Honestly, I feel that I lost the uniqueness of being an occupational therapist. If someone had to ask me, as P5 said before "What are you doing*

*now, how can you define yourself?" I don't define myself as an occupational therapist anymore. No I don't. Basically, I define myself on the type of clients, on the types of conditions that I see every day but I don't define myself as an occupational therapist.*

The point made by P32 seems to be more assertively presented and the underlying concept also seems to be taken to rather more extreme limits. It might be argued that working in these two highly specialised areas constitutes a fundamental move away from the tenets of the profession and some qualification of the definition of what one does is expected. But it is somewhat extraordinary for an occupational therapist to declare that she/he does not define professional self as such. But practitioners from practically 'all walks of service' seem to profess that the type of client group with whom they are working with, appear to guide them as to how they define and identify themselves:

*P17: It (the definition) depends on what client group you are working with.*

*P14: Exactly, because with children it is totally different, with mental health it is completely different, here it is different. Palliative care - very different but it is always ... obviously what I always say is that the patient is at the centre of our care.*

*P18: Our experiences, I think, our individual experiences at work that would, that would obviously impact on our professional identity. Because if you have been working with ... if I have been working with geriatrics and young patients, ... I would automatically link my professional identity to what I do with these type of patients ...*

*P30: Usually ... on an introduction of an assessment I introduce myself as an occupational therapist and tell them, "... I am going to tackle performance, school performance which involves writing, attention, coordination and other difficulties that the child might be meeting, ADLs in self-care and leisure – play, sports and other ..."*

Such a way of defining occupational therapy would seem to be characteristic of the profession, at least in Malta. It also begs the question as to how much this works towards characterising the distinguishing and unique qualities of the profession to the public, and also how much this aspect is uppermost in the way of thinking about themselves in occupational therapy practitioners.

The following extracts portray the characterising and explaining of occupational therapy in relation to specific service sites. These also carry a reference to a philosophy of occupational therapy, which seems to be a surrogate of the idea of having a common, overarching and unifying quality to the field:

*P2: So, sometimes it is difficult and I make it a point that, for example, what I am explaining refers to working in geriatrics because in mental health OTs do different, other things although the philosophy is the same, but what they actually do is different.*

*K5: In Paeds, in Geriatrics also, but unfortunately it happens that we portray images according to where we are working. And yes, I think that students can get lost and young therapists, and they will say, for example, with that particular population they do newspaper groups, so “We are the newspaper group therapists.” At Mater Dei, they do ADLs and washings and “We are the washing therapists.” But it shouldn’t be so and whoever is supervising students and young staff should be able to explain that there are the personal differences so, one case can be treated differently by different professions. There are the population, the sample differences, but we still should have one arching philosophy, occupational performance through occupation.*

In this subtheme, I have explicated how practitioners in occupational therapy appear to associate explanations and definitions of their field around the service and client group that they serve, instead of overarching explanations which clarify the nature of occupational therapy. This way of defining the profession does not seem to be limited to the more specialised services, but seems to be a common occurrence across service sites. Some participants have referred to a common philosophy linking the different service sites. One is prompted to ask why this philosophy is not proffered upfront to explain occupational therapy to potential interlocutors who might have a vested interest in learning about the field. This notion will be further explored in the next subtheme.

#### **7.4.4 *Articulating the Unique Quality of Occupational Therapy***

Through the narrative arc of this subtheme, I have sought to unpack the articulations that the participants have externalised when they are confronted with transmitting the unique or distinguishing feature of the profession of occupational therapy. On the one hand, they seem to be faced with the proverbial embarrassment of the choice, but also might experience difficulty aligning themselves to a characterising construct.

As a starting point, I will demonstrate how practitioners appear to acknowledge or realise that professional identity can be reduced down to a distinguishing or unique quality. The following extracts make reference to a quality which demarcates occupational therapists from other professionals:

*P35: Yes, what makes us unique as an occupational therapist rather than another professional.*

*K4: Ok, what I understand by professional identity is that one focuses on the core skills of the profession. When one thinks of oneself, for example, as an*

*occupational therapist, one can focus on the specific skills one is able to perform in a particular set-up.*

*P18: And also what makes us different from other professions, as well. That we have our own professional identity and we are different from other professionals.*

Other participants have ascribed this unique quality to a characteristic that is shared by occupational therapists across service sites. This is exemplified as follows:

*P20: I think professional identity is the philosophy we all share of the profession. It is the shared values, we all share and the dynamics of the profession, as well. ... that is what I think is the professional identity.*

*P31: Depending ... if you are working in a mental health setting, here in physical. It is something common that wherever we work ...*

*P26: [Even the areas, the distinct areas that we work in. Although we work with different clients in different hospitals, we have the same concerns that we, as a profession work upon.]\**

Far from being at a loss to identify what is the unique quality of occupational therapy, the participant practitioners were able to identify a wide range of constructs that they feel are unique to the profession of occupational therapy. These seem to be the perennial buzzwords that saturate the profession; but they come across as more akin to identifying ideas about the field, rather than satisfactorily coherent articulations. Examples of these are represented in the following extracts, grouped under a number of key terms:

❖ Key word – Function

*P7: Yes, I use words like 'function,' 'regaining skills' which is very important. 'Independence,' of course. I don't use the word 'quality of life' because I mean, my setting is not exactly related to that but basically, mainly those three words.*

*P9: That we value functional performance because that is so obvious that nobody gives it a second thought.*

❖ Key word – Coordinating

*P24: But can I tell you something? Because I think like what also makes us an OT, at least I think so for myself ... we ... tend to coordinate things for the patient.*

*P11: The whole picture. You speak with the relations you know, you coordinate; it is us most of the time, it is us who end up coordinating ... with the other professions to put everything in a circle because you will have all these segments.*

*P24: So we tend to refer, we tend to liaise a lot.*

❖ Key word – Holistic

*P11: I think it is truly us that we see the person in front of us from a holistic point of view.*

*P24: We, so we ... because we are more holistic I think, even [compared to] physios I think we still are more holistic it is still a quality which is ours, I think. Because we see all the ADLs, we see everything. So, bathing, domestic, work, leisure, so we would get a very good idea of the patient. Even family and even sometimes when we have couples, you get an idea of the dynamics between the [laughter] couple and all those things and now we are getting, as well, more into sexuality.*

*P18: And I think, sorry, I think function ... is more holistic because if you think about paedcs they might not be independent. You know, maybe children who have severe disabilities, they might not be completely independent but at least they can ...*

❖ Key word - Task analysis:

*P19... task analysis, we adapt the activities according to clients' needs, [that is what I can relate] to the OT background.*

*P14: We are the ones that [who] can understand the patient on those levels and we break down tasks according to the skills needed and we can intervene.*

❖ Other key terms/qualities:

*P17: Activities. The use of activities.*

*P4: I think that something which is heard is 'enablers' and 'empowerment' for the patient.*

*P12: It is one word for me, 'community.'*

*P14: And what ... we are very client-centred and what the client wants is our priority. We try to compromise with the client regarding our goals. But mostly I try to tell them that we try to give quality of life. We try to make them, make patients more independent in activities of daily living. That is it basically, but mostly we stress on quality of life and independence.*

*P24: I don't know whether it's perhaps function and quality of life.*

Some clinicians have disputed whether in fact certain qualities, generally recognised as uniquely occupational therapy, were actually truly exclusive to this profession. Such discourse is illustrated in the following focus group exchange, which refers to the key qualities of client-centredness and quality of life:

*P22: Ah ha, that is why I think it is a bit vast saying 'quality of life' because even if you ask a nurse, they say "I am here to improve their quality of life."*

*P24: Perhaps client-centred being client-centred or that is not a bit ...*

*P22: Everyone says that they are client-centred now!*

*P15: Everyone [says] it, whether they do it or not is another thing but everyone [says] it.*

*P20: Everyone is using this term now, even politicians. [laughter]*

The notion that the concept of being holistic (cited earlier) was unique to occupational therapy, was also contended:

*K2: "We are holistic. We are holistic." But now, to be honest, all professions have caught on and are ... we have physios saying that they are holistic, podiatrists saying they are holistic, nurses are holistic so it is nothing unique.*

*P34: Holistic, exactly [laughter]*

*P30: However, a lot of professions are using that buzzword.*

In some instances, the idea of the unique quality of occupational therapy is captured in a complex articulation, but not conveyed in a single descriptor. Examples of such instances are given in the following extracts:

*P13: I think that as I have said before, that not just seeing the person as a problem or as John with a CVA, but who is John? And John's family and what did he used to do before and how was he before? What can he do now? Not what can't he do. ... if you had a weighing scale trying to balance things the person being in hospital ... it is already a big thing to having to stay in hospital to get all these tests done, CT scans or whatever. Having someone that gives him hope and gives him a positive outlook.*

*P21: I think that something that we have that makes us unique is the fact that [...] people, given the required amount of information and empowerment can adapt to new situations. If you [harness] their potential and you help them through every step of the way, you can help them face what is challenging them at the moment ... especially in the case of trauma patients. They just end up in hospital because something happened and they are now ... in bed with a broken leg or anything but if you help them understand what their strong points are and you work on those, they can do things, but different to what they used to do before this episode happened. Then, we can help them to improve their outlook on life and actually their performance. Even psychologically, it gives them a lot, it gives them a boost.*

In these instances, it is as if something is bubbling under the surface as these practitioners attempt to explain the uniqueness of occupational therapy. An attempt to

convey an authentic and genuine flavour of what the profession is and means, but which might come across as vague and 'woolly' to a potential interlocutor from outside the profession. Although the concept of occupation is now widely accepted as being what is at the foundation of occupational therapy, it is not cited spontaneously by the participants to characterise the field. This appears to be a minority occurrence. Instances of the use of occupation to convey the unique quality occupational therapy are given below:

*P37: [Furthermore, in connection to the question you were asking before, I think it's the idea of occupation perhaps, I am biased, well not maybe, I am biased.]\* Occupation is a determinant of health. [I think that is] what makes us, "us."*

*P30: Yes, sometimes I ask myself, "Why? Can't someone else do it? Why do I have to do it? In the sense, is it my professional role to do ... what I am doing or can someone else with less training do it?" So what makes me unique is the way I look at the child's occupation.*

*P23: I think it is the reference that there is to occupations - no other profession does that. ... we are the only one, the only profession who [which] looks at the child's .... and assess and see their level of participation in their relevant occupations ...*

*K2: I think ... occupation as occupational therapists, occupations, roles, the occupations has to be the common defining, defining identity in all areas. From mental health, elderly, everything. So, obviously in [the] elderly we have different occupations, even if it is just getting up, washing, eating and remembering certain events, you know? Just their personal ADLs but ... and then it could be to young stroke patients who need to be rehabilitated to go back to work, but it should be something that is a common vein through all departments.*

Although a minority of participants mentioned the term 'occupation' to characterise their profession, it could be argued that their utterances stood for strongly held positions, which were powerfully articulated. Still, the use of the word 'occupation' to embody occupational therapy was questioned by some of the participants. It was felt that occupation could not be applied as an all-purpose explanation to represent the discipline.

The term 'occupation' might not account for or cannot be applied to the very dependent clients. The view of some practitioners was that an explanation of occupational therapy has to be more fine-tuned. The word *engagement* was suggested as characterising the uniqueness of occupational therapy, in lieu of occupation, as it was a more inclusive term.

The following extracts illustrate this perspective:

*P9: ... It's occupation but it needs to be edited according to the relevance of the setting mostly. If, for example, we have ... apart from the very dependent patients again, the bedridden with contractures, and NG tubes by the way, who come here in that state, already ... I think the explanation of OT should be more widespread than this and it should take into account those clients who will not be able to be occupied and be integrated in an occupation because many of our clients are not. And I think that rather than occupation, engagement is a much better word because it offers a lot of subtleties ... I think it [occupation] is limiting. I think it is valid and for some places, it is 100% true, but it cannot be used as a general explanation of occupational therapy when you see the realistic settings that it is going to be applied to.*

*K7: So, I am trying to find a perspective that binds us. I think, I would say 'engagement' but I am sure [laughter] not all OTs understand what I am saying ... I think that [it] is a crucial role that we get the person to engage in whatever the person needs.*

Perhaps related to the above discourse, the following extract explains how the term 'occupation' may, in fact, be limited to encompass the scope of occupational therapy:

*K3: ... I wouldn't say that the 'exclusive' domain of occupational therapy is occupation because as OTs, we have a vaster [wider] role. Like I said, we can be there developing policies, standards. Looking at contexts, looking at new issues which are being faced, for example, the immigration. How is that affecting people within occupation? Alright [maybe] within ... but it is not only about occupation and it is occupation because even their daily tasks are occupation and their socialisation, you know?*

Although the occupational therapy literature could be bandying about the term and concept of occupational as a panacea for the identity and scope of the profession, this might be, in some cases, actually limiting the scope of the profession. The proliferation of terms and concepts tendered by participants to characterise the uniqueness of occupational therapy, reviewed earlier in this account, could be taken to support the view that occupation could be limiting as a term. This is especially the case when one considers the "vastness" of professional terrain, also identified as a subtheme herein.

This reflection is echoed in the following extract, where this participant makes reference to limiting the explanation of occupational therapy to a single factor:

*P22: I think we do need it but then at the same time, if you just say that, for instance, if you are explaining OT, you limit ourselves and we lose all of the other things that we do ...*

The purely semantic implications of the term 'occupation' were also contested, it is as if there is the worry that the general public might construe 'occupation' for its more mainstream usage, i.e. what people do for a living, and not in the broader way that occupational therapists understand it:

*K3: ... It can be, but the word 'occupation' might be misinterpreted I think if it is not defined in its broad term. ... This is a definition that is understood by OTs. The public will not understand.*

I consider this subtheme as a key finding of this research and contributes considerably towards our understanding of how Maltese occupational therapists conceptualise themselves as professionals.

The descriptive sweep of this complex subtheme has spanned a narrative of discourses articulated by the participants around the issue of identifying the unique quality of the occupational therapy profession. The starting point was the acknowledgement that professional identity is associated with a distinctive quality that is shared by occupational therapy practitioners across service settings.

An overview of the many constructs suggested by participants to characterise the unique quality of occupational therapy was considered; some of these characteristics were disputed as being actually unique to occupational therapy. Next, important justifications on the use of term occupation were considered. The account of this subtheme was concluded by a consideration of arguments that were brought to bear on the possible limitations of using 'occupation' as an explanation or for portraying the uniqueness of occupational therapy.

#### **7.4.5 Values/Traits Underpinning and Exemplifying the Identity of Occupational Therapy**

Within this subtheme, the values and traits that Maltese occupational therapists seem to hold very dear are explored. Discourse on the values that underpin professional identity were prompted by reflections that the participants were encouraged to make on the definition of professional identity ascribed to Ibarra and Schein: *"Professional identity is defined as one's professional self-concept based on attributes, beliefs, values, motives, and experiences"* (cited in Slay & Smith, 2011), which I utilised during the interviews. Therefore, most of the statements around this issue have been extracted from the interviews that I had conducted with key informants, namely managers of occupational therapy services and senior practitioners principally involved with administrative work, after I had completed the focus groups. I have to note however, that participants in focus groups had alluded to values indirectly when they referred to occupational therapy as being a vocation, in order to highlight its profoundly humanistic nature and ethical mission. This finding was further explored in the key informant interviews.

In the following focus group interaction, participants first introduce the idea of vocation in an attempt to highlight the central importance of personal qualities or traits that could motivate the taking up of occupational therapy as a career:

*P33: [I see it as a vocation rather than identity, professional identity, because if you take up this job, for example for the pay, or because you liked one aspect of it, if you don't feel an intrinsic liking for it, I don't think you can be a good professional and have a professional identity?]\**

*P37: [I want to continue with P33's point. All the points that you mentioned tie in with who you are. I think that generally you choose a certain line of work because there is something which resonates within you, with what you are.]\**

These germinal points were further developed by reflections from key informants on the implications of considering occupational therapy as a vocation. Participants seem to assume that being considered as a vocation, the individuals pursuing the discipline have personal qualities or traits that could be termed broadly as caring but can be much more.

The participants also reflected on the fact that if occupational therapy can be viewed as a vocation, this makes it more than a mere job, once again highlighting the humanist calling of the profession:

*K7: It is easier if a person sees it as a vocation, rather than a job. In fact, I think the difficulties that I encounter as Head of Department would be with persons who see OT as another job because for me, they wouldn't be viewing the holistic aspect of the person but concentrating on seating ... I don't believe you can be a good OT if you don't have passion [laughter] because it is a vocation.*

*K4: Because occupational therapy is not a job. I mean, if you are looking for a job to make money, I don't think it is the right job because we are not there to make money. The main aim if one is working in [such] a profession is care. I think the only occupational therapist[s] who do not work that closely with people are those in management, otherwise, an occupational therapist has to be hands on, working most of her ... spending most of her day in direct contact with service users.*

The following extract from an interview of a key informant explains how the profession of occupational therapy requires personal traits that might not coincide with those of other health professionals; this also links to the reference made in an earlier quotation, to the "the holistic aspect of the person":

*K3: ... Even with ... severe disability in an institution ... or somebody who has had a traumatic brain injury ... or somebody with mental health issues who is highly depressed [or]... somebody who is hallucinating, somebody*

*who has schizophrenia [or] a child who is non-responsive, ... you have to see beyond the presentation, the symptoms ... We are not there to treat symptoms, like a doctor is ... We are not there to treat a hip fracture or muscles or the bones. ... We are not there to do tests, or blood tests ... we are not there to project a voice. We are there to help the person, or the family, or the carers to make the most of the situation and to improve that person's quality of life. So, it is a vocation because not everyone is able to do that ... I mean, not everyone will ... have the characteristics to work as an OT.*

A similar point is underscored in the following extract that underlies the fact that the personal qualities that make good occupational therapists could be rather different from those required in other health professions:

*K7: I like this statement because I think that as a profession - occupational therapy - there are certain qualities that a person needs to have. It is not just being trained or skilled in something but ... in fact, we joke about it sometimes we see persons going for physio and we tell them "Ah you should have done OT, you have the qualities of [for] OT." So, the personal part has a lot to do with it. It is true that with training, with experience you get the professional identity from there, but the make-up of the person, what builds him, his psychological formation, I think [has] an impact on his professional exercise.*

The same participant explains another possible key trait in an anecdotal fashion. This is the idea of the people-centric ways of working of occupational therapists, which may require the relinquishing of a professional locus of control to an extent not expected in other health professionals:

*K7: ... I know of a person who wanted to go into medicine, he didn't get all the grades, so he decided to go in for OT. When I heard that he was starting OT, I said, "He won't last." And in fact, he didn't last. [laughter] Because I know him from [as] a friend of my son. I know his mentality. He wants things done, now, by himself. OTs ok [want] things done but in a team, there is the team aspect, there is the letting go of what I say and the person-centredness. So, yes you would tell me, "Would he do [make] a good doctor?" [words not clear]. I would say "Yes, very much." Because in medicine you need to take certain decisions, yourself.*

Altruism is cited as a key value or trait of occupational therapists. The importance of altruism is linked to the fact that occupational therapists have to deliver services to highly compromised clients and in very demanding settings that can involve chronicity and clients with a low level of function and high dependency.

Extracts which articulate the value of altruism are reproduced below:

*K2: Altruistic characteristics, wanting to help others, genuinely help others. Wanting then, to give them skills to help themselves.*

*K3: ... The beliefs [so] I first got into OT because I believed I wanted to help other people ... I felt that I ... my personality is a bit ... but I am a bit altruistic I think as a person. I want to give, I want to see people better ... and be a good OT if there isn't that sense of altruism and wanting to give, wanting to help, wanting to get people to be the best that they can and a vocation means being dedicated, being motivated even in, in very difficult situations because sometimes we work under different circumstances. In the acute, there might be very quick turnovers we have to constantly adjust, you know? But you have to remain focused because otherwise you become a machine, you become ... very ... repetitive in your approach so unless you see it as a vocation where you are seeing literally the individual not the numbers then ... you won't be a good OT ... In ... more ... chronic conditions or long term care you have to have a vocation because otherwise if you just see that this is a dead-end for the individual and you don't see beyond that, beyond the person, the very frail elderly, for example, who is stuck in bed with an NG-tube.*

What I consider a different type of value also comes across from the data that is worth reviewing here and this is the issue of advocacy. In the following extracts, advocacy is linked with occupational deprivation in long-term institutional care and beyond; the points made are rather powerful and very strongly felt:

*P37: [But the issue that we "No, because we are not here to occupy"]\* No. Because that is our role to advocate and to make sure, and to be consultants on the basis of that these people, who are staying here for years [some of them] they have, you know, a meaningful schedule of, meaningful routine [words is not clear] ... Being the advocate for not having occupational deprivation and maybe ... consulting with the nurses and with the others what kind of activities these people need, of course that it is our role!*

*K3: ... of educating the family, educating the public, you know? Maybe representing the needs of the ... service users. [It is as if] we, we advocate for [repeated] the service users and their needs.*

*K7: For example, it is not ... we had an amount of persons, me included, that [who] were to a certain extent shy, but if you have a strong sense of justice, for example, you can still do the advocacy for the patients even though you are shy but the sense of social justice would help you to overcome that shyness.*

Advocacy might have a ring of idealism to it and one is prompted to question whether it should or can be the focus or expectation of a professional, and if, within the general population, this value can be considered as posing an attraction for occupational therapy? The following reflection from a key informant seems to deny idealistic considerations associated with the humanist vocational nature of occupational therapy, which was reviewed earlier in this subtheme account; this participant refers to knowhow and knowledge and seems to imply that professional qualities can be taught:

*K1: I don't ... when people see our work as a vocation, they will then tend to assume that we are like volunteers, doing, helping people ... We're ... I mean, for me, I chose this profession not because I want to go on [mission] work or something. For me, volunteer or vocational is that. That ... you dedicate your life [to] helping people in an unpaid way. We are paid and we have to stand up and give a service not because we are giving a vocational service. How can I explain it? ... Yes, you have the know-how, you have the knowledge. Not just, like, for example, it is a vocation as well to go to Kenya or in ... and help the orphanages. That is a vocation but I don't compare [occupational therapy] to that level.*

An additional, alternative explanation or facet, concerning the qualities required of occupational therapists will be considered to bring this subtheme review to its conclusion.

