A Firm Persuasion in Our Work

Professional Identity and Workplace Integration

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"A Firm Persuasion in Our Work," a continuing series in the American Journal of Occupational Therapy, features autobiographical briefs that mark profound engagement and rewarding careers in occupational therapy. The stories featured have transformational power and can be used as inspirations for sustaining our deep commitment to practice. The narrative of our work journeys can reveal knowledge about leadership and courage. Work journeys are full of adventure and drama with unpredictable and nonrational events (Whyte, 2001).

When I was asked to describe my work journey, I thought of the concept of place integration described by Malcolm Cutchin (2004), a geographer and ally of occupational therapists. Like Cutchin, I believe in the perspective of locating my professional identity in the place or spaces that have surrounded me during my work journey. Place integration is more than location in space, for it includes the coordination and reconstruction of social, cultural, and physical environmental elements in order to adapt. My professional identity emerged from my journey within the various places I practiced. Identity is a developmental process by which one recognizes to which group one belongs. This sense of self unfolds in stages and changes over time in various settings. The relationships I encountered in each of the places I lived, and the culture of those places, helped shape my identity as related to my work role and functions. These relationships also defined groups or individuals with whom I did not identify, also known as symbolic others (Abreu & Peloquin, 2004). In this piece, I describe experiences of place integration in four geographical spaces, each of which helped to shape my professional identity: Puerto Rico, New York City, Los Angeles, and, presently, in Galveston, Texas.

Puerto Rico

I embarked on my professional journey in Puerto Rico many years ago. I cherished the warmth of deep relationships with the people of my tropical island. I valued the critical role and obligations of community ties with family and neighbors and, being the oldest child in a large family, my interaction as a caregiver. I was greatly influenced by my grandma, who was my first mentor and caretaker of all the children in my home. She was also the cook, the maid, and the advisor. Grandma was easygoing with a positive attitude that was contagious and inspirational. Her high energy level also exuded calm. She exemplified respect in her inclusivity. She encouraged me to look deeply at persons who were insensitive to see if there was another side to their actions. These skills were essential in shaping my interactions on my professional journey.

My grandma also facilitated my professional development when she encouraged me to pursue occupational therapy as a way to help other people. During my studies in Puerto Rico, I was fortunate enough to be afforded an opportunity for adventure and expansion of my geographic landscape when I was offered two internships in New York. At the conclusion of my occupational therapy program, I was offered a permanent position in New York City, which led quickly to directorship. I accepted the position and moved to the Big Apple.
The Symbolic Other in New York City

One of the most important influences on my professional identity that I encountered in New York was the dualism of being Puerto Rican in an American city and the struggle with the symbolic other. I struggled with the duality of having been born and raised in a foreign land while now established in a “foreign” city. As a Puerto Rican, I was caught between the influences of two island cultures, which seemed like two different worlds. On the one hand, Puerto Rico was a slow-paced, Caribbean island with conservative norms and values. My perception of its culture was that people moved more slowly, were gentler, appeared less proficient in business, and were more quiet, humble, and friendly. On the other hand, New York was a liberal, contemporary, fast-paced bastion of diverse values. My perception of New York culture was that people moved too fast, were totally focused on work outcomes, seemed brutally honest and very vocal, and believed that they were superior. My questions became, “Who am I? Am I Puerto Rican or am I a New Yorker or both?”

I now understand that New Yorkers were my first symbolic others. Frequently, I saw intense work confrontations immediately followed by amiable resolutions. In my Puerto Rican culture, I was familiar with intense professional dialogue, but many times we personalized the work drama and displayed less cordial conflict resolution behaviors. In New York, there was a strong cultural separation of business and personal issues. My “place integration” included my adoption of a New York state of mind, including a disassociation of personal and work–related issues while keeping my humanistic perspective.

The Clinical Journey in New York City

I began my direct care practice in New York in the mid 1960s, working with individuals with physical disabilities within a medical model framework. I wore a white uniform, white shoes, and identifying name tag. I learned the protocols of the medical model under the supervision of psychiatrists, neurosurgeons, and neurologists, hand surgeons, and neurosurgeons. What I remember most vividly is that the physicians held high expectations for a new occupational therapist, and they trusted my judgment. At the time, I was not an expert in physical disabilities. My schooling had given me an excellent knowledge base, but it was not sufficient to master the scope and breadth of physical disabilities with my limited experience. I gained more knowledge through extensive reading, apprenticeship, mentoring, and continuing education. I was fortunate enough to study with many of the best clinicians of the time, including Anna Jean Ayres, Irene Hollis, Mary Fiorentino, Berta Bobath, Signe Brunnstrom, Dorothy E. Voss, and others. Occupational therapy prescriptions ranged from evaluating and treating impairments to addressing participation, even though we did not use those terms. For example, I had orders for splinting not only the hand but also the skull and the toe. Other medical orders were to increase movement and function in the upper extremities, decrease pain, provide psychosocial support, minimize discomfort, and occupy the clients’ time. Some of these orders may seem heretic in this day and age.

Sadly enough, I saw that, regardless of the individual’s medical condition, age, or gender, most clients behaved