The following focus group exchange appears to survey the issue of diversity of occupational therapy practice and the required underlying traits of the practitioners. This point might negate the arguments made that occupational therapy requires certain specific deeply-held values:

*P14: But the basics ... would be there. If, you have the client and you have to show real interest in him whatever the age, whatever the diagnosis. I mean, you can have a two-headed child, he is your client and you have to ... use your skills but you have to demonstrate empathy and interest in your clients.*

*P9: But then again, P14, I think that the variety of settings and the variety of skills required in each setting will target every potential therapist because some will feel fulfilled in some places, which do not require certain skills that are required somewhere else, you know?*

*P14: I felt fulfilled when I worked with children and when I worked in mental health and here, because the basic (principle) is there, that you have a genuine interest in your clients.*

*P9: But then again, if you work in a fast-paced acute setting you won't need those set of skills.*

*P9: And those people who do not have it, choose that place. Everybody tends to gravitate towards where they feel better.*

The diversity of settings and ways of working within the profession, can have a corresponding diverse range of values that, in turn, attracts or accommodates a range of individuals with arguably different innate traits, aptitudes, vocational orientation and 'idealisms.' This could obviously be a strength, as it widens the appeal of the profession. But it could also be a source of conflict since diverse traits could influence work choices - how individuals work or don't, and where they *like* to work, with a possible corresponding lack of uniformity of how practice in occupational therapy should be. This

could also prove to be a source of strain with allocation of staff - "although occupational therapists," they may lack the personal traits necessary for a particular practice site. By the same token, this could be a source of tension for staff moving from one practice site to another, with attendant adjustment challenges perhaps more marked than in analogous situations in other professions.

The trajectory of this subtheme has spanned discourse related to the values and traits that characterise the professional identity of occupational therapists in Malta. The participants' considerations were principally expressed by reflections about the vocational nature of the profession and the humanistic qualities associated with this – altruism, client-centredness and advocacy. There was the implication that occupational therapy necessitates a special or exceptional type of persona. The idealism of this position is somewhat negated by a realignment to the idea that occupational therapy is a profession which can be taught, and that the diversity within the profession cannot be linked to a specific trait.

## **7.5 Conclusion**

In this chapter, I have overviewed the second Principal Theme that I had constructed from the data of this case study, namely The Articulation of Professional Identity. I have differentiated this theme into five subthemes, which I feel best represent the complex discourse associated with the articulation of professional identity by Maltese occupational therapists. I have striven to impart a strong narrative logic to my representation of this theme, in an effort to best convey my understanding and organisation of the findings to the reader. To this end, I have presented the sequence of subthemes in a nominal hierarchical order or as cogs mutually driving (arguably wearing down) internalised professional identity.

The review of the subthemes started by looking at the basic mode of the articulation of professional identity, which was the attempt at defining occupational therapy. Directly associated with this is the subtheme overviewing the realisation of the vastness of the professional territory of the profession and then, the challenge of defining it. The next subtheme could be construed to represent a type of coping strategy about the articulation of professional identity: defining practice around the service or client group serviced. Another subtheme was developed around reflections on the unique feature of occupational therapy – a sort of 'professional identity identifier.' The chapter also reviews the last subtheme which overviewed discourses associated with the values and traits underpinning the professional identity of occupational therapy. I have subjected each subtheme to a process of involution, i.e. an inward growth that enabled me to encompass

a range of meanings associated with the overarching conceptual and factual range of the particular subtheme. This chapter concludes the review of the themes and the allied subthemes which I have constructed from the various data sets.

In the next chapter, I proceed to discuss and interpret my findings in relation to discourse and research on the professional identity within occupational therapy. I start the discussion by fashioning a manageable synthesis of the findings detailed in the current chapter and the previous one. Next, I posit and develop broad or central explanations that advance the understanding of the tensions and possibilities that underpin the construction of professional identity in Maltese occupational therapists.

## Chapter 8 Discussion and Interpretation of the Results

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### 8.1 Introduction – Overview of the Findings

For the purpose of focusing this discussion, it would be pertinent to reiterate the research question addressed which reads as follows:

#### ***How is Professional Identity Articulated and Constructed within the Practice Environment of Occupational Therapy in Malta?***

From the thematic analysis which I conducted of the coded data derived from focus groups and interviews, I constructed two principal themes reflective of the concept of identity construction in the practice arena. Each of these principal themes I further differentiated into clusters of subthemes.

The first principal theme was *the experience of professional identity*. Allied to this were a number of subthemes that encapsulated aspects of the participants' discourse which ranged from the limited understanding by the public and other professionals of the professional identity of occupational therapists; congruence between identity and the underlying service philosophy and ethos of some of the practice sites; and interprofessional challenges experienced by practitioners. In other subthemes I also explicated emotive dimensions associated with the experience of professional identity. These included professional identity negating experiences and professional identity affirming experiences. This theme exemplified participants' experience related to the operationalisation of professional identity through practice. It was effectively composed from the participants' experience of outsiders' view of the profession of occupational therapy.

The second principal theme was constructed around the issue of *the articulation of professional identity by occupational therapists*. Participants professed to experiencing a challenge when they attempted to define occupational therapy, associated with an attendant anxiety when faced with struggling to encompass the range of concerns of the profession of occupational therapy within a unitary definition. Subthemes associated with this, ranged from attempts to articulate a definition and an explanation of the

profession; articulating the unique quality of the field; reflections on the vast identity of occupational therapy and the values underpinning it. This theme primarily embodied participant perceptions related to discourse and reflections on their professional identity and which could be construed as glimpses of their constructed internalised professional identity.

In my introduction to the first chapter of the results, I expounded the idea of *disaggregation* of data during the process of the analysis, which was the process of taking apart in an effort to manage the data and create evidence that can be transmitted as a finished research artefact. Disaggregation brought about a necessary and relative simplification of the complex constructed world of the participants and resulted in an objectification of this highly subjective experienced world of perceptions. This occurred through the process of coding. The subsequent assembly of the themes and subthemes constituted a process of re-aggregation of these codes across the data sets. In the next section of this report I will, in effect, posit a higher-order re-aggregation of my findings as a first step in a process that will enable me to tender broad or central explanations around the issue of professional identity based on the salient evidence of this case study. In order to do this, I have created explanatory frameworks or theoretical models based on a considered rationale which I will illustrate and articulate in the ensuing pages.

## **8.2 Mapping an Explanatory Framework Based on Salient Findings**

It is a considerable challenge to distil what could be considered salient in such a veritable maelstrom of rich data. I feel that the method of analysis and construction of the thematic material was a deeply considered process aimed to portray what is actually salient in the data. This, in itself, constituted a distillation of sorts and a concluded process, not requiring any further processing. But the analysed results as represented by the themes and subthemes are, in effect, an unfinished and open-ended process that does not offer explanations about the *in-situ* situation of the professional identity within the occupational therapy profession in Malta. My belief is that this process of the interpretation of the results requires a further subsumption of the range of themes. This will be a process of relative and apparent simplification that makes the findings more suitable to framing in theoretical perspectives that advance an understanding of the outcomes of this research. What follows is a rationale for and a description of this additional data reduction.

I feel that it is indisputable that the basic and most salient feature of this research is the concept of constructed professional identity. That this construction resides, albeit in a fluid manner, within the personal space of the participants is also irrefutable and I therefore posit that we can speak of a *constructed internalised professional identity*. That

this is part of the professional persona of the practitioners, in the way that it imbues them with professional knowledge and skills, is another incontestable consideration; and it follows that this identity is operationalised or actualised in the process of the professional's activities and the concurrent experience of these activities. These have been amply established by the findings.

Another way of externalising of the professional identity imprint is when this is *articulated to other actors in the field and to the self*; also firmly illustrated by the data. I have also demonstrated in this research that there are conducive and affirming professional interactions stemming from the experience of this identity, as there are those which were challenging and less reinforcing. In the domain of professional identity articulation, I have substantiated instances where these articulations have been problematical or characterised by a hesitancy; as, conversely, there is enough evidence in the data to demonstrate ways how to articulate the professional identity of occupational therapy in more propitious ways. These various phenomena are unmistakably overlaid with an emotional element which is evident in the findings, manifesting either as a negating or reinforcing influence.

I therefore posit that constructed professional identity, as established in this research, is the result of the convergence of factors or influences originating from professional experiences in the practice domain of occupational therapy and the articulations around professional identity, as manifested in discourse with the self and public. These influences have an emotional overlay which can have both reinforcing, as well as dispersing effects on professional identity. I suggest that occupational therapy professional identity is a construct that can be influenced by vectors originating from both its articulation and its actioning and consequent experience of it.

Figure 8.1 is an attempt to comprehensively illustrate the argument that I have developed in the foregoing pages, as dynamics of professional identity construction.



Figure 8.1: Dynamics of Professional Identity Construction

I believe that this explanatory framework is a comprehensive explanation derived from the research findings that avoids any sense of being spurious. But it presents some challenges in setting up a dialectic with the literature by virtue of it spanning such a comprehensive range of concepts. Next, I will attempt to reduce this framework to a more elemental structure with a more manageable scope.

### **8.3 Beyond Saliency – Further Mapping and Framework Reduction**

In this section, I will again recast my findings into a more essential framework which will be the basis of the structure broadly adopted for the discussion of the results. I propose to contain the findings on identity in two broad areas or domains: *personal domain identity issues* and *interface or public domain identity issues*; although the demarcation between these two areas can occasionally prove to be labile and there are mutual influences and connexions, as I shall demonstrate.

*The personal domain identity issues* are centred around the participants' confidence in articulating their professional identity. This domain captures the communication of a meaning of occupational therapy to the self and thus being able to impart this to an interlocutor. Communicating<sup>1</sup> the meaning of occupational therapy also carries with it the understanding that a unique feature or uniqueness of a sort is or should be explicated in order to establish a clear demarcation from other professionals. Communicating effectively a professional identity is required in order to ensure that the general public understands or stops misunderstanding occupational therapists.

*In the interface domain of professional identity*, the most prominent feature or finding is the persistent misunderstanding that occupational therapists are faced with when they actualise and experience their identity at some (not all) of the service sites. This feature was differentiated into the participants' feeling of having an unseen professional identity and a sense of 'ill-fitting' in some service sites. The interface domain could also link to forms of articulation effected by the practitioners, both in discourse but also in action. Professional practice could also be considered a form of articulation of professional identity that transcends discourse and enacts meaning through action. This demonstrates a link with the personal domain of identity from where articulation emanates, and professional action is impelled and initiated. The fact that in some areas of practice, occupational therapists effect an identity that could inhabit a grey or shared

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<sup>1</sup> The term 'communicating' refers exclusively to the utterances of the participants as captured in the data. It does not refer to other possible means of communication such as webpages and documents.

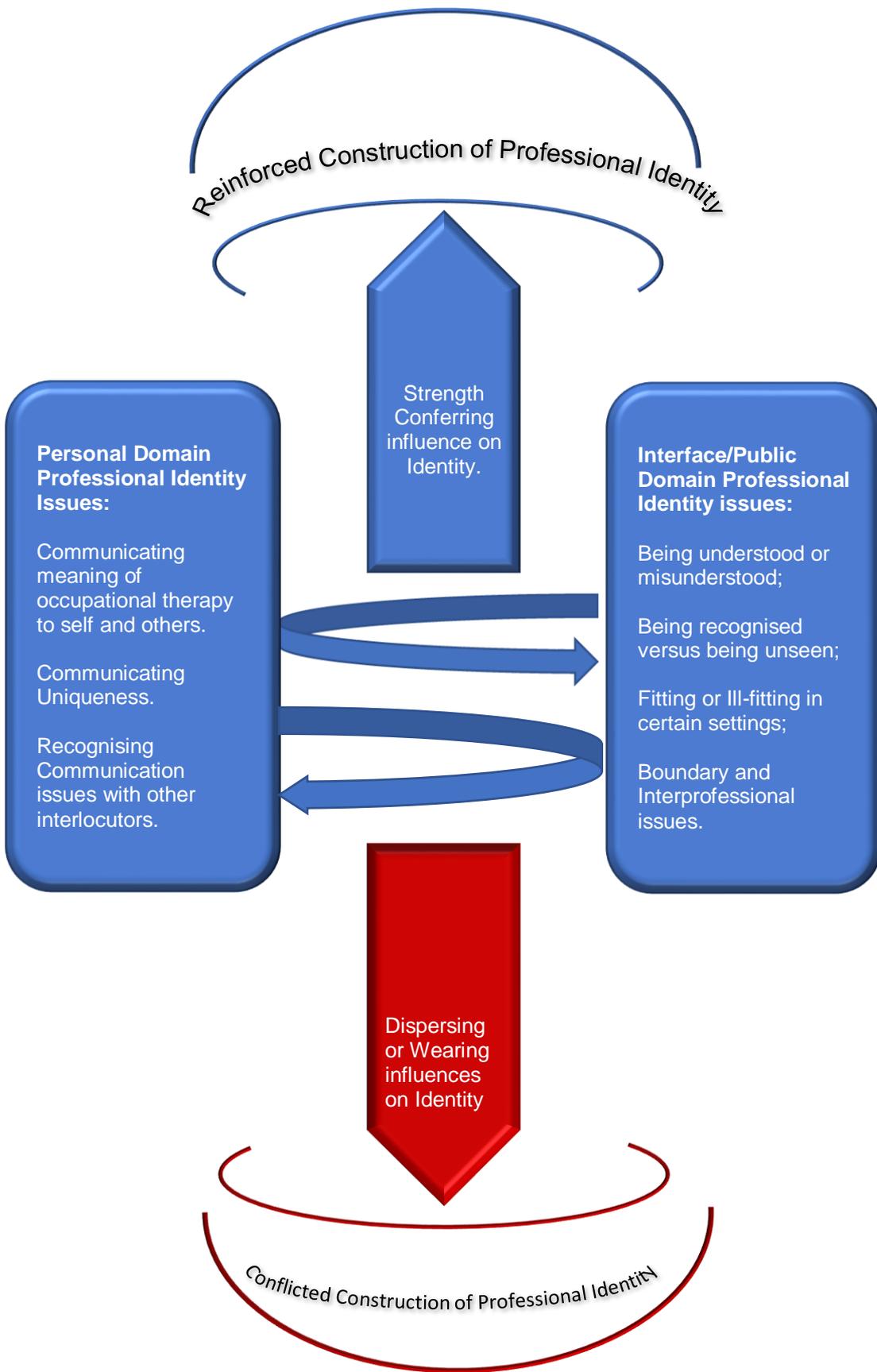
area of practice, is bound to create boundary issues with other professionals leading to potential conflict or misunderstanding.

Therefore, the personal domain and the interface domain of professional identity are recognisably distinct but interconnected territories. Both carry agencies and factors that contribute to the construction of the professional identity of practitioners. And the practitioners themselves are agents in the synthesis of their identities within this matrix of symbols and abstractions.

There is an internal friction or counterpoint of actions involved in identity construction that is not devoid of emotional toll, which can either result in strength-giving or dispersion as well as wearing effects on identity.

The interaction, recognition and strategic or non-strategic exploitation of these influences by practitioners can lead to either reinforcement of their identity or the potentially conflicted status quo of professional identity.

This domain-based interplay, as a construction of professional identity, is illustrated in Figure 8.2.



**Figure 8.2: Domain-based Interplay in the Construction of Professional Identity**

## **8.4 A Reflexive Note on Form, Composition and Content of the Discussion**

The form of the ensuing discussion will reverse the order that I had adopted in my results and will be starting from and giving primacy to the personal domain identity issues, rather than the public domain. The rationale underpinning this is that although identity as I have illustrated in the previous sections, is an interactive and a mediated construct, the nature of the personal domain could be considered as constituting a sort of origin or source of the issues that need to be unpacked in the discussion of the results. This is then followed by a relatively smaller-scale discussion of the public interface identity issues. The final section of the chapter develops reflexive points on recommendations for practice and education.

The results are self-contained, self-substantiating and self-explanatory constructions of a social construction, which is the nominally defined and labile concept that is professional identity. Creating a discussion around the results, one is faced with three basic dilemmas: 1) not adding to what is already a self-contained and realised end point; 2) discovering a mere resonance or lack thereof in the extant literature with these findings; 3) posing explanatory arguments that advance insights into the fundamental motivations of this research. The first option is out of the question and would defeat the need to have a chapter that discusses the results and which advances further understanding. I have tended to align myself mainly with the third category and in order to do so, I had to immerse myself in literature sources prompted by new insights and connections motivated by reflection on the results. This was an *a posteriori* process and its siting in the discussion demonstrates that the form in which the results were constructed was as free as possible from strongly preconceived concepts dictated by my previous exposure to literature. I can say that the data was 'allowed to speak for itself' and the results prompted possible theoretical connections. This approach has occasionally necessitated the exposition and critical appraisal of literature sources, which I feel was inevitable for me to authentically frame the results and develop my arguments. The framing of the findings is made in overarching, broad brush strokes which reflect the new synthesis proposed in the previous sections of this chapter.

## **8.5 Discussion of Personal Domain Identity Issues.**

### **8.5.1 Preamble**

The area which I have designated as personal domain identity issues is patently dominated by the articulation dimension of professional identity. This is an area which is mainly delimited to discourse that the occupational therapists make to describe and

express their professional identity ranging from defining it, explaining a distinguishing feature, to the values that underpin it. This discourse could be construed as representing a glimpse of the script that underlies all of their internal constructions associated with their professional identity. Discourse has been considered as being constituted by recurrent patterns of language that structure and reveal a discipline's intellectual obligations by acting as the medium through which its practices are constructed (Tinning, as cited in Hooper & Wood, 2002). The set of themes illustrating the personal domain might have conveyed a picture of tension around this area for the occupational therapists involved in this study and a correspondingly negative or even despondent outlook on the profession. Therefore, a short preamble on the current professional standing of occupational therapy profession internationally would be in order to establish a perspective of the baseline of professional status internationally that might not be evident from the results of this research.

The occupational therapy profession is represented internationally by a world federation, as well as influential professional bodies in the major countries. It is supported by a healthy research activity, showcased in peer-reviewed journals. And it has generated research-based models of practice and numerous standardised practice assessments and profession-specific knowledge. The professional status of the discipline is beyond disputing and this should be a source of comfort for practitioners in this field. Therefore, confronting the rationale, the *raison d'être* and the findings of this study, with the indisputable robustness of the professional machinery just outlined, begs the question: why do practitioners seem to be challenged to talk about what they do? Why the issues with encompassing this conceptually and linguistically? These are pertinent questions one can make when looking at the evidence from this study which has demonstrated an anxiety, paucity and diffidence experienced by staff around the issue of describing what they do. The ensuing discussion will take on the challenge of defining and explaining occupational therapy as the starting point and then progress to look at the possible underlying origins of this.

As the point of departure for the discussion on the definition and articulation of occupational therapy and beyond, I quote a very revelatory point made by Mocellin's (1988):

The literature on occupational therapy abounds with definitions (one alone consists of 81 words, six commas and two full stops), theories, models of practice and frameworks for practice, often coloured with jargon, which cause and continue to cause confusion. (p.4)

I now reproduce a quotation lifted from a focus group in the current study:

*P7: But I believe that occupational therapy, its definition is so vast. I remember my first definition, I mean, reading it on a book, I don't remember which book, it had fourteen lines. So, we look at quality of life, holistic approach, we look at the psychological aspects and many other things, many, many other things and it is not related to one area. So, our role as occupational [therapists] is so unique that we have to find a lot of words to define it and that in itself ... is good. ... our philosophy of care is so beautiful and yet and yet, unfortunately because our definition as OTs, is very vast, skills, independence, function, quality of life, being client-centred and all those definitions which we all know, so vast.*

My view is that these two quotations, one from the literature and one from research data – similar to a certain extent in gist, perhaps contrasting in detail - make for very good scene setting for the ensuing discussion. These quotations carry the basic germs of the arguments I will posit: the problem of defining the profession and coherently articulating its nature, and the conceptual underpinning pool which is the possible origin of this.

### **8.5.2 Importance of Articulating the Professional Self: The Antechamber to the Issue**

Quite apart from trying to understand the origin of the tensions that occupational therapists experience to articulate themselves - although these will be discussed as a sort of aetiology or causality and subsequent treatment of the problem in an ensuing sections - is the pressing realisation that there is an immediate need for them to be able to distinguish their contribution in a crowded healthcare professional field and the implications that this brings with it.

Wilding and Whiteford (2008) have stressed the importance of the need for occupational therapists to be able to articulate what they do in order to ensure that their contribution to the health field is acknowledged. The skill in imparting an intelligible description of the profession could contribute to advancement and appreciation of occupational therapy (Di Tommaso & Wilding, 2014). Occupational therapists should also have a vested interest in being best placed to represent themselves about what they do and have the main responsibility to be articulate about it (Lycett, 1991). Notwithstanding this essential mandate, talking about occupational therapy is apparently not a simple matter, as will be evidenced in the following and the way that this is characterised very much reflects the findings of this study.

The challenges of defining and articulating occupational therapy by occupational therapists is a long-standing concern and is well-recognised within the profession. For

example, Madden (1984) suggested that explaining psychiatric occupational therapy could be an art in itself. Feaver and Creek (1993) acknowledged that occupational therapists find difficulty articulating the nature of what they do to others, but it is still important for them to rise to this challenge in order to tackle the “ills” of the profession.

Shannon (cited in Feaver & Creek, 1993) declared quite categorically that it was not possible to give a “descriptive” nor a “normative” definition of occupational therapy. Creek (2006) sought to establish standard terminology for a number of terms used in occupational therapy and also to devise a definition of occupational therapy in a Delphi study involving review of documents and interviews with an expert panel. As the data collection cycles progressed the number of definitions of occupational therapy increased instead of decreasing. It has to be noted that at the starting point of the data collection, some thirty seven definitions were offered for review and analysis to the expert panel. As in the case of the current study, Lycett (1991) studied the spontaneous definitions tendered by some forty six occupational therapists sampled from practice sites in the United Kingdom and found that there was a notable lack of uniformity in the definitions given, with an attendant lack of consistency in the phrases and terms that practitioners used. The terminology used by clinicians also did not sufficiently distinguish the profession from other disciplines in the field, with the author venturing to suggest that this difficulty was related to the fact that the profession calls upon an assortment of ideas related to its fundamental purpose (Lycett, 1991).

One of the subthemes of the current study described how occupational therapy practitioners tended to circumscribe their identity around their own area of practice rather than the whole profession. It is remarkable that this finding is mirrored in the study of Lycett - now three decades old - where it was also demonstrated that the language used by the therapists seemed related to the work setting and explanations relied on examples of practice from their work setting. Lycett’s study comes to the conclusion that for an improvement in the definition of occupational therapy, such a definition needs to be related to an area of practice, but has to make reference to the activity base of the profession. This conclusion might have been acceptable during the time of the study – the early 1990s – but appears somewhat out of step with the current times, where an emphasis on ‘occupation’ is central to illustrating the nature of occupational therapy (Gillen, 2013). Molineux (2011) highlights this issue when he emphasises that occupational therapists working in different settings should stop seeing themselves as unique and describing themselves differently, but strive to see themselves as a collective of practitioners across settings who enable clients to achieve and maintain health through occupation.

A study by Taylor and Rubin (1999) that looked at how occupational therapists defined their role in community mental health practice in the United Kingdom, also reported that half of the sample of participants expressed finding difficulty when it comes to offering a definition of the profession. The authors highlight the importance of subscribing to a definition that illustrates the unique contribution of occupational therapy, especially in the light of the fact that occupational therapists work in an interprofessional setting. Yet, there was very little evidence of this from this study, as there was also a notable dearth of the use of the word 'occupation' being called upon to characterise the uniqueness of the field. Findings from Taylor and Rubin's study also indicated that practitioners, rather than articulating a definition, often resorted to examples from practice to explain what they do. Analogies to these findings can be found in the current study, perhaps indicating that the existing state of occupational therapy in Malta is not unique or the result of specific cultural, developmental, historiographic and geographical factors. Maltese occupational therapy could, after all, be a mere inheritor and a product of a UK and US professional legacy. But these reflections should not stop practitioners in the profession in Malta to pause, reflect and take strategic action to address issues of articulation and professional identity.

Rigney (2000) declared that occupational therapy as a profession will be at a disadvantage to argue for a unique and individual role in healthcare if occupational therapists themselves have put in a professional dividing line that demarcates the profession broadly along the areas of physical and mental health practice. This implies that semantics concerning defining or articulating the nature of the profession is 'institutionally' not unified within the occupational therapy profession. I suggest that this could act as a further damper on any efforts to articulate a description of the occupational therapy profession that is coherent and that characterises its uniqueness. The division of occupational therapy in physical and mental health, as well as paediatric services, is very much prevalent in the Maltese setting and this could act as a further compounding factor in the domain of professional identity articulation.

Rigney (2000) does not restrict her arguments against an established division within the profession to the issues of professional identity and articulation, but also to the aspect of services delivered to the clients. Her view is that this separation reinforces divisions which already exist in the health systems to the disadvantage of clients "who do not fit neatly into a diagnostic box" (p.178) and might end up being deprived of services as they do not fit into a specific category. Occupational therapy services should be integrated and safeguard service delivery to each client who needs it. This could be a function of a coherent and intelligible identity.

Wilding and Whiteford (2009) underscore this point when explaining another dimension of this concept as they expound their belief that having a clear view of one's own professional identity is akin to an ethical obligation. The authors suggest that in the light of occupational therapy's prevailing identity issues and attendant work of its professionals outside the purview of their identity, could be tantamount to having failed in their compact of care with the clients. The occupational therapy profession is the only discipline with the requisite skills and motivation to assist clients with occupational challenges and it should ensure that it targets this domain of concern in its service delivery. Although this point cannot be directly correlated to the findings of the study, participants in this study have reported instances where referrals have been rather poorly made, based on a limited understanding of the professional role of the occupational therapist. This has the potential of impacting on opportunities for the provision of optimal patient care. This is an argument worth considering as it highlights the importance of determining and enacting the tenets related to professional identity and how these need to be a fundamental mandate for practitioners.

In this subsection, I have demonstrated that the issue of defining and articulating occupational therapy is a long-standing and enduring concern of the occupational therapy profession, with very important implications. It is not a phenomenon that is confined to the professional environment of Malta but appears to be widespread and international. Given that some of the sources being used here to frame the findings from the Maltese setting appear dated, might beg the question - but can't the rest of the world have moved on? But sources from the UK from as recent as 2018 (Pentland, Kantartzis, Clausen & Witemyre, 2018) about complexity, from Australia dated 2016 (Britton, Rosenwax & McNamara, 2016) about practice in acute care and a study about describing occupational therapy from New Zealand dated 2014 (Di Tommaso & Wilding, 2014), all these three sources used in this chapter, indicate that the issue of professional identity remains current even internationally. Recognising that this trend is so prevalent might give some comfort to the Maltese occupational therapists in realising that 'they are not alone,' but this is of little assistance unless insights are ventured into the possible cause of this condition and how this can be strategically addressed.

In the ensuing sections, I will be constructing an argument that covers considerable theoretical ground in my attempt to characterise the complex underpinning influences on the problematical articulation of occupational therapists' professional identity. I start by looking at the epistemological influences in the field; I then dovetail this perspective into a consideration of the wide-spanning ('vast') conceptual territory of occupational therapy

and eventually conclude my arguments by an allusion to complexity in the profession, which I feel takes this part of the discussion through a full and logical circle.

### **8.5.3 *The Dichotomous Condition – Epistemological Tensions Underpinning the Articulation of Identity in Occupational Therapy.***

Occupational therapy seems to be saddled with contrasting practice, epistemological and philosophical underpinnings related to adapting to its very diverse practice environments, as well as its basic nature and legacy of its origins. These seem to manifest as a recurrent theme characterised by dichotomies that appears to pull the profession along continua such as art/science; holism/reductionism, as well as structuralism/pragmatism; positivism/interpretivism. These tensions have acted as foci for research and conceptual development in the discipline throughout the twentieth and twenty first centuries and have resulted in the accumulation of a crowded and wide-ranging conceptual pool, perhaps the extent of which effectively challenges the existence of a monolithic occupational therapy profession and, by extension, identity. One might extend this point to posit that this situation is the source of the many and disparate specialisms in occupational therapy. These unresolved tensions might still be transmitted to practitioners through professional discourse, educational programmes and practices in occupational therapy as they are part of its ineluctable professional substratum. It is as if these concerns are inextricably linked to the professional DNA of occupational therapy, bound to be reproduced and transmitted with nearly every conceivable act of its professional operations. Consciously reconciling and being able to coherently articulate these characteristics within a professional persona - features no doubt carried by each practitioner if the foregoing argument of a genetic heritage is accepted - might call upon a supreme act of insight and attendant dialectical skills, possibly not within the scope of a practitioner in the field, especially of a basic, unseasoned, practitioner or student.

I start with an example of this dichotomy being revealed or emerging as a response to a practice environment and affecting how practitioners articulate themselves, which could also shed light on a range of subthemes that were constructed in the present research such as *defining and explaining occupational therapy*, *the vast identity of occupational therapy* and *professional identity congruence*. Results from a study by Wilding and Whiteford (2007) start out by uncovering tensions almost identical to those of the current study: conflicts concerning describing and explaining occupational therapy. The authors specifically looked at the experience of the use of theory, evidence and occupation, and how occupational therapists describe their profession at an acute medical facility in Melbourne, Australia. Extensive passages from transcripts of the interviews that the

authors conducted with their participants illustrate the difficulty and angst experienced when describing occupational therapy. In this instance, there was an uncanny resemblance - if not in vocabulary or idiom, but certainly in spirit, essence and connotation - to the language used by participants in the Maltese study.

Wilding and Whiteford (2007) describe how participants tended to be over-inclusive in their explanations about occupational therapy. Participants professed an anxiety at being misunderstood and undervalued if they offered a short or simple definition of occupational therapy. The authors explain this by suggesting that underlying factors in the acute practice environment undermine occupational therapists' efforts to explicate themselves and be understood. This could be the competing epistemological paradigms of biomedicine and occupational therapy present in an acute setting. Practitioners were drawn to mimic the trappings of the medical model by adopting comprehensive definitions of their profession which left out the unique and most basic tenet of the profession which is participation in occupation; the latter appears to be a modest concern - albeit subsuming a lot of hidden complexity - when confronted with the high drama of medical and surgical intervention in an acute setting. It was as if the practitioners, in their professional articulations, were trying to 'square' their pragmatist nature with the positivist/reductionist framework of medicine. This is a manifestation of the dichotomous tension present within the profession brought to the fore by an issue of identity congruence with the acute practice setting.

Hooper and Wood (2002) have foreshadowed the arguments articulated above concerning competing epistemological tensions underpinning the identity of occupational therapy, in the notion of competing discourses in the profession's historical emergence and development. Hooper and Wood's position is worth reviewing in detail in this context as it sheds light on occupational therapists' discourse on their professional identity aligned to fundamental philosophical standpoints that underpin the intellectual make-up of their field right from its very inception, continuing through its development in the twentieth century and, as I hope to demonstrate, still persisting today. It is a perspective which exemplifies in a fundamental way the dichotomous nature of the profession of occupational therapy.

The authors posit that occupational therapists contend with two different discourses: "one that concentrates on restoring persons to satisfying lives and another that concentrates on fixing body parts" (Hooper & Wood, 2002, p.40) and they label these respectively as pragmatist discourse and structuralist discourse - more specifically a conversation or tension between pragmatism and structuralism. At this point, I feel that

it is important to take a historical detour in order to illustrate how far reaching and influential these factors are in occupational therapy.

Pragmatism emerged as a dominant intellectual discourse in the United States in the late nineteenth and early twentieth century and has informed a number of disciplines (Hooper & Wood, 2002). It is considered as one of the seminal influences on occupational therapy at the beginning of the twentieth century, and is principally associated with the influence of Charles Sanders Pierce, William James and John Dewey (Reed & Sanderson, 1999). In occupational therapy it has informed how it is indispensable to consider people in the context of their environment, life history and experiences. Pragmatism extolled a perspective of the human that was holistic and rejected anything that restricted humans to anything less than their total experience, or that which implied dichotomies or separations, such as mind/body; thought/action; rational/practical. It also assumed that individuals were capable of agency and possessed potentials to influence their environment and placed the individual in the foreground of all pragmatist considerations. Pragmatists characterised knowledge as flexible, fallible and prone to being adjusted by newer and better ways of understanding; ideas and theories are socially rooted in the present and the product of past discourses, and as such, cannot be considered as theoretically neutral, timeless or detached of a specific temporo-political context (Hooper & Wood, 2002).

Hooper and Wood (2002) argue that although pragmatist discourse has persisted throughout the twentieth century in occupational therapy, pragmatic knowledge has fallen out of favour, “thwarted by the early challenge of structuralism” (p.43). The structuralist view of humans was as composites of recurring general frameworks, analogous to a kaleidoscope in which patterns are constituted from a finite number of recurring elements. This downplayed the elements of agency of individuals, holism and transformation through initiative and experience, which were so prominent in pragmatism. Instead, structuralist views bestowed a veritable ‘scientification’ of social sciences around the middle of the twentieth century where people were perceived to act within a general system and with a general internal system. In the realm of knowledge perspectives, structuralism viewed knowledge as enduring and empirically verifiable and that mechanisms can be identified and applied to all instances of human biology and behaviour. This pursuit of objectivity is detached from the element of individual human experience and minimises the contextual, subjective and case-specific importance of knowledge generation. Such a view has had a profound impact on the conceptualisation of practice in occupational therapy. The focus of practice shifts from holistic concern of occupational performance to the underlying elements or components of performance,

such as motor control, developmental age and muscle strength. There is the assumption that change in these underlying structures can change occupational performance (Hooper & Wood, 2002).

These authors contend that a pragmatist and structuralist conversation in the practice of occupational therapy has existed throughout its history and an appreciation or understanding of this dichotomy can shed light on the process of evolution and subsequent enduring issues of professional identity. They proceed to develop this narrative along two strands: first the changing discourses in occupational therapy, in tandem with (or perhaps in response to) the larger cultural ethos in the American Society; and second, the internal incongruence between a pragmatist view of the human and a structural view of knowledge.

I feel what is of fundamental significance to this study is the second strand of Hooper and Wood's developments on the argument of discourse in occupational therapy and this merits a more detailed consideration. The view is that occupational therapy developed from its beginnings a fundamental mismatch between a much-extolled pragmatist perspective on humans, coupled to a potentially discordant structuralist approach towards knowledge. Knowledge in occupational therapy seems to be considered as "objectively fixed, theoretically neutral, context-free, universal and derived from external authority" (p. 46). According to the authors, the origin of this mismatch in discourses can be dated back to occupational therapy practice in the First World War. At this time occupational therapists were motivated by a moral imperative to train more practitioners who could take up duties in the care of injured soldiers, but lacked their own knowledge base or standing and academic clout to claim specific educational practices as their own. This lacuna was filled by an esteem towards the medical profession and its expertise. Gradually subjects originating from biomedicine appropriated the core of occupational therapy curricula.

By the 1930s and 1940s occupational therapy was under pressure to fit its holistic notion of occupation within a construct that could correspond to exigencies of medical epistemology. This gave rise to the adoption and development of structuralist discourse and knowledge related to the inner systems of humans, such as internal neurologic, psychic and kinesiological workings. Perhaps the 'institutionalised' confirmation of the predominance of a structuralist perspective in occupational therapy or else the end result of the process outlined by Hooper and Wood is exemplified by the introduction of the influential Uniform Terminology document by the American Occupational Therapy Association in 1979. This document and its subsequent reiterations in two further

editions, 1989 and 1994, cemented the view that the domain of concern of occupational therapy can be represented by a comprehensive list of finite performance components, very much aligned to a natural science perspective of human behaviour and reflecting the kaleidoscope analogy ascertained by Hooper and Wood. Although this outlook is somewhat mitigated by the fact that the Uniform Terminology document gives consideration to contextual factors concerning the environment of the client and the performance areas of occupation, there is little evidence that it operationalises the unique holistic perspective of occupational therapy around the principle of health through occupation. Although it is now a superseded document, it should be noted that the professional template fashioned for the occupational therapy by the Uniform Terminology established the underlying structure (arguably the structuralist approach) of all occupational therapy textbooks emanating from the United States and helped to 'export' this perspective of the profession to the rest of the world, including Malta. It offered a system that practitioners could readily identify with, and a way of establishing a more professional footing for the profession within the traditional medical milieu, mostly using a language which can be recognised by other health professionals. Additional efforts to create a terminology for occupational therapy as alternatives or, more accurately, culturally specific alternatives in Europe and the UK, ended up more or less reproducing the structure of the Uniform Terminology - perhaps a testament to its enduring influence and utility.

This reference to the Uniform Terminology can be linked to one of the reflections that I expressed to introduce this section and that was the 'vast' conceptual territory within the profession. The Uniform Terminology is a mere signpost that, in truth, is only the tip of the iceberg of the wide-spanning and variegated, and detailed conceptual knowledge base of occupational therapy. This is, on the one hand, a demonstration of the richness and scope of occupational therapy. On the other hand, it could also be considered as constituting a disparate base that subsumes epistemologies, rationales and techniques that are difficult to reconcile and wanting in an element that unifies and characterises one overarching or *unique* feature for the profession.

I feel that this poses considerable challenges for practitioners when they articulate their professional identity across very diverse practice concerns and using very different means and methods. Quite apart from issues of the articulation of professional identity, this wide-spanning conceptual base could also be a source of strain for practitioners and students when changing practice areas, as they are required to relearn different ways of reasoning and doing and practising of their profession; essentially enacting their professional persona

practically from scratch. The following quotation from a focus group faithfully captures this notion:

*P12: I think that the reason is that the physiotherapy principals never change. Our profession is so vast, that every rotation it is like starting from scratch. If I go to a neuro medical ward and then they send me down to the hands. If someone doesn't tell me, I might not realise that both of them are OTs because the things that we do are totally different.*

It could also be one strong influence that conditions practitioners to define themselves according to their area of practice, which is captured in the theme *circumscribed identity defined by the area of practice*. It could also be a major identity dispersing influence for practitioners in occupational therapy. This is what I attempt to explore in the next section, using the uniform terminology as a fundamental starting point.

#### **8.5.4 Occupational Therapists – Navigators of a Conceptual Archipelago**

In order to set the scene for my argument I feel I have to first give a basic overview of the Uniform Terminology and its nature. Figure 8.3 reproduces the outline of the third and final edition of the Uniform Terminology (AOTA, 1994). A cursory look at this chart should demonstrate the 'vast territory' of occupational therapy's professional domain of concern, combining seemingly disparate elements spanning the anatomical, physiological and psychosocial, termed as performance components – these basically constituting micro-concerns. The Uniform Terminology also includes contextual elements, such as the environment and the areas of occupational performance – which could be considered as macro-concerns.

The Uniform Terminology is actually a static and superficial representation of the major areas of practice which could potentially be targeted by the services provided by the profession - after all, its main purpose was to establish a consistent language for occupational therapy and not the application of theories in practice. It is a sort of broad map of territory, which constitutes the domain of practice, and could be considered as analogous to the periodic table in chemistry; some might argue that it is closer to being a taxonomy. But this substantial territory of practice hides a correspondingly extensive conceptual territory spanning theories, models of practice, frames of reference and techniques linked to practically each construct or descriptor carried within the Uniform Terminology. These conceptual or practice frameworks constitute the underpinning rationales and skills of intervention. In each of these areas, practitioners are expected to marshal the attendant knowledge and skills in order to practice.

Hooper and Wood ascertain that the Uniform Terminology of occupational therapy is a manifestation of the structuralist bias of a profession that professes to have a pragmatist outlook in its concern on human occupational behaviour. I posit that the practice of occupational therapy itself, as outlined by the Uniform Terminology is, firstly another manifestation of the dichotomous nature of occupational therapy, as exemplified by a concern for the holistic as represented by occupational performance; coupled to a concern with the microscopic, which is demonstrated by a focus upon the continuum of components arching across the biomedical and psychosocial areas. It is also a demonstration of the span or breadth of professional concerns stretched between these extremes and lacking a unifying thematic element that establishes a core or unique identity for the profession. This poses challenges to practitioners when they are called upon to make spontaneous articulations to characterise what they do, but also when they actually practice.

Hooper and Wood speak of occupational therapy as having an “eclectic array of media and methods [that] have at times scattered in a helter skelter of directions.” (p48). I suggest that this is the root problem that underpins occupational therapists' discomfited articulations on their field and calls on them to seek a unitary vision, commonality and identity as professionals. I propose an analogy to characterise this condition: occupational therapists are, at best, like navigators in a conceptual archipelago; at worst, they are like waders in a conceptual swamp with the attendant challenges to orientation that this might cause. This might be the difficult internal script that they have to contend with when they are called upon to explain themselves as professionals and what they do, *and a major identity-dispersing influence*. I now attempt to develop this argument and support my points by referring to various literature sources.

I. Performance Areas	II. Performance Components	III. Performance Contexts
<p>A. Activities of Daily Living</p> <ol style="list-style-type: none"> <li>1. Grooming</li> <li>2. Oral Hygiene</li> <li>3. Bathing/Showering</li> <li>4. Toilet Hygiene</li> <li>5. Personal Device Care</li> <li>6. Dressing</li> <li>7. Feeding and Eating</li> <li>8. Medication Routine</li> <li>9. Health Maintenance</li> <li>10. Socialisation</li> <li>11. Functional Communication</li> <li>12. Functional Mobility</li> <li>13. Community Mobility</li> <li>14. Emergency Response</li> <li>15. Sexual Expression</li> </ol> <p>B. Work &amp; Productive Activities</p> <ol style="list-style-type: none"> <li>1. Home Management <ol style="list-style-type: none"> <li>a. Clothing Care</li> <li>b. Cleaning</li> <li>c. Meal Preparation / Clean up</li> <li>d. Shopping</li> <li>e. Money Management</li> <li>f. Household Maintenance</li> <li>g. Safety Procedures</li> </ol> </li> <li>2. Care of Others</li> <li>3. Educational Activities.</li> <li>4. Vocational Activities <ol style="list-style-type: none"> <li>a. Vocational Exploration</li> <li>b. Job Acquisition</li> <li>c. Work or Job Performance</li> <li>d. Retirement Planning</li> <li>e. Volunteer Participation</li> </ol> </li> </ol> <p>C. Play or Leisure Activities</p> <ol style="list-style-type: none"> <li>1. Play or Leisure Exploration.</li> <li>2. Play or Leisure Performance</li> </ol>	<p>A. Sensorimotor Component.</p> <ol style="list-style-type: none"> <li>1. Sensory. <ol style="list-style-type: none"> <li>a. Sensory Awareness.</li> <li>b. Sensory Processing <ol style="list-style-type: none"> <li>(1) Tactile.</li> <li>(2) Proprioceptive</li> <li>(3) Vestibular</li> <li>(4) Visual</li> <li>(5) Auditory</li> <li>(6) Gustatory</li> <li>(7) Olfactory</li> </ol> </li> <li>c. Perceptual Processing <ol style="list-style-type: none"> <li>(1) Stereognosis</li> <li>(2) Kinesthesia</li> <li>(3) Pain Response</li> <li>(4) Body Scheme</li> <li>(5) Right-Left Discrimination</li> <li>(6) Form Constancy</li> <li>(7) Position in Space</li> <li>(8) Visual-Closure</li> <li>(9) Figure Ground</li> <li>(10) Depth Perception</li> <li>(11) Spatial Relations</li> <li>(12) Topographical Orientation.</li> </ol> </li> </ol> </li> <li>2. Neuromusculoskeletal <ol style="list-style-type: none"> <li>a. Reflex</li> <li>b. Range of Motion</li> <li>c. Muscle Tone</li> <li>d. Strength</li> <li>e. Endurance</li> <li>f. Postural Control</li> <li>g. Postural Alignment</li> <li>h. Soft Tissue Integrity</li> </ol> </li> <li>3. Motor <ol style="list-style-type: none"> <li>a. Gross Coordination</li> <li>b. Crossing the Midline</li> <li>c. Laterality</li> <li>d. Bilateral Integration</li> <li>e. Motor Control</li> <li>f. Praxis</li> <li>g. Fine Coordination / Dexterity</li> <li>h. Visual-Motor Integration</li> <li>i. Oral-Motor Control</li> </ol> </li> </ol> <p>B. Cognitive Integration and Cognitive Components</p> <ol style="list-style-type: none"> <li>1. Level of Arousal</li> <li>2. Orientation</li> <li>3. Recognition</li> <li>4. Attention Span</li> <li>5. Initiation of Activity</li> <li>6. Termination of Activity</li> <li>7. Memory</li> <li>8. Sequencing</li> <li>9. Categorization</li> <li>10. Concept Formation</li> <li>11. Spatial Operations <ol style="list-style-type: none"> <li>12. Problem Solving</li> <li>13. Learning</li> <li>14. Generalization</li> </ol> </li> </ol>	<p>A. Temporal Aspects</p> <ol style="list-style-type: none"> <li>1. Chronological</li> <li>2. Developmental</li> <li>3. Life Cycle</li> <li>4. Disability Status</li> </ol> <p>B. Environmental Aspects</p> <ol style="list-style-type: none"> <li>1. Physical</li> <li>2. Social</li> <li>3. Cultural</li> </ol>

**Figure 8.3: Outline of the Third Edition of the Uniform Terminology**  
Source: AOTA, 1994

I. Performance Areas	II. Performance Components	III. Performance Contexts
[given above]	C. Psychosocial Skills and Psychological Components <ol style="list-style-type: none"> <li>1. Psychological               <ol style="list-style-type: none"> <li>a. Values</li> <li>b. Interests</li> <li>c. Self-Concept</li> </ol> </li> <li>2. Social               <ol style="list-style-type: none"> <li>a. Role Performance</li> <li>b. Social Conduct</li> <li>c. Interpersonal Skills</li> <li>d. Self-Expression</li> </ol> </li> <li>3. Self-Management               <ol style="list-style-type: none"> <li>a. Coping Skills</li> <li>b. Time Management</li> <li>c. Self-Control</li> </ol> </li> </ol>	[given above]

**Figure 8.3: Outline of the Third Edition of the Uniform Terminology (cont.)**  
**Source: AOTA, 1994**

Mocellin (1988) points out that the occupational therapy professional literature is replete with definitions, conceptual and practice frameworks and this has constituted a source of confusion. He suggests that this has come about because occupational therapists have adopted techniques from other sciences, but in the absence of an agreed unequivocal meaning of occupational therapy, these theories have been erroneously appropriated as theories of occupational therapy. Mocellin felt that the outcome of this condition was that occupational therapists often find themselves in situations akin to a scientist having to change hypothesis while carrying out research. This no doubt happens because occupational therapists can bring to bear so many perspectives on an individual's functional status as a result of their underpinning identity and conceptual 'ambidexterity.' Mocellin (1988) seems to consider this as problematic and ascertained that occupational therapists also seemed to have a propensity of treating all aspects of the patient that they consider as dysfunctional, with correspondingly vague outcomes, when in fact they need to be more selective and specific in what they treat. I believe that this consideration reflects the wide-spanning range of concerns occupational therapists and that can act to undermine professional identity.

Creek and Feaver (1993) in one of the early attempts to rationalise and explain the many terms that refer to theory and theory application in occupational therapy, noted that terminology in occupational therapy did not have absolute and fixed meanings and that there is a tendency for writers to use the same terms in different ways. The meaning of these terms is dependent very much on the context – a rather undisciplined *modus operandi* within a practice discipline! This situation continues to persist into the twenty-first century. For example, Duncan (2006a) in his summary conclusion of a chapter on the theoretical foundations of occupational therapy, declares that:

The complexity of issues presented, and multiple use of similar terms is often disheartening for students and practitioners who are trying to grapple with the theoretical influences of the profession (p.39).

These instances perhaps justify the use of my earlier metaphor: “wading in a swamp” and could also be the source of the hesitancy and lack of fluency that occupational therapists experience when talking about what they do. This has been very amply demonstrated in the data.

Cole and Tufano (2008) synthesise a number of different writers’ take on the organisation of theory in occupational therapy and come to the overarching conclusion that there is little agreement among the writers about how knowledge should be described and organised and that there is evidence that writers seem to have agreed to disagree. The authors acknowledge that the problem might lie with the fact there are many levels of theory in occupational therapy, implying a sort of hierarchy of knowledge in the profession. These levels or types of theory in occupational therapy are linked to specific types of epistemological transformations that the profession sustained in its evolution and how these transformations influenced knowledge acquisition and development during the past century. For example, in the mid-twentieth century, a reductionistic perspective led occupational therapists to investigate applied theories and techniques specific to a number of impairments. This resulted in the development of a type of theory that illustrated aspects of occupational performance in a fragmented manner, rather than broader theories on human occupation, very much aligned to a reductionist, medical model outlook. Research in the later decades of the twentieth century, focused on the development of more holistic theories, such as the model of human occupation by Kielhofner and Burke (1980). Both of these types of applied theories are still extant and in use by occupational therapists. This suggests, once again, the enduring dichotomy in occupational therapy between the micro disease component concerns, juxtaposed to the macro/holistic concerns of occupation.

Duncan (2006b) also suggests a type of hierarchy of knowledge in occupational therapy serving different functions. This assertion occurs practically at the same time as the discourse of Cole and Tufano (2008) discussed earlier and constitutes a welcome collimation of thought in relatively recent occupational therapy literature. Although it has to be noted that the classifications tendered by these different writers is slightly but essentially different. It reflects nuances and epistemological differences between the United States and the United Kingdom, but also potential conceptual misalignments for practitioners and also educators who have to transmit consistence in a territory

potentially rife with equivocations to their students. In his review of practice frameworks, Duncan includes this very telling disclaimer:

In defining theoretical terms, consideration has been given to lessening confusion by providing clear and (hopefully) uncontroversial taxonomy (p. 62).

This very brief overview only scratches the surface of the issue of the dilemmas and challenges involved in the terminology of occupational therapy and the attendant conceptual/practice frameworks. A more detailed review of the matter would be beyond the scope of this thesis, but the implications of this state of affairs, I feel, are manifold and central for occupational therapists' identity. It supports the thread of the argument that I have been building up in the forgoing text - that a proliferation of concepts and terms with possibly different epistemological and professional value implications, could prove to be a challenge for occupational therapy practitioners to internalise and articulate, as they pose considerable scope and coherence issues. Perhaps more fundamentally is the unrealistic expectation that such a breadth of detail and dialectical interplay might be expected to be within the capabilities of junior staff or students, with their limited experience and developing conceptual knowledge. This also has profound implications about the structure and scope of entry-level curricula in occupational therapy that educators would need to adopt in order to satisfy professional practice requirements and cover the manifold interests of the professions' domain of concern.

Furthermore, another important educational mandate and challenge could be how such knowledge can be strategically organised in order to best represent the professional identity of occupational therapy. It might make a case for the need to support higher education degrees in occupational therapy and consider the adoption of an entry point above that of undergraduate, in order to better accommodate the range of requirements of the profession.

It has to be noted that although the diversity and proliferation of conceptual practice models and applied theories may have acted to create incongruity in the field and challenged the identity of occupational therapy, these also serve a purpose which is to give a structure and theoretical rationale to the myriad and also very diverse interventions of occupational therapists. But there is another side to this issue. There is a culture in occupational therapy that seems averse to strictures that theories and models of practice might seem to impose on practitioners and perhaps stifle creativity, as well as restrain the tailoring of therapy to the specific needs of the client, as exemplified in the very cardinal ethos of occupational therapy which is client-centredness.

Barnitt (1991) declared that like good politicians, the best of occupational therapists could be characterised as having “enthusiasm with doubt” (p. 210). Feaver and Creek (1993) noted how occupational therapists are known for their lack of certainty and self-doubt. Occupational therapists’ adoption of models of practice might bring more certainty and clearly demonstrate a rationale for occupational therapy intervention, but with this certainty practitioners might be induced into deciding or dictating what is best for the patient and changing the client-centred dynamic; or they might lose the sensitivity that is a requisite of client centred practice (Feaver & Creek, 1993).

Perhaps a unique characteristic of occupational therapists is that, more than other professionals, they share their professional locus of control with their clients, in order to better construct a shared and nuanced understanding of occupational performance challenges. This implies complexity and a context-dependent nature of occupational therapy practice that might not be possible to encompass in one model of practice (Feaver & Creek, 1993).

The issue of complexity is a much-celebrated concern in occupational therapy (Creek, Ilott, Cook, & Munday, 2005). These authors acknowledge the near futility of trying to devise a definition of occupational therapy in the face of this complexity, but do not seem to give much prominence to the matter of identity and articulation of occupational therapy posed by this complexity. Complexity may be a deeply characteristic aspect of the profession, which needs to be internalised and articulated, however I feel that it might pose some challenges when it is squared with the professional identity issues uncovered in this study. This begs the question - can occupational therapy lay claim to a singular identity if it admits the possibility that because of the complexity of what it is and how it does it (especially when one factors in the shared locus of control with the client), its role is fundamentally a context-based construction?

In the next section, I develop an understanding of complexity as a fundamental and representative trait of occupational therapy and the challenges this might pose, both in terms of identity and articulation related issues, as well as from a purely interprofessional standpoint.

### **8.5.5 Complexity as a Characterising Dimension of Occupational Therapy and the Implications for Professional Identity**

If I had to summarise the trajectory of this discussion up to this point in order to give some essential signage to the reader, I could say that I have attempted to trace the origins of the *idiom* of occupational therapists, uncovered by the findings of this research,

and potential explanations for this in the literature. This idiom - characterised by hesitancy and a tentative fashion of articulation of the professional self - was taken as a function or evidence of internalised professional identity, which is in turn constructed from the meaning-making tools of occupational therapists. It was assumed that these tools were a product of the internalised epistemologies and a corresponding range of conceptual knowledge sources.

In the previous section, I introduced the concept of 'complexity' as an exemplifying feature of the profession with implications on professional identity of occupational therapists. I feel that the issue of complexity needs to be unpacked as it contributes another fundamental explanatory dimension that helps to frame the issues of identity uncovered in this study.

This quotation from Cilliers (as cited in Creek *et al.*, 2005) best captures the quandary or irony of complexity in occupational therapy and links it to the profound misunderstanding about its identity ("more than meets the eye") revealed in this research:

... the simple and the complex often mask each other ... Many systems appear simple, but reveal remarkable complexity when examined closely ... Others appear complex, but can be described simply (p281).

As early as 1988, Yerxa claimed that the central characteristic of occupational therapy was complexity with the corresponding underpinning knowledge, and that this quality has to be made evident. The author argued that the fact that occupational therapists work with conditions such as stroke, cerebral palsy, learning disability and mental illness is testament to the fact that they are called upon to exercise this complex knowledge in order to deal with lingering disability that has a major impact on lifestyles and necessitates fundamental life adaptations.

In such situations, the medical profession has little in terms of what could be offered to turn around life prospects and improve quality of life. It is not a question of simply treating the impaired body systems involved in these conditions, but a recognition that the impairments impact upon 'higher human function,' such as the social, cultural and symbolic aspects of occupational function. This is an early synthesis of complexity as a characterising dimension of occupational therapy. Yerxa's outlook on complexity goes a long way to incorporate the various conceptual influences in occupational therapy as well as valorising occupational therapy as a profession that can offer a unique and fundamental contribution to society. But I posit that the idea of, or possibly the reflection upon complexity as a characterising or emancipating professional dimension might

create more quandaries for occupational therapists in their efforts to explicate a professional identity. In the ensuing discussion I highlight some of the challenges that this perspective might pose.

Jennifer Creek's seminal work on complexity as captured in her work for the Royal College of Occupational Therapists (Creek, 2003) is a way of making complexity in occupational therapy more evident and operationalised and, to a certain degree, reconcile it with a perspective developed in medicine to address complexity. In fact, the point of departure for Creek's formulations is aligning occupational therapy with complex interventions, as described by the Medical Research Council (MRC). Complex interventions have been termed as interventions that involve a number of interacting components. These could include a range of behaviours, the number of group and organisational levels involved, a range and variability of outcomes, as well as situations which allow for adaptability with the intervention (Craig *et al.*, 2013). These pose a different set of challenges to study, compared to interventions that can be studied through traditional randomised controlled trials.

Although arguably beyond the scope of this discussion intended to shed light on the results, I feel it is important to highlight that the characterisation of occupational therapy as a complex intervention has also led to a conflation of concepts: the idea or philosophical standpoint posited by Yerxa (1988) that occupational therapists deal with complex issues with complex means, and complex interventions as conceptualised by MRC. This might move the argument on complexity in a different direction. Some writers have pointed out the interchangeable use of occupational therapy as a complex system and occupational therapy as a complex intervention, when talking about complexity in the profession (Duncan, Paley, & Eva, 2007; Lambert, Harrison, & Watson, 2007). There is also a semantic implication: occupational therapy is not merely an intervention, but a profession; and what it does might not always be complex (Lambert, Harrison & Watson, 2009).

Furthermore, the consideration of occupational therapy as a complex intervention has led some writers to extrapolate a number of rather startling and arguably disruptive inferences: for example, that the active components in occupational therapy are difficult to pinpoint; that the occupational therapy process cannot be standardised and that occupational therapists should take pride in the unpredictability of their process (Creek, Illott, Cook, & Munday, 2005).

Although there is a considerable degree of truth in these claims, and which can be equally applicable to a range of health professions (not excluding medicine), such a position from authorities representing a profession might not necessarily be a virtue. It would be abundantly naïve to make such claims as paradigmatic of a health profession in an interprofessional environment that commends and has developed positivistic constructs around quality, outcomes and evidence-based practice. Quite apart from these considerations, the conclusions made by Creek *et al.* (above) can hardly be considered as contributing constructive perspectives that facilitate how occupational therapy practitioners can articulate their professional identity or indeed in the advancing of the professional standing of the profession. Concern about this stance has been raised within the profession itself by a number of writers (Duncan, Paley, & Eva, 2007; Lambert, Harrison, & Watson, 2007), with the implications of the views extolled by Creek *et al.* (2005) being comprehensively analysed.

The Royal College of Occupational Therapists has since commissioned and issued an updated document on complexity in occupational therapy (Pentland *et al.*, 2018). This was the result of a three-pronged research exercise which involved review of documents, a survey and a focus group that aimed to tease out images of the current practice of occupational therapy.

From this research, the authors developed a model for occupational therapy and identified components of practice which could be aligned to complex intervention principles, as outlined by MRC. The authors also attempted to address the tensions created by the early iterations on the issue of complexity and identify the fundamental conflation of concepts or semantical confusion on the use of the term complexity. This is best represented by the following quotation:

An alternate point of view permits a reconciliation of these two theoretical positions and aligns with the proposed model of occupational therapy developed and presented earlier. Complexity in occupational therapy is not solely a result of internal features of intervention (though they may be multiple), nor is it solely because the process itself is inherently complex and adaptive (though responsiveness and flexibility feature). *Rather, occupational therapy is complex because it is focused on causing changes to take place to person(s)-in-context, by therapists operating in context, both of which can be thought of as systems.* The purpose of occupational therapy is to alter how these systems function, so that occupation emerges in a way that contributes to health and wellbeing (Pentland *et al.*, 2018, p.45; italics added).

Figure 8.4 represents the application of the model to a scenario in occupational therapy of a case involving a client with early stages dementia. This model illustrates the details

of the various components involved to display explicitly the complexity of an intervention and is a taster of the work produced in the document. The process is rigorous, comprehensive and well-conveyed, but in my opinion, gives rise to a highly elaborate model for occupational therapy.

The casual reader in the field might feel slightly alienated from it by virtue of the, arguably, contrived intricacy of the components. It certainly demonstrates a profession capable of working in the very arena where the terms of reference have been set up by the Medical Research Council. I am not sure if this helps to go some way to address the identity issues of the field, apart from definitively settling the question of occupational therapy being a complex intervention. The overarching dimension of what is or makes occupational therapy might appear diluted or perhaps even lost.



These reservations notwithstanding, I feel that this document offers useful insights that add to the explanatory framing of the results of this study that I am developing. For example as a preamble to setting out the research methodology undertaken, the document articulates discourses on epistemology and ontology in occupational therapy of considerable significance to the findings of this study. These reflect the argument that I have been threading through this discussion, tying all these related strands into a logical conclusion. There is the acknowledgement that a number of frames of reference in occupational therapy have a reductionistic ontology, but the core focus of the profession which is 'occupation' is located or can be captured within a different ontology.

The diversity of possible ontologies operant in occupational therapy and exercised to understand and remediate occupational performance issues, which in themselves cannot be understood by a 'single set of laws,' imply that the profession is based on an assortment of diverse perspectives. Furthermore, a mere mapping of components of practice would be inadequate to bring about an understanding of occupational therapy as it is context-dependent and/or closely related to social constructions. Therefore, any understanding of occupational therapy would have to adopt a constructivist approach which accounts for the fact that any insight into occupational therapy would be dependent on "socially mediated experiences, perception and interpretation, and influenced by convention" (Pentland *et al.*, 2018, p.56).

These realisations serve to underscore the challenges of objectively pinning down the identity of occupational therapy and, by extension, the challenges for practitioners to articulate and perhaps construct their identity as they are compelled to marshal this range in epistemology in a succinct fashion that an articulation and a reflection about their nature would require. A nature which is inextricably associated to practice setting, as well as social and personal context, might ill-adapt to an overarching, all-encompassing and determinative description. This line of reasoning impels me to suggest that the identity of occupational therapy is metamorphic or polymorphic, in the sense that it can adapt and change its shape according to the practice setting and client/practitioner context and resources available. Such an identity could challenge the one carrying it as he/she might constantly have to justify and explain the mutability of the how and what of his/her doing; at the same time it presents to the observer a chameleonic professional form of practice which can be construed as unorthodox or perhaps, lacking in substance, being so changeable. This quality has been cited as a sort of 'asset' by some authors.

Creek (as cited in Robertson & Finlay, 2007) claims that if occupational therapists had to define what they do too specifically, they would jeopardise their flexibility and responsiveness to specific client needs, and this is a uniquely valuable part of what they do. Others have found this quality a distinct liability.

Fortune (2000) argues that this could make the practitioner akin to a jack of all trades; while the chameleonic quality as being a cause of blending into the background and not advertising a unique quality. This might lead to a sort of 'invisibility' in the professional environment. Fortune asks: "If the chameleon is not noticed when it is present, will it be noticed when it's absent?" (p.228), implying professional disposability. Robertson and Finlay (2007) studying occupational therapists in acute care, have considered this mutability of role as flexibility and the ability to respond to pressures in the working environment.

The discourse around complexity in occupational therapy deepens the insights on the issues of professional identity and, potentially, its construction by practitioners. It tenders further refined articulations, notwithstanding the potentially confounding aspects of the debate, as depicted earlier in this section. But perhaps, it is not the best avenue to take in order to seek a remediation - if such is required or is at all possible - of the quandaries that face the profession about its misunderstood idiom. The conceptualisation of complexity admits a strong element of context-dependent construction and hence, less fixity with the identity of occupational therapy. Considering the richness of the profession which this discussion has made very amply clear in the foregoing sections, the inevitable conclusion is that occupational therapists have at their disposal all the necessary professional tools - granted, of wide-spanning and potentially disparate epistemology - to assert themselves. Perhaps the issue lies in how strategically and consistently they capitalise on these strengths in order to advertise and assert themselves.

I feel that the discussion around complexity has built a very robust argument or perspective when it comes to determining the professional identity of occupational therapy. Equipped with this perspective, I feel some reassurance in interpreting other aspects of the findings of this research. So far, I have been principally delving into a possible cause for the articulation issues of professional identity, which I have figuratively termed late in this account as an idiom. A substantial part of the findings of this study were constructed around the experience of professional identity and essentially, these covered experience of occupational therapist with other actors in their area of practice - clients and other professionals. In the introductory stages of this chapter, I subsumed thematic material of experience of professional identity within the 'interface or public

domain aspect' of identity. And it is towards this aspect of the research that I now turn my attention.

## **8.6 Discussion of the Interface/Public Domain Professional Identity issues**

So far, I have developed a discussion where the assumption was that the internally-held professional identity script or blueprint of occupational therapy practitioners based on their knowledge, specifically the diverse and extensive epistemology was a possible source of the tensions that they experience with articulating their identity and encompassing it in spontaneous definitions and a unitary representation of themselves as professionals. The discussion was therefore centred around the personal experience and inner world of the practitioners.

In the following sections, occupational therapists become 'citizens of the world' again and inhabit their practice fields where they are inevitably interacting with other parties. They are subject to varying forms of scrutiny or observation and are the recipients of feedback, or they form impressions of and reactions to others' responses to them. Here, the array of arguments developed is conspicuously much more limited in range and scope when compared to the previous sections. This is because I feel that the foregoing discussion - which basically concerned the moulding of the profession and its 'psyche' as reflected and internalised in its practitioners - offers deeply embedded and underlying factors that extend into the experience of professional identity in the public interface.

I have taken the liberty of using the collective pronoun 'us' in the ensuing section titles. The adoption of this type of nomenclature does not imply that I am abandoning objectivity as a researcher, but I feel that this is a way of being expressly empathic with the concerns of the participants and immersing myself in their perspective.

### **8.6.1 "How they See Us" - Occupational Therapy as a Mosaic**

Some, although not all, of the subthemes delineated around the experience of professional identity principal theme, might be effectively explained or framed by the perspective that I feel links naturally to that of complexity and continues to develop that argument.

These subthemes were the:

- Misunderstood identity of occupational therapists;
- The internalised identity which is unseen by the public;
- Interprofessional awareness and cultural intelligibility of professional identity.

The origin of these various types of tensions experienced by occupational therapists could be a by-product of the apparent mutability of their professional *modus operandi* and the attendant 'third-party' perceptions of professional identity, which might engender attitudes about how occupational therapists are seen or looked upon.

To illustrate this, I take one of the most widely used intervention strategies of occupational therapists across a number of settings in physical rehabilitation, which is self-care training. It is therefore fair to assume that a lot of the images of the profession in practice, even in Malta, are conveyed through this interface of service provision.

Guidetti and Tham (2002) have studied this type of intervention in order to characterise the strategies used by occupational therapists. The authors identify eight strategies used by occupational therapists when they are working with clients who had sustained a stroke or spinal cord injury. These range from creating a relationship built on trust, finding the best way to motivate the clients, supporting the client in setting up goals and adjusting training to the specific needs of the client, rather than focusing on teaching clients the use of specific compensatory techniques. Another important finding from this study once again brings up the chameleon metaphor to highlight how occupational therapists, through their profound understanding of the client's unique situation, can vary their strategies and adapt themselves in order to meet varying individual experiences and needs during training. Linked to this image of a chameleon are the constantly morphing of the role of the therapist. This could range from taking an encouraging role, a coach role, a supportive role and a pedagogic role. These roles change during the developing therapeutic relationship, for example, as a pedagogue, the therapist can act as a mirror reflecting the client's performance in self-care; at a certain point the role of the therapist can even look static and sharing a locus of control with their clients:

The occupational therapists also said that they saw themselves as passive experts in self-care training and that their clients were the ones who knew what was the best for themselves and what they should achieve. Therapists viewed their own function as a partner in the client-therapist relationship (Guidetti & Tham, 2002, p270).

This range of possible strategies used by occupational therapists - which could potentially even involve a role which looks passive and apparently 'non-interventional' - with self-care training is testament to the client-centred nature of their work, which is purposely tailored to the context-dependent needs of each client - not a one-size-fits-all approach. It could also be another manifestation of the complex nature of their intervention.

Guidetti and Tham have reported that the strategies they uncovered were quite consistently described across their sample of practitioners. Hence, one is induced to assume that this repertoire of professional skills is internalised and existentially experienced by occupational therapists as a fundamental trait, and yet there is the potential that an observer might not appreciate this as a robust professional exigency. The shifting roles and strategies that occupational therapist make recourse to, do not reinforce an apparently consistent image of practice. This could, in turn, make the identity of occupational therapists difficult to pin down for someone who is not an insider in the field. I feel that this consideration could be fundamental in how occupational therapists are seen and as a consequence of this, how they experience their identity through the feedback that they receive.

At this point, it would add another useful perspective to this argument if the earlier use of the concept of 'kaleidoscope' is brought to bear. The kaleidoscope was used by Hooper and Wood (2002) to typify structuralist knowledge as being made up of a finite number of parts that are cast in recurrent combinations to explain social realities to which the client may pertain. I propose that the professional identity of occupational therapists and by extension, the collective of the occupational therapy profession is more akin to a mosaic rather than a kaleidoscope. It is an identity made up by a myriad of microvariations, adjustments and role adaptations or transitions that might not look strictly prescriptive and fixed - a far cry from being recurrent or limited as in the kaleidoscope. This might pose a challenge for the observer interested in obtaining an unequivocal understanding of what the profession is.

Credence is lent to this argument by the numerous points made so far, but I venture to refer to another professional document that purports to outline the range of what occupational therapists do to an external audience. The Occupational Therapy Practice Framework: Domain and Process (OTPF) (AOTA, 2014), now in its third edition, effectively replaced the Uniform Terminology document cited earlier in this account. The OTPF is the official document of the American Occupational Therapy Association which sums up the interrelated constructs that describe the occupational therapy profession. It is obviously beyond the scope of this discussion to go into the full details of the OTPF, but it would be entirely significant and sufficient to give a concise account of the way that interventions are categorised. The document describes both occupations and activities as the main avenues of 'treatment;' but these are followed by a range of other interventions that are within the purview of the profession. These include preparatory methods (including assistive technology, orthoses and prosthesis); education and

training; advocacy and the use of groups, both to target a client population and as a therapeutic modality.

The OTPF further describes approaches to treatment that the occupational therapist might make use of. These are reproduced in Figure 8.5. The last sentence introducing the chart which is here reproduced verbatim: “Approaches inform the selection of practice models, frames of references, or treatment theories.” (S.33). This is very telling and once again, underscores the intricacy of the occupational therapy process and the apparent challenge in subsuming it in a single overarching description. Furthermore, the use of models and frames of reference also confirms the profession’s basis in science, which could belie its aspirations as a true pragmatist concern.

Approaches to intervention are specific strategies selected to direct the process of evaluation and intervention planning, selection, and implementation on the basis of the client’s desired outcomes, evaluation data, and evidence. Approaches inform the selection of practice models, frames of references, or treatment theories.

Approach	Description	Examples
<b>Create, promote (health promotion)</b>	An intervention approach that does not assume a disability is present or that any aspect would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all people in the natural contexts of life (adapted from Dunn, McClain, Brown, & Youngstrom, 1998, p. 534).	<ul style="list-style-type: none"> <li>• Create a parenting class to help first-time parents engage their children in developmentally appropriate play</li> <li>• Provide a falls prevention class to a group of older adults at the local senior center to encourage safe mobility throughout the home</li> </ul>
<b>Establish, restore (remediation, restoration)</b>	An intervention approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533).	<ul style="list-style-type: none"> <li>• Restore a client’s upper-extremity movement to enable transfer of dishes from the dishwasher into the upper kitchen cabinets</li> <li>• Develop a structured schedule, chunking tasks to decrease the risk of being overwhelmed when faced with the many responsibilities of daily life roles</li> <li>• Collaborate with a client to help establish morning routines needed to arrive at school or work on time</li> </ul>
<b>Maintain</b>	An intervention approach designed to provide the supports that will allow clients to preserve the performance capabilities they have regained, that continue to meet their occupational needs, or both. The assumption is that without continued maintenance intervention, performance would decrease, occupational needs would not be met, or both, thereby affecting health, well-being, and quality of life.	<ul style="list-style-type: none"> <li>• Provide ongoing intervention for a client with amyotrophic lateral sclerosis to address participation in desired occupations through provision of assistive technology</li> <li>• Maintain independent gardening for people with arthritis by recommending tools with modified grips, long-handled tools, seating alternatives, and raised gardens</li> <li>• Maintain safe and independent access for people with low vision by increasing hallway lighting in the home</li> </ul>
<b>Modify (compensation, adaptation)</b>	An intervention approach directed at “finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques . . . [such as] enhancing some features to provide cues or reducing other features to reduce distractibility” (Dunn et al., 1998, p. 533).	<ul style="list-style-type: none"> <li>• Simplify task sequence to help a person with cognitive impairments complete a morning self-care routine</li> <li>• Consult with builders to design homes that will allow families to provide living space for aging parents (e.g., bedroom and full bath on the main floor of a multilevel dwelling)</li> <li>• Modify the clutter in a room to decrease a client’s distractibility</li> </ul>
<b>Prevent (disability prevention)</b>	An intervention approach designed to address the needs of clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).	<ul style="list-style-type: none"> <li>• Aid in the prevention of illicit chemical substance use by introducing self-initiated routine strategies that support drug-free behavior</li> <li>• Prevent social isolation of employees by promoting participation in after-work group activities</li> <li>• Consult with a hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeepers</li> </ul>

**Figure 8.5: Approaches to treatment extracted from the Occupational Therapy Practice Framework: Domain and Process.**

**Source:** AOTA, 2014.

The conceptualisation of the occupational therapy profession in the OTPF suggests a professional role that spans a health worker dealing with procedures, an educator role and a role in advocacy. I believe that it should not come as a surprise that the identity of occupational therapists presents a challenge to be understood as it might fail to fit within the normative and accepted tenets of healthcare practices. Perhaps nowhere is this more emblematic than the image of an apparently passive practitioner who allows the client to take the lead in his/her rehabilitation.

This reflection dovetails with another important subtheme which is that of *professional identity congruence*. The sense that what the occupational therapists do in some practice environments generates a sense of practice discordance or a sense of 'going against the grain,' with attendant misperceptions by third parties.

### **8.6.2 “This is too Small for Us” - A Question of Professional Role Restriction?**

In the previous section, I attempted to build a case around the wide-ranging scope of the role of the occupational therapist and how this might indirectly impact upon the experience of professional identity. The argument was that the variegated nature of what occupational therapists do could be challenging for an observer to encompass into a unitary professional identity and that this could be a source of the 'misreadings' on their identity that practitioners experience from feedback from other players in their field of practice. The logical step that follows from this is to ask the question:

*How can this wide scope of practice of occupational therapists be contained and enacted in some of the traditional health settings? Is it congruent, or does it fit within the boundaries of health settings?*

Although this study was not set up to sound and determine tensions and grievances from different practice sites and compare them, I will hazard to say that the source of data codes that I have used to construct the professional identity congruence subtheme come from the acute setting and long-term care. This is not to say that there is a direct link to these settings, but I have to point out that extant literature has considered practice in the acute setting to uncover sources of professional identity tension, indicating that this could be a source of contention for occupational therapists.

Britton, Rosenwax and McNamara (2016) studied practitioners in an Australian acute hospital and their overarching conclusion was that practice in this setting is a modified sort of occupational therapy.

The study uncovered how building a professional identity in the acute setting was difficult as the full scope of practice could not be showcased. The role of practitioners was influenced by the 'pragmatic' factors associated with working in an acute setting, such as the need to discharge clients as rapidly as possible. These challenges were further compounded by the fact that practice is referral-based and this contributed to reduce the practitioners' presence on wards, which in turn reduced the visibility of the profession and its attendant foothold. More of concern was the finding that participants seemed to adopt modes of intervention that were visible, recognisable by the medical team and led to quicker discharge of clients. By adopting this modified and restricted identity, the participants found themselves out of alignment with the university training that they had received and unable to enact their identity (Britton *et al.*, 2016). One of the identity-affirming influences that was uncovered in the present study was the experience of successful or powerful stories in rehabilitation.

With the process of occupational therapy reduced or "truncated" (Britton *et al.*, 2016, p261) to the level of assessment and discharge from the acute setting, I suggest that practitioners could be deprived from the full cycle or scope of occupational therapy. The end point of this cycle implies that an appreciable change in the client that contributes to a substantial amelioration in participation in meaningful occupations is achieved, but this might not be the case in an acute setting. An 'incomplete cycle' of occupational therapy sustained over a period of time, could be akin to working in chronic or institutionalised conditions where a source of professional satisfaction is suspended, as a matter of course. This is ironic considering that an acute setting implies an element of challenge and rapid turnover. But the outcomes of this process might not be aligned to the more holistic outcomes that occupational therapists envision for their work. Although in no way claiming a causative association, I feel that this research does prompt us to reflect on this inference. Clinicians might experience a dissatisfaction or a negation of their identity because of a restricted professional role.

In contrast to this consideration and its rather negative prospects, Robertson and Finlay (2007) report that staff working in acute settings were satisfied with the value of their work. Experiencing membership in a team of occupational therapists contributed to support them as they worked in a potentially stressful setting. Furthermore, adopting a positive attitude towards the possibilities offered by their milieu - taking the unpredictable quality of the setting as a source of excitement or interest and taking comfort in the fact that, however restricting the practice environment is, they are still making a difference in the patients' lives by prescribing equipment that contributed towards independence - were useful coping strategies.

Reflection, taking stock and counting blessings could be alternative and reinforcing ways of looking at themselves. Perhaps occupational therapist should consider that like other professionals working in acute care they are faced with instances of the worst of challenges faced by humanity as focused and concentrated in this one single health setting. The fundamental difference for occupational therapists might be that when they compare themselves to other health practitioners, they can call upon the relative 'luxury' of having been exposed to brighter and more hopeful service arenas, such as schools, work settings and healthy populations, as part of their training. It perhaps should not come as a surprise then that they feel restricted or going against the grain when they try to espouse such values as participation, rehabilitation, engagement, occupational justice and client-lead/centred practice (discussed in the previous section), with settings where the immediate concern is preservation of life, survival and succour from pain.

Shiri (2006) suggested that occupational therapists should be prepared to cope with the realities they face in acute care in their basic education. Practicing within the tenets of rehabilitation in acute care could be challenging and occupational therapists need to be able to explicate their practice in keeping with the time limitations imposed by the setting.

So far, in my interpretation of the results I have tended to highlight the more wearing and dispersing influences on professional identity, represented in Figure 8.2 with the downward pointing red pointer symbol. This was more an effort at trying to frame the problems within a sort of diagnostic framework that attempted to determine an aetiology. I feel that it is now time for me to look at the possibility of suggesting recommendations that the professional might contemplate as strategic action or reflection on improving its position on the health professions map in Malta and reinforcing its identity positively, i.e. the blue upward pointing symbol of Figure 8.2. Although I have occasionally dropped some indicators to this effect, I believe space needs to be created in this study that discusses the matter more systematically and comprehensively. I have to pre-empt that this will not be a strictly prescriptive account - the situated and narratively complex issues uncovered in this study would preclude such a simplistic approach. Although presenting some concrete, if nuanced propositions would be useful.

### **8.7 "How we can Better see Ourselves" - Reflections on Recommendations for Practice and Education in the Maltese Setting.**

Proposing a set of clear-cut recommendations which the profession can adopt comes with the underlying assumption that this gesture will contribute to the amelioration of the professional identity and perhaps the standing of the profession. This is simplistic, presumptuous and slightly misguided. The urge to recommend in this context would be assuming that this impulse will cut across years of a long history of doing, perceiving,

being perceived and reflecting. The practice community can call upon minds which are equal and even better than my own and hence is well placed to evaluate its professional positioning. The far-reaching and extensive insights captured in the results are testament to this.

Proposing recommendations could also convey the impression that there is a utopic future (Stronach, Corbin, McNamara, Stark, & Warne, 2002) to look towards mediated through a sort of 'waiting for the messiah complex' or a *deus ex machina* to bring about deliverance to the profession. I feel that it is more a case of an evaluation of resources and bringing together of the many strings of the professional identity narrative, rather than a profound reality shift that can be contemplated. The hope therefore is that this section will at best act more as a platform for reflection rather than prescription; more specifically, a series of reminders or flash cards.

In order to understand the ideally invested mind-set of occupational therapists - indeed any ethically and principle-driven professional - with respect to their profession, I will quote David Whyte (as cited in Wood, 2004):

To have a firm persuasion in our work - to feel that what we do is right for ourselves and good for the world at the exactly same time - is one of the great triumphs of human existence (Wood, 2004, p.249).

To achieve this persuasion, practitioners might have to overcome the various dispersing influences that have been cited as potentially undermining their identity. It is logical to assume that practitioners in occupational therapy want to have a firm belief (Wood, 2004) that what they do is good for their clients and positively reinforces their views of themselves. The wellspring of this belief should be the individual occupational therapists, although one cannot account for each practitioner's strength of motivation and concern in this regard. So, the profession as a body might want to strategically seek to develop a consensus understanding of its condition in order to advance its professional agenda in Malta. It has to be noted that the instances of professional identity tension captured in the data are the result of the prevalent professional culture of the health settings, and not the outcome of any audit and managed care culture. An audit culture does exist in Malta, for example the University and it would not be far-fetched to assume that in more straitened financial situations and/ or a change of government policy, could give rise to a situation where the health sector would have a strictly metered financial administration where professions have to be able to articulate and justify their existence, as well as be able to measure their contribution. The profession of occupational therapy could exploit on this 'lull' so that through reflection

and preparation be in a stronger position to portray its resources and assets. It is a juncture where it can look at instituting professional change "inside-out," rather than having to assist to a situation where appointed "experts" who are not interested in the professional value are the instigators of change "outside-in" (Stronach *et al.*, 2002). The fact that occupational therapy has survived and thrived in such a regulated and arguably output driven healthcare environment as the United States can be taken as testimony to the profession's resilience. Although a counter argument to that point would be that the United States constitutes another cultural, ecological setting for the profession which in no way can be compared to Malta. From these important scene-setting preliminary points, it is time to commit to some recommendations for practice prompted by this discussion.

### **8.7.1 *"That's how we are!" - Coming to terms with the challenges of Knowledge in Occupational Therapy and Accepting one Conceptual Narrative?***

Since so much stock has been given in this discussion to the importance of epistemologies in occupational therapy as a factor that contributes to the construction of professional identity, I feel it would be inconsistent if reference is not made at this stage to this discourse. The argument that I had developed was that occupational therapists face a dilemma reconciling the range of disparate epistemologies in their field. The diversity and complexity of occupational therapy is its ineluctable nature; it is its boon and bane, and however much it poses a challenge to marshal and articulate, practitioners have to come to terms with it and somehow use it to their advantage. I believe the first port of call has to be a way of looking at themselves. There's not a one size fits all solution, so the "one" in the title is patently unrealistic, but the dilemma is clear - wanting a unitary identity for the profession and accommodating the diversity, and not losing it. Perhaps it is a matter of personal predilection for me, but I cannot find any conceptual schema in the profession which rivals the one that was proposed by Kielhofner (1992, 2004) from around the start of the 1990s as *The Conceptual Foundations for Occupational Therapy*.

This schema has been reviewed in detail elsewhere in this thesis and I will not restate it, suffice to say that it casts the knowledge of occupational therapy in concentric layers - as a sort of onion configuration - serving different functions: namely, an identity conferring paradigm; various practice mediating models for practical application in different fields and related knowledge. My first encounter with Kielhofner's writing over two decades ago was an authentic road to Damascus moment and I feel that it offers an elegant, usable and valid schema of how occupational therapists can regard themselves and sustain their identity consistency as they move across different fields of practice. It

is a way of looking at the profession that allows the reconciliation of the disparate epistemological tensions. Also, Keilhofner's analysis of the history of the profession through the lens of shifting paradigms, offers insights into the diverse generative epistemologies underpinning the discipline and its identity, and profound insights into the identity of the profession to both scholar and practitioner.

Turning once again to the introduction of this section where I referred to practitioners having a firm conviction about what they do, I have to bring to bear another important contribution of Kielhofner to the field and that is his Model of Human Occupation (MOHO) (Kielhofner, 1995). I refer to MOHO as another platform for thinking about practice in occupational therapy and its unique contribution to healthcare and further afield. It is beyond the scope of this passage to review the details of the model, but the view of the human as an open system, with participation in occupations that allow individuals to inhabit or re-inhabit roles and by extension restore identities, is a very powerful perspective to spotlight the contribution of the profession. I am not implying that these are a panacea but can be fundamental tools for education and reflection about occupational therapy - perhaps an 'inside-out' way of change of mentality.

### ***8.7.2 "But it's Rote Learning!" - Developing the Skill of Talking About the Profession***

As professionals, occupational therapists might lack the identification bestowed by public to such professions as the nurse, the teacher and the doctor. The public images of well-known professions might be replete with clichés and stereotypes, with which the holders of the titles aforementioned might feel uncomfortable or limited, but at least they constitute a foothold in the public's general knowledge of professions and imagination. Occupational therapists might have a double challenge as they are difficult to identify by what they say, but also by what they do. This might not be uniquely circumscribed to them, but it is something that they share with other disciplines such as psychologists and social workers. But in any case, it behoves occupational therapists to develop skills to be able to talk about themselves and ensure to highlight their uniqueness. Being able to speak about occupational therapy in a way that showcases its assets and apports the justice it merits is not a simple feat and seems to challenge even the most seasoned of practitioners, as this study and literature has demonstrated. Some have suggested that defining the discipline is an art; but I suggest it could be a matter of rote learning and coaching in the best way to speak about it.

Di Tommaso and Wilding (2014) studied the use of strategies by students to increase their confidence in explaining occupational therapy to others.

The authors delineated four strategies that could be used to improve articulation: explicit reference to or use of the word 'occupation' as this forms part of the denomination of the profession; use of terminology from theories (this ties in with the arguments developed in the previous section); the avoidance of terminology from the biomechanical domain and drawing on examples of occupation from life. These strategies are annotated in Figure 8.6, together with the underpinning rationale for each.

Strategy	Reasoning for strategy development
1. Our domain is in our name	As the word 'occupation' appears in the name 'occupational therapist', occupational therapists ought to be explicit about the connection between the profession's title and their skills (Whiteford, 2007). Use of 'occupation' enables therapists to identify themselves as "experts in occupation" (Wilding & Whiteford, 2008, p. 183).
2. Focus on theory	Words from theories of human occupation can act as a starting point for a definition of occupational therapy
3. Avoiding biomedical language and frameworks	Unconscious conformity with biomedicine may perpetuate lack of understanding of occupational therapy (Wilding, 2011). Using words such as "function" and "activities of daily living" instead of "occupation" may dilute or distort the focus of occupational therapy (Wilding & Whiteford, 2008).
4. Using visualisation	An informal strategy that involved thinking about a favourite occupation and connecting with the feelings that arise when doing this favoured occupation and then thinking about how one would feel if he/she could no longer participate in this occupation. A person is asked to compare and contrast his/her feelings in these two scenarios to highlight how occupation can vitally impact upon satisfaction, enjoyment in life, and well-being.

**Figure 8.6: Proposed Strategies to Improve the Description of Occupational Therapy.**  
**Source:** Extracted from Di Tommaso and Wilding (2014)

Wilding and Whiteford (2007) suggest that the word "function" - pervasive in occupational therapy speak and shared with other professionals - should be substituted by the word "occupation" in definitions of occupational therapy and when speaking about what occupational therapists do. The word occupation is explained to mean all that individuals do to occupy themselves, rather than the familiar usage of the word which denotes what one does for a living. Furthermore, the use of the word 'occupation' should be used in interprofessional documentation. Talking the talk of occupation is a good starting point, but this should be reinforced in a continuum, as it is translated into the observed and doing aspect of occupational therapy perceived by the public.

### **8.7.3 "Practising what we Preach" - Actually Practising Occupationally.**

It would follow naturally from the previous section to recommend that occupational therapists go beyond the talk and actually practice in a fashion which brands them as occupational therapists to the public. But there is evidence to suggest that the rhetoric around occupation is not actually translated into practice and that educational

preparation is implicated in this as well as conformity to established work practices (Di Tommaso, Isbel, Scarvell, & Wicks, 2016).

Furthermore, some practice sites might not be naturally congenial to working in an occupational-based fashion and are more naturally associated with an impairment-based approach; e.g. hand rehabilitation and acute practice. At this point a reflexive annotation would be unavoidable. If academics do not seem to be imparting skills for occupation-based practice, conformity to established practices exclude it and certain practices might not be amenable to it, is this an idealised state that is mediated through the ivory tower of academia and occupational therapy writing or lore? There is the mitigating factor for this consideration and that is that certain practice sites in occupational therapy, do lend themselves naturally to an occupation-based approach of intervention. Consequently, recommending that practitioners practise more occupationally, might be pushing against some deep-seated professional culture 'lead weights' and is a recommendation offered in full awareness of a range of provisos.

#### ***8.7.4 "We have to Improve our PR" - The Need to Promote the Profession***

Considering the still extant issues of visibility, limited familiarity with and public knowledge of occupational therapy, promotion at both a macro level and micro level remain a major priority. With promotion at a macro level, I refer to promotion that falls within the remit of appositely appointed committees and would be major and focused initiatives. Due to the substantial financial outlay that it might involve, it could also be of a sporadic nature. But since promotion might play such a central function to the profession, it could have to be pursued on a macro level regularly with the relative mobilisation of funds and resources in order to produce professionally executed campaigns on key media. It is also incumbent on each individual practitioner to promote the profession and not only during formal promotional settings, but as a matter of course. Public identity issues have to be uppermost on practitioners' list of commitments. This might not be a requirement for more mainstream professions, but not the case for occupational therapists.

Recommendations covered in the foregoing sections all contribute to this and are instances of the micro-promotional dimension. A public relations activity which becomes second nature to the individual; part of the professional attire as evidenced in capable articulation, unique professional language and unique set of insights on the effects of participation in occupation and health.

### **8.7.5 "We need to Support Each Other" The Importance of Staff Supervision.**

Equipped with the knowledge of the range of professional identity issues that could impact its practitioners, with potentially negating or perhaps even deleterious effects that these may have, the profession needs to be fully aware of the potential reach of staff supervision. The very wide scope of the profession, with the attendant latitude in knowledge and practice skills could make the transition from student to clinician a major concern. Also, the movement of staff from one practice site or speciality to another could pose similar issues.

Ongoing and unaddressed identity issues that are a natural response of staff in some practice environments, is another matter that needs to be dealt with by management in occupational therapy. Leaders in occupational therapy play a major role in sustaining formal and informal networks that contribute to the retention of staff (Ashby, Ryan, Gray, & James, 2012). Research has also shown that resilience of staff is linked to the ability to communicate an "occupational perspective and the use of occupation to enable occupation in others" (Ashby *et al.*, 2012, p.116). This might need to be modelled by the more seasoned and aware professional leaders. This also underscores once more the importance of the conceptual epistemological script that sustains identity in occupational therapy.

Investing more resources and time towards supervision should not be construed to be an indicator that the profession is more prone than others to sustain the wearing side-effects of its identity, but taken as a possible indicator signifying that it has reached the pantheon of the complex established professions as it shares with these disciplines staff supervision as a major focus of its operations.

### **8.7.6 "We might need higher entry qualifications" - Possible Expanded Scope in Education**

Basic entry-level qualification in the United States for occupational therapy has advanced from undergraduate to Master's degree (AOTA - Qualifications of an occupational therapist, n.d.), the same applies in Canada (Brown, Crabtree, Wells, & Mu, 2016). The American Occupational Therapy Association is in the process of recommending that the single point of entry into the profession in the US would be a clinical Doctorate degree starting in 2027 (ACOTE's update on entry-level education, 2018).

The educational situation and professional human resources in Malta are certainly not comparable to the United States, and the profession in Malta should not have such vaunting ambitions, having embarked on its undergraduate programmes just over two

decades ago. I am certainly not suggesting that a Doctoral entry point is in anyway indicated, but the arguments made on the complex conceptual base of the profession is certainly enough motivation for the profession to consider what level of education should its beginner have, and the attendant skills set that needs to be honed in a potential graduate. The possibility of moving into non-traditional emerging areas of practice could necessitate more developed or higher clinical acumen that is beyond the scope of undergraduate (Brown, Crabtree, Mu & Wells, 2015). The natural step for Malta might be a move to a Master's degree entry point. The most obvious disadvantage fostered by this move would be that the number of applicants requesting admission would, in all probability drop as a consequence of higher entry qualification into the programme. This would defeat the profession's major goal of increasing its visibility.

A more immediate concern in education is the possibility of a gradual moving away from a possible medical model knowledge scaffolding in the current programme. This is to ensure that client-centred practice and occupation-focused practice is portrayed and modelled for students to articulate. This needs to be developed with equivalent changes in the field of practice. There is also the attendant risk that with the inception of a modified curriculum there is the creation of graduates whose knowledge is unintelligible to the clinicians and whose skills are not those expected by clinicians. This is the worst-case scenario, but a fundamental change of professional epistemology could bring with it some tension-laden adaptations in the field. This would involve collaboration between the university and the service sector. The education sector has to avoid a situation of 'throwing out the baby' if it subscribes radically to a new epistemology.

#### **8.7.7 "Agreeing to Agree" Seeking Consensus across the Profession and Consolidating the Professional Project.**

During the time of the data collection of this research, the profession of occupational therapy in Malta was in the process of adopting an occupation-based model of practice which would have contributed to developing a sort of "corporate image" (Boniface *et al*, 2008) of the profession and also a change in professional language and doing, which might have had the effect of scaffolding an occupation-focussed and client-centred base for intervention. The attendant implications and possible effect on the public identity of the profession of this exercise were undeniable. This event is documented elsewhere in this thesis (Appendix 13). I was involved in it and because of my positioning within the milieu of the profession can attest to the outcome or the denouement of the undertaking.

Although the enterprise cannot be labelled as having been futile or a failure, more than anything it proved to be a litmus test of the extent of consensus on perspective of practice

in Malta and the openness of the profession to change. On both of these counts the profession proved to be challenged: diversity of perspective was wide; openness to change was limited. The adoption of the model was very narrow, even in sites which seemed more amenable to its inception; although a number of sites opted to implement a watered-down version, which is still in use.

The final outcome of the situation was more a case of 'agreeing to disagree.' Change was expected to happen 'outside-in' - change instigated by the whole profession and transmitted to the respective sites and clinicians. However, the extent of change was limited, testament perhaps to the embeddedness and entrenched nature of the localised identities and ways of doing. There is also the temptation to make an inference - entirely not evidence-based - that the diversity of epistemology highlighted as a possible underpinning causative factor on the experience of identity might also manifest as a diversity of individual psyches which will make any pursuit of consensus difficult. And so, 'agreeing to agree,' might be a goal too far for the profession. The tolerance of pluralistic voices is healthy and inevitable for a professional environment but the profession cannot remain insular and locked in an echo chamber that reverberates arguments for a professional holding pattern. It needs to be armed with self-knowledge to appreciate its positioning within local healthcare.

Assessing the situation of occupational therapy in Malta through the lens of the professional project, one can conclude that the profession satisfies the requirements. Notwithstanding, its practitioners still appear to sustain tensions associated with their professional identity and this could reflect on the broader image and standing of the profession in the public eye and its interprofessional relations.

Recommendations for change are made in full awareness of the many variables that need to be mobilised. A leap of faith might need to be promoted together with a dose of ambitious ruthlessness. There is perhaps a pressing requirement for the profession to consolidate market closure before other players in the field of healthcare appropriate its niches. Reduced to absolute terms, the question of professional identity, transforms into a matter of purely utilitarian professional status; from collegial and cool intellectual climes, to the more urgent and militant ones on the practice front.

## **8.8 Reflections on the nature of an Over-Emphasis inherent in a Uniprofessional the Study**

The results of this study have been illustrated over the considerable span of two detailed chapters. Throughout this chapter, in an effort to develop a discussion that shed light on the range of themes constructed from the data, these findings were then subjected to

intensive theoretical framing. Any reader who covers this considerable trajectory of discourse and empirical evidence cannot be blamed for possibly taking away an impression of a profession uniquely burdened with a fraught identity. But this impression needs to be urgently and objectively tempered with the reflection that this was a *uniprofessional study* motivated to explore in-depth certain dimensions of the occupational therapy profession in Malta as a case study, without resorting to a comparison with the professional situations prevalent in other disciplines. Therefore, any sort of impressions that the reader might perceive could be the consequence of an over-emphasis that a systematic and comprehensive exploration engenders in the absence of an interprofessional comparison. The latter would have necessitated additional theoretical digressions or even an altogether different full-scale study.

## **8.9 Summary and Conclusion of the Chapter**

In this tract I sought to discuss the findings that had been illustrated in the two previous chapters of the results, with the purpose of developing interpretations and insights that advance the understanding of the principal research question and objectives of this case study.

I started this tract by proposing a synthesis of the results for the purpose of focusing the discussion and making possible a more manageable reframing of the results. The product of this initial synthesis was the construction of two overarching areas of professional identity: a personal domain and an interface or public domain. This synthesis was further conceptualised into a model that suggested a dynamic interactive relationship between the two areas and possible outcomes of this interaction; a negative pathway resulting in wear or dispersion of identity and a positive reconstitutive, pathway which could facilitate the reinforcement of professional identity.

Explanations of the findings subsumed within the personal domain were framed within the perspective of possible multiple and disparate epistemologies which underpin the professional knowledge and knowhow of the profession of occupational therapy. It was also suggested that these conceptual and knowhow multiplicities could translate into a diversity of professional roles and approaches that occupational therapy practitioners can occupy. This consideration was employed to propose explanations for the interface or public domain identity issues.

The next section of the chapter developed a discussion on recommendations for practice and education in occupational therapy. The discursive format was adopted to reflect the holistic and deep-rooted issues that had been uncovered. These issues,

correspondingly, demand that any proposals for remedial action have to be charted in a reflexive and situated manner.

The final section carried a brief consideration of the implications of a uniprofessional study, highlighting possible pitfalls that could be inherent in research that may have overstressed the issues of one particular profession, when these concerns could actually be shared with other disciplines.

## Chapter 9 Conclusion

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### 9.1 Introduction

As I now reach the final stages of this thesis, I feel it is time to reflect on the net value of the research and create a parting shot, a sort of summative postcard of this project. I will first be reflecting on my positioning within this research, which I feel is so fundamental given my relationship to both the area that I have investigated as well as with the participants. Next, I will briefly restate the main findings and then move on to highlight the value of this research around the factors of uniqueness, contribution to the field, its strengths and limitations. I then proceed by reflecting on possible future research that might be explored prompted by the outcomes of this study. One final look at the 'lessons learnt' and net value of this project to the profession concludes this chapter and this thesis.

### 9.2 A Final Look at the Researched, the Researcher and the Language of This Case Study

I was always interested in studying the field of occupational therapy since undertaking my Master's degree, but at that point I thought that the time was not ripe to conduct such a study and the resources within the profession were also still very limited. With the steady rise in the practitioner population in the profession and a concurrent rise in first degree and post-graduate qualification holders over the period of just over a decade, I felt it was the right time for me to finally systematically study my profession specifically around professional identity issues. Little did I imagine that through my familiarity with the field that I would be studying and the fact that I had played such a key role in contributing to the development of it, especially from the educational sector, would actually act as a fundamental barrier to my understanding and organisation of the data I would generate. The following quotation from the preface to Lytton Strachey's biographical essays (Strachey, 2003) of four eminent Victorians written at the beginning of the twentieth century, captures my sentiments perfectly:

The history of the Victorian Age will never be written: we know too much about it. For ignorance is the first requisite of the historian - ignorance which simplifies and clarifies, which selects and omits, with a placid perfection unattainable by the highest art (Strachey, 2003, p.5).

To continue in the same vein, I simply did not have enough 'ignorance' of my subject/s to help me clarify and simplify my understanding of the data. But Strachey was conscious of the daunting potential of his chosen historical epoch and subjects, and very wisely had expressly not set out to theorise. He could afford the luxury of creating a subtle understanding of his subjects as important and diverse exemplars of their era and create literary art from biography. In contrast to this, I was faced with an enormous body of data - perhaps of a more prosaic, but of equally fascinating nature nonetheless - that required to be simplified and organised into a system that could be proposed as a basis for the further understanding of my chosen case. I am not in any way suggesting being kindred with Strachey's intellectual prowess, but this reflection prompted by his proximity to his subject matter perfectly captures my mindset, as I navigated the two years of data collection and another two years to data analysis.

The analysis process and methods posed an almost 'moral' inhibitory influence on me. What had to be done to and with the data was always 'staring me in the face.' But coming to terms with having to break down, chunk and chop the data into codes and decontextualise it and later create abstractions out of the participants' meanings and language was a process that I could not reconcile with representing them faithfully and comprehensively. Having to be the arbiter of what and how data can be reconstructed into the results was, for me, something akin to anathema. Alternatively, this could simply have been the product of my narrow-minded and positivist consideration of what research should be and how data should be treated. There was also the factor alluded to earlier of my lack of ignorance about the subject of professional identity and having a meaning matrix of the case - however unsystematic, undifferentiated and pre-set - quite well-established in mind. This needed to be unpacked and deconstructed. Adopting thematic analysis, which I consider as perhaps the most authentic and naturalistic form of qualitative data analysis - or at least the one most congenial - was key in finally getting the job done of creating the results. Although the possibility of having left something out or not faithfully representing my subjects, constantly weighed on my mind. The way I have written the results, with the process I refer to as involution, has allowed me to develop a complex 'inner life' for the themes and subthemes, revealing a range of voices, grievances and achievements. This gives me some comfort.

Broadly adopting the concept of reflexivity has also been an integral part of feeling comfortable in having to work in the grey areas that I feel are 'a given' to the role of a qualitative researcher. At a basic level, reflexivity was translated into being able to unpack the issue of my positioning as an insider in this case study. Having been a mentor and/or educator to a lot of my participants, I had imagined that there might be a

level of inhibition or reserve about the information that they would unburden themselves from with me. The range, richness and unfettered nature of the data I managed to collect, dispels any such concerns.

I think I have also built-in reflexivity throughout, in the way I articulated my thinking around processes and rationales that have underpinned this research. But the act of writing as a reflection of the inner life of thought is perhaps an over-simplification limited by the parameters of language. In my case and that of the subjects of this research, this comes with an added layer of challenge as both parties have to cope with a bilingual or trilingual communication system in order to transmit and articulate inner meaning. I apologise to the native English speaker for the often and unwitting abuse that your language has been submitted to in the quest of extreme nuance, over-inclusiveness and abstraction engendered in the name of 'reflexivity' and articulating the innards of identity. It is the by-product of a trilingual inner life.

### **9.3 Central Findings and Explanations**

The data was constructed into two main themes and an attendant respective cluster of subthemes, after a process of thematic analysis. One of these major themes concerned the participants' articulation of their professional identity as occupational therapists. The range of subthemes illustrated tensions or a 'struggling' experienced with encompassing a unitary overarching definition of the profession and explaining it to others. Another dimension of this theme was the realisation that occupational therapy had a wide-spanning identity ('vast identity'), and that definitions of the profession tendered were often related to the area of practice, rather than the whole profession. Another fundamental finding within this theme was that the concept of 'occupation' was rarely used to characterise the unique feature of the profession. It was posited that this theme and range of subthemes represented a sort of glimpse of the internalised professional identity of the participants and could be subsumed synthetically within such a concept.

As a possible explanation to interpret this theme area, it was suggested that the multiple and disparate epistemologies that underpin the professional makeup of the profession could be responsible for the challenges that practitioners experience to contain their identity within a unitary concept. This notion was logically linked to the wide-ranging conceptual basis of the profession as another possible factor that challenges practitioners in articulating their identity.

The discussion around the tensions of articulating identity was concluded by a consideration of the concept of complexity and the attendant implication that the

professional identity of occupational therapy has a strong element of contextualised construction that further challenges the belief in the possibility of contemplating a unique and monolithic identity for the profession.

In the second major theme, I described the experience of professional identity. The subthemes allied to this spanned the issue of having a misunderstood professional identity; having an internalised identity that is unseen by the public; interprofessional awareness and cultural intelligibility. For the purpose of facilitating interpretation, these findings were comprised within the synthesis of the public domain or interface professional identity. The interpretative lens applied to these findings extended the argument of epistemological diversity described in the foregoing. It was theorised that this diversity translated into the range of diverse roles, different ways of doing and approaches that occupational therapists embody, and how these were perceived by the public and/or other professionals who in turn, give feedback on how they perceived occupational therapists. This feedback could have a negating ('dispersing') or reinforcing influence on professional identity.

The literature does not seem to support a culturally situated nature for the construction, articulation and experience of professional identity in occupational therapy, as almost identical findings can be found in studies on professional identity conducted in a number of countries. Some participants seemed to suggest that their profession was perceived more favourably or understood better by some foreign nationals, rather than the Maltese client population which they serve. Although some literature does suggest that the tenets of occupational therapy are not understood in certain cultures, I suggest that there is limited scope to extend discussion in this area, especially when considering that discourse seems to be limited to one author and one particular country. This point is briefly discussed in the literature review chapter of this thesis.

#### **9.4 Uniqueness and Contribution of this Research**

This study is obviously unique because it is the first one of its kind to be conducted in Malta and about the Maltese occupational therapy profession. It is also the first of its type to be conducted in a small Southern Mediterranean sovereign state. Within the international setting, quite a number of studies, published in peer-reviewed journals and as unpublished dissertations, have purported to study professional identity or dimensions of it in the profession of occupational therapy, but circumscribed to a particular practice site. This study aimed to create a snapshot of the professional identity in Malta across the major practice sites available at that time within the profession. This practically targeted a major, I could say, the majority of the services of importance within the

profession in Malta - basically a substantial cross section of the whole profession. This constitutes uniqueness as no other study has involved the whole of the milieu of the profession of occupational therapy of a particular country through a constructivist theoretical lens. No heroics are being claimed here; this is the outcome of the relatively small size of the profession, locally and the conveniences that the compact geography of Malta affords. I also feel that the central explanations proposed to frame the results in the discussion chapter, although not original, constitute uniqueness in the way that these have been applied and combined to the blended representation of the findings.

In terms of the overall value and contribution of the study, the findings served to comprehensively illustrate the issues that underlie and impact upon the professional identity of Maltese occupational therapists. Professional identity is an issue which still holds currency for occupational therapy and this study contributed to the already extant body of knowledge that has been generated around the subject. The discussion of the results suggested that professional identity issues will remain a perennial concern for some time to come as these might be an inextricable aspect of the nature of the profession. Therefore, insights and realisations developed from new studies from different parts of the world are important.

The value of the study for the Maltese occupational therapy community rests in the fact that the study has presented ways of understanding, unpacking and explaining the range of tensions that practitioners experience with their professional identity. The perspectives constructed and broadly explained herein allow practitioners to reflect upon, as well as frame through a lens of rationality what previously might have been felt as discouraging or disorienting aspects of their professional identity experiences. The findings also have the potential to establish some parameters and remediation measures which could be deployed in apposite settings for the purpose of reflection, discussion and support of staff in settings that might bring to the fore issues related to professional identity. In fact, the study made clear the potential of the identity-challenging properties of certain practice settings. And this served to underscore the importance of staff mentorship and supervision in order to support and clarify for junior staff and students, the challenges that some settings pose for the identity of occupational therapists.

The findings that are grouped under the internalised identity umbrella have been considered as a representation of what underpins the professional identity of Maltese occupational therapists. This could serve as an important indicator for the development of profession-specific discourse in education and how a focus on the more unique features of the profession and its professional terminology can be strategically exploited.

The more immediate and obvious benefits of the study are that the findings and discourses developed will contribute to pre-empt and afford the opportunity to strategically discuss identity concerns with students. By means of fostering a better understanding of professional identity, its ownership and acceptance, one could safeguard student retention in the short-term, while in the long-term protect against staff burnout.

Beyond the profession of occupational therapy, the study has potential resonance for other professions that experience identity issues. These would include professions with small work forces that are consistently failing to establish a consistent foothold within their practice milieu. Emerging professions that are not easily 'pigeon-holed' by summary or simplistic public abridgments, I feel would also have much to learn from the results and the theoretical constructions that were illustrated in this research around the public interface perspective dimension of professional identity.

#### **9.5 Final Consideration on the Study Design - Strengths & Alternative Methods**

The major and obvious strength of the study is that it has comprehensively researched a significant part of the practitioner population of occupational therapists in Malta. Selecting case study methodology, with the possibility of triangulating data across ten focus groups and the interview of key informants, was another strength. I feel that this methodology was especially suitable for studying the profession of occupational therapy in Malta, in its totality. The nominally reiterative process adopted for the data collection through focus groups, also allowed for a certain degree of verification and more in-depth probing and understanding of the areas that were being studied. The data produced was very rich and I feel that this has allowed me to construct a robust and comprehensive thematic analysis.

I have already very comprehensively articulated my concerns about being an insider in this research and will not restate these again, although this remains a major concern and could be construed as a limitation. Having conducted a study that draws from data sets across the practice sites, I am not in a position to ascribe the possible different states of professional identity construction related to specific sites.

In order to contemplate a study that compares the various sites, a different research methodology or paradigm would need to be adopted. I am not convinced nor comfortable with the assumption that identity can be a quantified construct, since it is very multifaceted and as I reported elsewhere, it is only a nominally defined concept. A good alternative to this study would be a reiterative qualitative study, akin to a grounded theory

approach, but conducted at a single site. A disadvantage of such an approach is that it starts with the preconception that one service site has or has even more issues of identity than another.

In various instances in the previous chapters, I have expressed my concerns and ambivalence with qualitative data analysis. This is perfectly captured in this quotation:

Abstraction and generalisation work together to divide a transcript into decontextualised units, to abstract general concepts from these units, to extract the content of these concepts, and to rewrite it in new terms. This is very strange! ... And finally we replace the interviewee's words with our own. (Packer, 2010, p.69)

Coding of data seems to be a way of applying formal objective language to the subjective and contextualised expressions of the research participants (Packer, 2010) and this leads to a degree of masking of voices. In the case of this study, this is mitigated somewhat in the way that the themes have been reported and the use of apposite and often extensive quotations. However, I have also felt ambivalence in the way that the results are interpreted in a separate discussion chapter.

An alternative to this could have been reporting and discussing the results in tandem, i.e. interpreting findings as these are being reported in the chapter of the results. I feel that such an approach leads to a fragmented report, where piecemeal explanations are offered at specific points with the relative literature citations offered to substantiate or echo the findings. I have tended to interpret the findings in central and overarching explanations, which I feel result in a more convincing, robust and coherent report. There is the disadvantage that not all the different thematic nuances are subjected to interpretation. But I don't believe that this is the ultimate or possible scope of qualitative research. I feel that research should seek to have value for the field, but has to be relatively manageable to handle and encompass. Inevitably, there is a degree of compromise in both of these approaches.

The results are interpreted very much in a profession-centric theory mindset. Given my preparation and immersion in my field, I think that this is perhaps inevitable. Identity (not necessarily professional identity) is a much debated and written about subject in the social sciences and psychology. Unfortunately, I do not feel I have the academic background, preparation and the required intellectual armatures to fluently handle arguments about identity from the aforementioned sciences. So, I had to rely on my modest 'medicine man' and healthcare educator's repertoire of tools.

## **9.6 Suggestions for Further Research**

I believe that a crucial research prompted by this study would be a longitudinal study involving newly qualified ex-undergraduate students starting out in the field. The study would purport to investigate how the perception of professional identity changes as the graduates undertake their first clinical rotation. Data collection could take place over the period of a year. The first data collection point would be conducted just after they qualify, followed by another after six months and a final one after a subsequent six months. This could contribute to our understanding of the influences on the development of professional identity as new practitioners go through the socialisation process in the field and the necessary props and supports that might be needed to ensure that professional development occurs constructively, contributing to professional well-being and workforce stability.

As I suggested earlier, another obvious candidate for research would be an in-depth reiterative study at one practice site. This could help to achieve theoretical saturation on practitioners' perception of their professional identity. Another possible research could be an action research type of study either looking into the possible adoption of a particular occupational-based model of practice or the adoption of professional language and terminology from occupational science. Although not original, similar studies have been conducted in the UK, such a study is essential in Malta and could study the challenges and lived experience of practitioners, as they face the challenge of integrating a professional language allied to the tenets of occupation.

## **9.7 Conclusion**

Practicing as an entry level occupational therapist and later as a senior practitioner managing a service, I have always asked questions on my professional identity and also sounded the views of my colleagues and co-workers on the subject. I confess that I felt fully fledged as a professional only when I finished my Master's degree. I ascribed this conviction on the internalisation of my new learning and scholarship, especially with being able to see myself as an occupational therapy professional using a system of knowledge as a sort of unique model of the profession.

As an educator, I did my best to impart this to others, mainly students, in order to help them reflect on reconciling the disparate complexities of their field. This was just part of the challenge of addressing the puzzle or solution of the issue of professional identity in occupational therapy. Through this research I was enlightened on another important dimension and this was the importance of public's - including other professionals and the clients served - perceptions of professional identity and the issues of fit/congruence or

dissonance between professional ethos and practice. This research has also been an opportunity for me to posit explanations about the manifestations and experience of professional identity issues in occupational therapy. I believe that reaching some of the objectives of this research has the potential to contribute to both educational training needs and some service sector issues.

Professional identity issues in occupational therapy are perhaps a state of fact and will remain a challenge integrating and reconciling. To my mind, this is a result of the vast diversity within the profession, which arguably stems from the very history of the profession with attendant paradigmatic transformations sustained from its advent in the beginning of the twentieth century and throughout that century. These transformations have left lingering epistemological traces that are the source of influence for practice and theoretical formulations in the field and through extension identity.

Through realising, coping, constructing and coming to terms with their complex mosaic identity, occupational therapists could continue to develop their resilience and be better promoters of their uniqueness and advocates for bettering the prospects and quality of life and participation of their clients. They should carry their values and professional convictions (Hanson, 2009) and learn to be comfortable in their skin. Their focus on occupation, their client-centredness and their attention to the specific ecology of their clients are their distinctive quality and they should not lose sight of this, notwithstanding any consideration of the particular practice environment they inhabit and the challenges that this might pose. Insights into their identity have a potential to prepare for these challenges.

The profession of occupational therapy in Malta is, in its own way, recognised, however much its practitioners might wish it to be recognised differently. The findings of this thesis can be taken as cautionary forewarnings about the significant need for the profession to demonstrate its uniqueness and the centrality of its contribution to healthcare.

Although change might be desirable to address issues of identity, it also should be cautious, reflexive and proceed with much foresight. With change, there is the possibility of the abandoning of the present intelligibility that has developed out of situated adaptation and over time, in favour of an imagined and new-fangled identity that might require a new set of trials and testing out.

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## Appendices

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- Appendix 1 Specimen Field Notes
- Appendix 2 Specimen Supervisor Debriefs
- Appendix 3 Approval from Malta Professional Lead Occupational Therapy Services
- Appendix 4 Approval by the Faculty and University Research Ethic Committee, University of Malta
- Appendix 5 Approval from School of Healthcare Studies, Cardiff University
- Appendix 6 Participant Information Sheet for Focus Group
- Appendix 7 Common Consent Form
- Appendix 8 First Set Focus Group Guide
- Appendix 9 Description of the Template Adopted for the Second Focus Group at the Acute Services
- Appendix 10 Example of the Template for Second Set of Focus Groups
- Appendix 11 Thematic Areas Explored in the Second Round Focus Groups
- Appendix 12 Specimen Interview Schedule
- Appendix 13 Parallel Event of Note

## Appendix 1 Specimen Field Notes

### Field Note Post Interview with a Key Informant - Interview with [ ] at [name of institution omitted]

[ ]\* asked to have questions in advance. I had to negotiate with her that this is not practiced in research. Reached a compromise after I had discussed the matter with Carly. We agreed that I would send her some of the discussion points in advance. I sent her the discussion points in the evening of the day before the interview.

Interview held at [name of institution omitted] at her office at 11.30 of 23 May 2016-05-24

The discussion/interview, in the main, flowed reasonably well with the replies being relatively more to the point and structured. This allowed me to drop back to the pick-up points from the interview guide.

[ ]\* had some very good points to make. Namely, she made it quite clear that the issue of overlap at [name of institution omitted] was not a big concern. That OT was respected and also consulted in this setting. Also OT could be counted to influence policy making even at ministerial level.

Issue of linking the multiple images of practice in OT to vocation and that this could be a threat to professional identity or a source of conflict, not confirmed by [ ]\* (again, as in [name of institution omitted] by [ ]\*). The common thread in practice of OT is helping the client and this was considered to be common to all sites and at the base of traits for vocation.

Issue of “cannot be seen as they see themselves” was grasped but [ ]\* and I believe that she gave a very powerful articulation about this phenomenon. See *interview*

INSERTIONS: I have elected to broach the subject of cultural issue in Malta and OT; crudely put, if OT faces challenges to be understood in the Maltese culture. This was in the updated sketch of the interview guide for [name of institution omitted], which I never managed to print, but could recall from memory. Used schedule for [name of institution omitted].

MISSED OPPORTUNITIES: To discuss the issue of crafts since it is such a concern at [name of institution omitted]. I managed to do this with recorder off so cannot transcribe it. Again, [ ]\* gave a very articulate reply. Her view is that OTs prescribe a craft activity based on rationale but it's not their job to be involved in the regular implementation of it. It was up to the support staff to do this. She narrated an anecdote about a member of staff going to the short stay ward for substance abuse clients where she felt she had to make a clarification with the staff member involved on the proper use of crafts. It would have been wonderful to have this on record ... alas.

24 May 2016

\* Note: [ ] Name of participant has been omitted.

Field Notes After the Focus Group at [name of institution omitted] of 22<sup>nd</sup> October 2014

Participants: Six therapists had indicated that they would participate, group was conducted with five participants, [.]\* reported in sick. The Group was held at the day centre board room starting at 11.30 AM

The first part of the discussion was centred around the misperceptions of public and staff about the professional identity of occupational therapy. Main offenders appeared to be the nurses; OTs felt to create unnecessary work for them with patients and after minimal contact left the ward to be run by the overworked nurses. Some staff members seemed to have some idea of what OT meant e.g. physios.

Association with crafts mentioned – is this specific to OT? Is it because it is a residential institution?

Participants were queried about whether their identity was manifested since they are being so evidently misunderstood.

Evidence of a conflict between the ethos of OT and the culture of the residence from the participants' utterances.

This first part was mainly about the public perception of the occupational therapy profession. The ISSUE OF A MALTESE CULTURAL CLASH WITH THE ETHOS OF OCCUPATIONAL THERAPY – YOU HAVE TO ADDRESS THIS FACTOR.

The discussion was then moved to manifestation of professional identity. The Participants felt that they adequately manifested professional identity. Issue that they are confused with PTs was again in evidence.

Taking a cue from the definitions which I had given them, I attempted to investigate the internalised image of their professional identity, how they explain themselves to others etc. From this point I also made an attempt to tease out the unique qualities of occupational therapy; the participants came up with things like the activity base of OT intervention, being holistic, concerned with functional performance, being concerned with cognitive abilities. THE ISSUE OF OCCUPATION WAS AGAIN NOT CITED.

The issue of proper referrals was then addressed. The participants felt that they do get proper referrals being sent to them.

Overall Comments: This was a rather good group which did manifest some of the tensions and frustrations which had been identified by the group at [name of institution omitted]. Some of the distinguishing features were the issue raised about the site being looked down upon by other OT in other settings, the importance of mentorship of staff, the importance of OT staff at the residence adopting a mindset which helps them adapt to the setting.

## Appendix 2 Specimen Supervisor Debriefs

University of Malta Mail - Debriefing after My First Focu... <https://mail.google.com/mail/u/0?ik=28ea3b2ac4&view...>

 L-Università ta' Malta Rene Mifsud <rene.mifsud@um.edu.mt>

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**Debriefing after My First Focus Group**

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Re: e Mifsud <rene.mifsud@um.edu.mt> 28 February 2014 at 13:27  
To:   
Cc: Rene Mifsud <rene.mifsud@um.edu.mt>

Dear Gail and Carly,

I am writing to share with you some thoughts and reflections which have beset me (rather unfortunate use of words) after my first data collection outing. I conducted the first focus group with the staff of the acute setting – is quite familiar with this site and may immediately grasp the import of the finding as we shall see later – last Wednesday 26<sup>th</sup> February. I feel that I have managed to generate a considerable amount of data.

I have used the tool and guidelines attached herewith; the former is, in the main, a slight development of the originally submitted version, but the simple guidelines and ground rules were devised as a sort of personal *aide-memoir*. Under the influence of my recent reading around focus group method, I have elected to introduce a little focus exercise with my participants in the form of brief reflection on the definition of professional identity and professionalisation provided at the beginning of the group (also attached herewith). Also, instead of starting with main inquiry areas (linked to me research objectives), I opted to go for generic discussion openers with a view to later focusing on the main areas of my research, as the discussion ensued.

My present impressions of the discussion which developed from the focus exercise and my posing of the topic openers are the considerably different take that the participants have on the issue of professional identity. They seem to ascribe identity to the way the public identifies or recognises them. This seems congruent with the second concept in my definition (“... a collective public identity”). But no matter how much I tried, I just could not extract their impressions on the “... perspective that binds members of a profession together ...”. This has been very central to my thinking throughout the development of my study and not to be able to elicit it has been a source of consternation and, in a way, disappointment. It also turns my perspectives topsy-turvy. I have not attempted to analyse so this impression could change with further familiarisation with the data. It could be characteristic of this cohort as could also be characteristic the issue of identity erosion which they seem to be sustaining.

My dilemma is whether to change my strategy when it comes to the next cohort, by going back to a more patently structured approach in the tool, or else continue with the current one just outlined. I also suspect that I may have sidetracked or influenced the participants' views by

1 of 2 06/01/2021, 13:04

presenting them with the definitions in the focus exercise. A change to the more structured approach is an attempt to regain my bearings; I think you can discern that ... but would this change of approach be legitimate? Should I just continue with what I have started? Please note that I plan to conduct another group with this cohort after I have transcribed and analysed the group under discussion. These are some of my thoughts after the fascinating but messy business of the first focus group.

I would be very glad to hear your feedback (and misgivings) on these impressions and apologise for my use of generalisations. Perhaps a video or Skype session would be in order at your convenience.

I thank you in anticipation.

Best regards,

René

*René Mifsud*

*Head, Department of Occupational Therapy*

*Faculty of Health Sciences*

*University of Malta*

Detailed Reflexive Supervisor Debriefing  
Plans for the Follow-Up Group at the Acute Hospital  
René Mifsud October 2014

I have found planning for the follow-up group at the acute hospital a bit of challenge because the first interview has consistently given me the impression that it is very comprehensive and anything else to be added or further investigation therein would seem like a foregone conclusion. But now that I have been through my preliminary analytic cycle, I think that I have developed enough insights to allow me to undertake the second group with some confidence. Notwithstanding I am still assailed by some nagging doubts that the affair will be a rather forced, unnatural and a bit obvious.

At this point my plan is to enact a second group which will be based around a tripartite inquiry. In the first part I will be reviewing some of the findings that I have derived from the first focus group; the second will try to explore professionalisation issues, which I feel were not addressed specifically in the first group; the last part will return to the issue of identity but anchoring it around the concept of occupation. I still have to develop more specific discussion triggers for these three aspects, but I am here recording some of my preliminary thoughts on the matter.

- 1) The discussion of the analysis points will have to touch upon some issues (rather painful ones) that there are evident tensions surrounding identity that the staff at the acute hospital seem to experience, especially their apparent inferiority complex with respect to physiotherapy. The fact that they seem to know what their professional identity is but seem not to portray it in public will also feature. They are not demonstrating a recognisable demarcation from the physiotherapy profession and “have to fight”. These are some of the main points that I plan to tackle in this part of the focus group.
- 2) The discussion of professionalisation will focus upon the issue of knowledge concerns specific to occupational therapy. I am rather unsure about this and feel that it can be an overtly tentative discussion. Addressing questions such as: “Do you think you have a particular area of practice which you think you only can provide?; “Can you say that you have specific practice knowledge which you can call your own and which is this?”; “Is it possible for you to identify a client population which depends specifically on your service?”, I feel can sound just a bit unsubtle at best, at worst rather trite. As a preamble for this I can look up some central concepts from professionalisation and present them to the participants.
- 3) The concluding part of the group will be the discussion around the construct of occupation. My plan is to attempt to prompt the participants into a discussion around a broad definition of occupational therapy leading to issues relating to occupation: “Occupational Therapy is concerned with enabling individuals to participate in required and desired occupations”; “Occupations are all activities that are identified, recognised and named within any given culture, and are the means of interaction with the environment, with others as well as permitting individual agency;” “The exclusive domain of OT is occupation and it should be researched, refined, systematised so that it becomes evident, definable, defensible and saleable. Kept as our focus and direction, the impact of occupation upon human beings will be the latent power of the profession”. Stimulating discussion around these issues feels more like therapy for therapists or continuing education: it is an attempt elucidate some milestones along the path to identity. I don’t want to sound patronising, because after all

the issues that they are experiencing, I have also experienced and I also have some indication about the “aetiology” of this condition.

These are my thoughts about a strategy of getting the data collection onto the next level. I am not completely convinced that this is the means to progress in a way which is perfectly natural and inspired, and I find it a bit contrived and deliberate. But perhaps this is part of the research process. I am obviously open to your suggestions and guidance.

I thank you in anticipation.

René

### Appendix 3 Approval from Malta Professional Lead Occupational Therapy Services

**Rene Mifsud**

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**From:** \_\_\_\_\_  
**Sent:** 08 April 2013 22:51  
**To:** Rene' Mifsud  
**Cc:** \_\_\_\_\_  
**Subject:** RE: Access to Potential Participants for Doctoral Study with Cardiff University

Dear Rene

Thank you for your email requesting approval to carry out this doctoral study with the OT practitioners and management. I feel that this would be very important research that will provide useful information and reflection within the profession and therefore I find no objection to your request.

I look forward to hearing from you.

Kind regards,

*Advanced Allied Health Care Practitioner  
Manager Occupational Therapy Services Malta*

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**From:** Rene' Mifsud [mailto:[rene.mifsud@um.edu.mt](mailto:rene.mifsud@um.edu.mt)]  
**Sent:** Mon 08/04/2013 8:21 PM  
**To:** \_\_\_\_\_  
**Cc:** Rene Mifsud  
**Subject:** Access to Potential Participants for Doctoral Study with Cardiff University

Dear \_\_\_\_\_

I refer to a conversation we had some time ago regarding the feasibility of conducting my doctoral study with staff in some of the major occupational therapy public service sites. I briefly remind you that the aim of the study will be to is to gain a comprehensive picture of professional identity within occupational therapy in Malta and how far this profession has progressed in its professionalisation agenda. I will be looking at how occupational therapy practitioners articulate their professional identity and how much the profession has been an agent in creating an influential role in practice. This will be a qualitative case study in which I intend to access various sources of information to shed light on the issue of the occupational therapy profession in Malta.

Please note that data collection will include two focus groups which I intend to conduct at each of five OT services including acute setting, rehabilitation, paediatrics, mental health and long term care. For practical purposes I have limited myself to the major services. It would be difficult to set up other focus groups at the smaller facilities. I am convinced that what I am proposing would be as-nearly-as-possible a comprehensive picture of occupational therapy in Malta. Apart from the focus groups, I also intend to conduct interviews with staff in leadership positions in occupational therapy such as heads of department and your good self as manger of occupational therapy services. This will contribute to give a perspective on the case which contrasts with the front-line, service delivery views furnished by the practitioners. This will enhance the quality of the research by generating alternative explanations for the purpose of triangulation.

I strongly feel that this research project will contribute to our profession's self-knowledge and could point out the necessary educational and professional props which need to be instituted in order to facilitate our professional consolidation.

I would be greatly indebted if you could consider this request at your convenience and let me know if you think it would be possible for me access staff and set up my research strategy. This would be the preliminary, informal approval before I progress with my ethics proposal to Cardiff University and subsequently the University of Malta, and the eventual formal approval for the study. I would be very glad to clarify the issue further if you think you need more information in this regard.

I thank you for you time and attention.

Best regards,

René

René Mifsud  
Head  
Department of Occupational Therapy  
Faculty of Health Sciences  
University of Malta

**Appendix 4 Approval by the Faculty and University Research Ethic Committee, University of Malta**

*To be completed by Faculty Research Ethics Committee*

We have examined the above proposal and advise

**Acceptance**                      **Refusal**                      **Conditional acceptance**

For the following reason/s:

Signature  Date 6/8/2013

*To be completed by University Research Ethics Committee*

We have examined the above proposal and grant

**Acceptance**                      **Refusal**                      **Conditional acceptance**

For the following reason/s:

Signature  Date 6/9/13

**Appendix 5 Approval from School of Healthcare Studies, Cardiff University**

Rene Mifsud

29<sup>th</sup> May 2013

Dear Mr Mifsud

**An exploration of the nature of professional identity and professionalisation within occupational therapy in Malta.**

At its meeting of 22<sup>nd</sup> May 2013 the School's Research Ethics Committee considered your research proposal. The decision of the Committee is:

**Pass - Proceed with Research**

Please note that if there are any major amendments to the project you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Mrs  
Research & Commercial Engagement Manager  
School of Healthcare Studies

Cc: Supervisor – |

## Appendix 6 Participant Information Sheet for Focus Group

### Participant Information Sheet-Focus Group *(Email attachment)*

#### Research project entitled:

#### **An exploration of the nature of professional identity and professionalisation within occupational therapy in Malta.**

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to discuss any issues you may have with the researcher René Mifsud.

#### *What is the aim of the study?*

The aim of this research is to gain a comprehensive picture of professional identity within occupational therapy in Malta and how far this profession has progressed in its professionalisation agenda. I will be looking at how occupational therapy practitioners articulate their professional identity and how much the profession has been an agent in creating an influential role in practice. This will be a qualitative case study in which I will be accessing various sources of information to shed light on the issue of the occupational therapy profession in Malta.

#### *Why have I been chosen?*

You have been chosen because you are a valued representative of your profession, with years of experience in the field. I am sure that you will have a wealth of thoughts, perspectives and information to convey about occupational therapy.

#### *Do I have to take part?*

It is entirely up to you to decide whether to take part or not. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without any consequences.

#### *What will happen if I take part?*

You will be asked to participate in two focus groups together with other members of staff from your department. The second focus group will take place approximately a month after the first and will be based on findings generated by the analysis of the initial group.

During the second encounter we will have the opportunity to focus our discussion in more depth on issues that may have emerged from the first group.

Please note that in order to ensure that I have an accurate and comprehensive record of these groups, I will be using audio recording equipment. Subsequently the recordings would be transcribed and I will later conduct an analysis. You will be provided with a copy of the transcript and I will also be able to share my analysis with you.

#### *Confidentiality*

When reporting my data I may have to quote some of your comments from the focus groups in direct speech. Rest assured that you would not be mentioned as I will be making use of pseudonyms throughout my reports and necessary measures will be in place to ensure that your identity is not disclosed or linked to the focus groups and this research. The recordings and transcripts will be pass-word protected and any hard copies kept in a locked cabinet at the university. These will eventually be destroyed 10 years after the completion of this project.

#### *Contact for further information*

If you have any problems or wish to raise any questions about this research, please feel free to contact me:

René Mifsud [*contact details included*]

or my supervisor:

Dr Gail Boniface [*contact details included*]

Thank you very much for considering taking part in this study, which has been approved by the School of Healthcare Studies Research and Ethics Committee, Cardiff University in 22.05 2013 and the Faculty of Health Sciences REC (Malta) and the University of Malta REC

A copy of the signed consent form will be provided for you to keep.

## Appendix 7 Common Consent Form

### CONSENT FORM

Title of study: *An exploration of the nature of professional identity and professionalisation within occupational therapy in Malta.*

Participant's name \_\_\_\_\_

**Please initial  
each box**

I confirm that I have read and understood the information sheet for the above study.	
I have had the opportunity to ask questions about the study and receive answers.	
I agree to take part in an interview for this study.	
I agree for this interview to be audio-recorded.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.	
I understand that all information about me will be kept confidential.	
I understand that information which I provide in this study may be used in publications and conference presentations.	
I understand that the study write up may need to include comments I make in interviews or focus groups. I agree to those being used, providing my name is not associated with them.	
<p>Signature of participant ..... Date .....</p> <p>I have explained the study procedure in detail:</p> <p>Rene Mifsud ..... Signature..... Date.....  <i>Researcher [contact details included]</i></p> <p>Dr Gail Boniface..... Signature..... Date.....  <i>Supervisor [contact details included]</i></p> <p>When completed, 1 for participant, 1 for researcher</p>	

## Appendix 8 First Set Focus Group Guide

### **Focus Group Guide - [Topic Openers]**

*I would like you to talk about your experience of professional identity as occupational therapists.*

*What immediately comes to mind when you think of your professional identity as occupational therapists? Does anything come to mind when you think about the / your professional identity as occupational therapists?*

**How do you (articulate) express your professional identity as occupational therapists? [IDENTITY ARTICULATION]**

How do you define/explain yourselves as occupational therapists?

How do you define occupational therapy?

How do you explain your professional role?

How do you describe yourselves as professionals?

Do you find it challenging explaining what you do?

Do you feel completely realised as a professional?

**What factors do you feel have contributed to the development of your professional identity? [IDENTITY DEVELOPMENT]**

Was it your experience in the university course programme that mainly developed your identity or was it exposure to the practice sites?

Do you attribute your professional identity to your skills or your knowledge?

**How is your professional identity unique/specific/distinct? [IDENTITY UNIQUENESS]**

What do you think makes it unique? In what way is it unique or specific?

Do you think you provide a unique service?

Do you think that other professionals perceive you as unique?

Do you think that the public perceives you as unique?  
Are you sought out to provide a specific or unique service?

Do you feel that you are providing a unique service to the parties that you serve?

Do you think you have unique knowledge and skills which you can bring to bear on clinical or health issues?

Can you mention examples of such knowledge or skills?

**How do you see the status of the occupational therapy profession in Malta?  
[PROFESSIONALISATION ... STATUS]**

Is it sufficiently well recognised?

Does it exercise noticeable influence in the health care arena/field?

Can you say that you have client populations served by you specifically, and whose welfare or wellbeing depends specifically on your intervention?

Can you mention examples of such populations and or interventions?

Would you say that you have a monopoly of professional services in this particular sector (or any particular sector)?

Where would such a monopoly be?

Do you feel that the profession is consolidated or consolidating itself - i.e. it has established a stable and recognised niche (an area of practice) - in the area of service?

**--INDICATE IMPENDING CONCLUSION--**

Do you think you are respected as professionals?

Do you think there are any threats to the status of occupational therapy?

What factors do you think would contribute to strengthen occupational therapy and facilitate its further development?

## Appendix 9 Description of the Template Adopted for the Second Focus Group at the Acute Services

### Description

1. *The discussion of the salient basic themes from the analysis* included the issue of the evident tensions surrounding identity that the staff at the acute hospital seem to experience, especially their apparent 'inferiority complex' in relation to physiotherapy; the fact that they seem to know what their professional identity is but not appear to portray it in or to the public; an apparent failure to demonstrate a recognisable demarcation from the physiotherapy profession and a 'fight' for professional territory. This part of the template was different for each setting as it was based on what emerged from the analysis that was unique for each setting. The themes discussed in the follow-up focus groups of each service site will be briefly overviewed in an ensuing section.

2. *The discussion of professionalisation* focused upon the issue of knowledge concerns specific to occupational therapy. The discussion was introduced by the following statement: "A profession is considered to have certain traits and these include being autonomous; being accountable for its actions; it provides a service which is needed by society; it has a code of ethics; it has its own body of knowledge. I think we can recognise these qualities in occupational therapy: we are quite autonomous – all we need is a referral; we are accountable for our actions – we document our treatment and can be audited; we are needed by society - we are recognised as one of the foremost rehabilitation professions; we have a code of ethics. We also have a body of knowledge. I would like to know your views on the final detail, our body of knowledge..." I used this approach for only three of the groups noticing that it was not proving especially productive in generating discussion. From that point on, I opted to use a rather more open approach in the form of the question: "What do you see a professional as being?" and "How do you see yourselves as professionals?"

3. *The concluding part* of the group moved the discussion to the issue of professional identity. The participants were prompted into a dialogue around a broad definition of occupational therapy leading to issues relating to occupation.

This was undertaken by presenting the participants with three statements as follows:

- “Occupational Therapy is concerned with enabling individuals to participate in required and desired occupations;”
- 
- “Occupations are all activities that are identified, recognised and named within any given culture, and are the means of interaction with the environment, with others as well as permitting individual agency;”
- 
- “The exclusive domain of OT is occupation and it should be researched, refined, systematised so that it becomes evident, definable, defensible and saleable. Kept as our focus and direction, the impact of occupation upon human beings will be the latent power of the profession.”

This approach was intended to gauge how much the rhetoric around emancipating the professional identity of occupational therapy around the concept of occupation, rings true or has some cultural resonance in the Maltese professional milieu.

## Appendix 10 Example of the Template for Second Set of Focus Groups

### Template

#### [Notes for the Introduction]

*As you might remember the focus group was based around two original discussion triggers in the form of definitions, one was professional identity:*

*Professional identity can be defined as the perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity.*

*And another on professionalisation:*

*Professionalisation is the process which an occupational group undertakes to consolidate its status in society and becomes recognised as a member of the established range of socially identified professions.*

*During the group there seemed to be two conceptual aspects concerning professional identity which were dominating the discussion: certainly the public's and other professions' perception of your professional identity and occasionally glimpses of your "internalised" identity.*

*1) The impression that I got from the focus group - especially immediately after, but slightly less so on analysis – was evidence of tension surrounding the issue of professional identity which you experience and a comparison with physiotherapy. You seem to be measuring yourselves – perhaps your professional worth? - Against physiotherapy.*

*I think we may also have to make a distinction between tensions arising from purely professional identity issues and those that are due to working conditions such as staffing levels (understaffing). Some quotations to illustrate this ...*

*P27: Unfortunately, here at wards level our professional identity, at least in certain wards and with certain professional people, especially with the medical doctors ... our professional identity is almost no[n] existent pg 6.*

*P21: And maybe that even affects the perception of outsiders, be it members of the multi-disciplinary team, be it patients or relatives. Because if they, for some reason, they know that there is a weak link, they will just consider occupational therapy as being inferior to other professions.*

*But if the person, for some reason, hesitates or there is maybe a lack of self-esteem etc. {then what one thinks that occupational therapy is,} for example, they might just think that the occupational therapist is there to dress up people. It is a misconception, but that is what they think or she is just there to do the bathings without considering all the various components that the OT might be assessing.pg4*

*P13 Where does our profession stand in respect to other professions? For example, professions who started before occupational therapy Pg 2 - instances where our work might seem to overlap or to, I mean, to resemble that of other professions*

*Anyway, I think about eighteen if not eighteen I mean, then something like that so if you had to compare numbers, they would outweigh us I mean, by far. It is like we are fighting a battle.*

- *Would you care to explain your feelings about these quotations? Is it as bad as “fighting a battle”? Why should we fight a battle with a profession which is different from us? Are we competing with a profession? Is the problem just down to number?*

2) You seemed to be very dependent on the public’s perception of you.

*P5 In my opinion, what makes our professional identity is what the lay person knows and thinks of occupational therapy as a profession.*

- *So is professional identity determined by the public? Don’t we have an internalised professional identity? Do we have to care (all the time) what the public thinks?*

3) You seem to be misunderstood by clients even after explaining yourselves:

Pg. 5 and 6 P21/P13

- *Do you think there is a sort of cultural issue with OT in this setting?*

4) Another point was made about how we may be perceived as very similar to the physiotherapists:

*P7: you can be seen, from my point of view, you tend to be seen as a sort of or pseudo physiotherapist or a hand therapist or for pg 5*

*When people ask me, “What is occupational therapy and what is the difference between occupational therapy and physiotherapy?” I just say some simple two words. They do not define what occupational therapy is and I might be a bit patriotic, I just say in Maltese, “Ahna ahjar minnhom” pg 15*

Do you have any views on this? Do you think that we may be perceived as pseudo physiotherapists? Do you perceive a risk for you being too similar to physiotherapists? Perhaps having expertise in this area (hand rehabilitation) makes your role consolidated and secure?

5) Another perspective about tensions on identity was portrayed as follows:

*P12: I think that this problem has come, has been coming for so long. Because we always ... sort of, we were always been in favour of the biomechanical approach. And it made us look similar to the physiotherapists in such a way that we nowadays cannot define ourselves in a different way. Pg 3 - Somehow, we seem to want to be like physiotherapists.pg 3*

- What are your views on this point? Do feel that there is too much adherence to the biomechanical frame of reference? (Do we want to be like physios?) Does this give us more credibility?
- Is there an alternative to the biomechanical approach? A focus on ADLs is an alternative, but does it do justice to the profession?

6) Questions About Defining Selves/Defining Occupational Therapy, we acknowledged that it is a challenge to define ourselves, which is natural for OTs, but ... :

*P32: No I don't. Basically, I define myself on the type of clients, on the types of conditions that I see every day but I don't define myself as an occupational therapist.pg 18*

*P5: Nowadays, what I feel, nowadays what I feel safer doing and I feel more confident doing is explaining what I am doing now as an occupational therapist. So what I say is I work with rheumatology clients, people who have arthritis, pg16*

- Can you please explain how you define yourselves according to the clients that you see? Does anyone else define herself in this fashion?
- Why don't you define yourselves as occupational therapists, since that's what you are? Is it because it's easier?
- Would this way of defining yourselves risk reinforcing misunderstandings about your role and your professional identity? Couldn't you be mistaken for someone else?

7) Some of you have expressed their difficulty about what seems like enacting professional identity in this setting:

*P12: Sometimes it happens that you have your own professional identity but it does not correspond to what you are actually doing now. Pg 27*

*You know what you want to do or what you should be doing but you are not doing it now because you cannot to do. Pg 27*

*P7: Also, because the philosophy of the hospital just does not want to implement that, it does not require that, so you are fine, you are doing medically fine so you can go home. Pg 27*

*P13: You can't go hand in hand with the philosophy of occupational therapy if your first aim is fast turnover and discharge, I mean, a fast discharge policy no matter what. That is not client-centred.*

*pg 9*

*P13: It is like playing football in a basketball pitch. Pg 27*

- I think this is a key point and would be very thankful if you could elaborate on it please

8) You claim to have a clear understanding of what the identity of occupational therapy is, therefore you have a good internalised identity, but others are not seeing this within this setting.

*P7: Thank you, so yes, I like this definition, this first part of the definition, I totally agree with that, jififieri [in other words] "professional identity can be defined as the perspective that binds members of a profession together." I believe that, that exists in occupational therapy in our profession and at Mater Dei, yes, we know what occupational therapy is, we know what our role is and I believe we are very much proud of is.*

*But, as much as we are unable to, sort of, come out, there is that amount of frustration because we cannot be seen as we see ourselves. Pg 15*

- To what extent do you think you fulfil this/your role professional identity in this setting?
- To what extent do you manifest it, this quality, your internalised professional identity to others, so that others can understand and appreciate you?
- Do you demarcate yourselves sufficiently from other professions?

9) Apparently not understood, but still get referrals:

*P7: Yes, yes but then interestingly we are getting a lot more referrals than we used to have. So some kind of acknowledgement ... pg 20*

- Can you please explain how you say that you are misunderstood and yet get referrals? Is this a sign of improving recognition and/but more is work required?

10) Work abroad has helped some of you to develop your professional identity:

*P38: In my experience as an OT since I graduated, I found that my work experience abroad has actually helped me form my professional identity.... But my work experience abroad has helped me quite a lot to discover my professional identity. Pg 26*

- I would be grateful if you could explain (to the group) how work abroad has helped you to develop your professional identity? Does anyone else share this view?
- Did you see your professional identity enacted in a different way than it was being enacted in Malta?

11) Apparent Tension with Internalised Professional Identity:

*P32: I think that is what I believe that we have a lot and a lot of good qualities as OTs but we cannot come up with a real role or a uniqueness of our profession. Pg 20.*

*But my personal belief is that, no, I find it difficult to pinpoint out just one thing which I can say ... Pg 20.*

- Some of you, perhaps not all, seem to find difficulty finding uniqueness in their profession.
- Does everyone agree with this position or view?
- Is this notion shared by anyone else here?
- But OT as we know is a unique profession, so how are we expressing this view?

---

12) A profession is considered to have certain traits and these include being autonomous; being accountable for its actions; it provides a service which is needed by society; it has a code of ethics; it has its own body of knowledge. I think we can recognise these qualities in occupational therapy: we are quite autonomous – all we need is a referral; we are accountable for our actions – we document our treatment and can be audited; we are needed by society - we are recognised as one of the foremost rehabilitation professions; we have a code of ethics. We also have a body of knowledge.

- I would like to know your views on the final detail, our body of knowledge...

---

13) Now I would like to wind down the focus group by asking you to consider these statements:

*“Occupational Therapy is concerned with enabling individuals to participate in required and desired occupations”*

*“Occupations are activities identified, recognised, named and valued within a given culture, and are the means of interaction with the environment, with others as well as permitting individual agency”*

*“The exclusive domain of occupational therapy is occupation and it should be researched, refined, systematised so that it becomes evident, definable, defensible and saleable. Kept as our focus and direction, the impact of occupation upon human beings will be the latent power of the profession”.*

- What is your opinion about these?
- Do you think these have relevance?
- Do you think that these have relevance in this setting, at Mater Dei Hospital?
- Can you use these to portray yourselves at Mater Dei?
- Do you think these are the best way to portray the uniqueness of occupational therapy? If so why can't we use them or subscribe to them?

14) What factors do you think would contribute to strengthen occupational therapy and facilitate its further development?

[Note: No salient comments]

## Appendix 11 Thematic Areas Explored in the Second Round Focus Groups

### Second Round Focus Groups:

- Themes explored in the Mental Health service follow up group: Occupational therapy as a vocation; knowing one's professional role; describing yourself to other parties or explaining yourself as an occupational therapist; the unique qualities of occupational therapy; occupational therapy clinical reasoning not appreciated by other professionals; association with crafts; occupational therapy recognised in other countries less so in Malta.
- Themes explored at the Rehabilitation Service: Challenges in defining occupational therapy due to variability across different settings; lack of respect for boundaries by other professionals; 'battle' or conflict with the physiotherapy profession; occupational therapy recognised in other countries less so in Malta; the unique qualities of occupational therapy; need to demonstrate uniqueness through use of specific professional knowledge; improvement in activities of daily living not a priority for clients, attributed to natural recovery rather than occupational therapy input; being independent not always a priority for the Maltese, but not so for the British clients.
- Themes explored at the Residential Service: The public's perception of occupational therapy; the ethos of occupational therapy going against the institutional setting expectations; other professionals seem to misunderstand what occupational therapy is; professional identity resilience; the issue of the use of crafts; the unique quality of occupational therapy; specific populations benefitting from occupational therapy.
- Themes explored at the Paediatric Service: Professional identity gives you status; the unique quality of occupational therapy; site-specific explanation or definition of occupational therapy; overlap with other professions; possibility of role release in relation to the early intervention teacher; issue of lack of teamwork; human resources at the service.

## Appendix 12 Specimen Interview Schedule

### Interview Schedule

#### Introduction

In this interview I would like to discuss the issue of professional identity in occupational therapy. I will be setting the tone of the discussion by looking at some of the definitions of professional identity.

***Professional identity has been defined as a perspective that binds members of a profession together and gives them a sense of themselves and a collective public identity (Kielhofner, 2004).***

If we look at this definition we can see that professional identity is a quality that gives a sense of identity to the individual members of the profession – perhaps an internalised professional identity. But it also identifies them as members of a profession, as a collective, a group to the public.

- What are your views on the professional identity of occupational therapy?
- How do you define occupational therapy or describe yourself as an occupational therapist?
- This definition also refers to a perspective that binds members of a profession. What do you think is the perspective that binds occupational therapists?
- Is this a perspective that is shared by occupational therapists across the different specialities? (Why isn't it shared by all occupational therapists?)

~~~~~

I would now like you to reflect on another definition of professional identity:

***Professional identity is defined as one's professional self-concept based on attributes, beliefs, values, motives, and experiences (Ibarra, 1999; Schein, 1978).***

- This definition is centred on the idea of self-concept. What are your thoughts on occupational therapists' sense of professional self-concept?
- Can you look back on your work with clients in the field and think/talk about of the values, beliefs and attributes that have accompanied your practice as an occupational therapist?

- Can you think of an episode or episodes where you feel you functioned as an occupational therapist?

~~~~~  
*Now it has been said that the existence of a particular profession is based on the fact that society recognises its ability to provide a unique solution to a number of fundamental social problems.*

- What do you think are the unique solutions that occupational therapy can provide?
- What is the unique quality of occupational therapy?
- What is the perspective of other professionals on the unique quality or service of occupational therapy? (Do they appreciate it? Why don't they appreciate it?)
- What is the view of the clients on the unique qualities of occupational therapy? (Do they appreciate it? Do they understand it? Why don't they appreciate it?)
- Do you think that OT is sufficiently well recognized as a profession?
- Does it exercise noticeable influence in the health care arena?
- Can you say that there are client populations served by occupational therapists, and whose welfare or wellbeing depends specifically on OTs?

~~~~~  
Closely related to the issue of professional identity, I would now like to discuss the nature of being a professional.

- What do you see a professional as being? (What do you see being a professional as?) OR What does being a professional consist of?
- How do you see yourself as a professional?
- (What are the factors which make you a professional?)

~~~~~  
Prior to this interview I conducted a series of focus groups with occupational therapy practitioners and I thought that some of the themes that had emerged from these groups could be worth discussing here.

*A number of group participants have mentioned that occupational therapy is a vocation. I think that this implies that an individual needs to have the right personal qualities or certain particular inclinations to become an occupational therapist.*

- What is your view on this perspective? Can you mention some of these personal qualities?
- I feel that occupational therapy transmits a lot of images of practice across its many services settings. Is there a risk for a beginner or a student to get attached to just one aspect of the profession?
- Do you think that this can be a threat or a source of professional identity conflict in occupational therapy, since it may not ensure a commitment to the profession across different practice areas?
- How can this situation be improved?

*Some of the participants in the groups have mentioned that although they feel like occupational therapists, I assume they mean to say they have an “internalised” professional identity, “but they cannot be seen as they see themselves.” It’s as if they are not understood.*

- Do you have any views on this particular phenomenon? [Are these practitioners actually demonstrating their particular qualities as occupational therapists? How can they “implement” or demonstrate their identity?]

*Some occupational therapists have suggested that there might be a cultural issue with OT in Malta.*

- Do occupational therapists have a problem with being understood in Malta? (Why is this the case?)
- (Is there a cultural issue for OT in Malta? Why is this?)
- (How can it be overcome?)

*Some clinicians have mentioned their “upsets” with the physiotherapy profession. They have talked about overlap and have used words like “it’s like fighting a battle” to describe their relationship with PT.*

- Why do you think is there this apparent conflict?
- What solutions can you think of to improve this situation?
- Can you think of risks that such a situation of overlap in certain settings can bring to the occupational therapy profession?

*When discussing the way that OT identity is challenged some OTs made reference to the lack of respect for professional boundaries and the fact that some team members were saying things that OTs should be saying at, e.g. ward rounds.*

- Why does it seem easy for team members to talk about what we do?
- Is it just because there is no respect for boundaries?
- Does this happen only with PTs?
- Is our language easily adopted or appropriated/taken over by other professionals?
- Do you think that ADLs are the exclusive domain of OT?
- Do you see a way of overcoming this lack of respect for boundaries?

We are now reaching the conclusion of this interview and I would like to hear your views on the following statements on occupational therapy:

*“Occupational Therapy is concerned with enabling individuals to participate in required and desired occupations”*

*“Occupations are activities identified, recognised, named and valued within a given culture, and are the means of interaction with the environment, with others as well as permitting individual agency”*

*“The exclusive domain of occupational therapy is occupation and it should be researched, refined, systematised so that it becomes evident, definable, defensible and saleable. Kept as our focus and direction, the impact of occupation upon human beings will be the latent power of the profession”.*

- What is your opinion on the significance of these statements as an underpinning philosophy of occupational therapy in Malta? Do you think these can be realistically used in Malta? Do you think that these have resonance with our culture? Do they have the “right ring” to them? Would occupational therapists be in a position to put them into practice?

And now to finally conclude:

- Do you have any more views on this topic? Are there any factors or issues you can think about that would contribute to strengthen occupational therapy and facilitate its further development?

## Appendix 13 Parallel Event of Note

### Description:

Almost about the time of the start of the study the management of the occupational therapy profession in Malta undertook the commitment to adopt a model of practice that could be used across all the various practice sites. At first, this process started on a small scale with the setting up of a steering committee with representatives from the services and meetings with an academic consultant from the United Kingdom. Gradually, and on a regular basis, lectures and workshops started to be organised for staff to introduce them to the tenets of the Canadian Model of Occupational Performance (CMOP), which was accepted as the model of practice which would be adopted by the services. This served to introduce some of the 'old guard' clinicians to the most up-to-date conceptual knowledge in occupational therapy and refresh the sizable population of graduate staff with knowledge which had, thus far, perhaps remained as simply academic rhetoric which they had learnt in their B.Sc programme and later in their Master's degrees, but never actually conceived of applying in practice.

This initiative had a sort of culmination around the autumn of 2015, when one of the principal authors of the CMOP and a considerable authority from the forefront of the profession was invited to hold an intensive set of workshops in Malta to train staff, in collaboration with the British consultant alluded to earlier. I had the opportunity to attend one these events. After the workshops were concluded, members of the steering committee and the various Heads of service, as well as myself as representative of the educational sector, met for a very intensive discussion which was intended to summarise what was achieved and envision a way forward. This was a major source of "stock-taking" for the services and the educational sector. I cannot go so far as to consider this opportunity as part of my fieldwork, but it did serve to give me an added perspective on the study: an authentically insider view of a profession involved in developing its language, the way of presenting and identifying itself to the public and also adopting a new *modus operandi*. This could also be a development that sets in motion a process of identity transformation for the profession of occupational therapy in Malta. This matter is later briefly considered in the discussion chapter of this thesis.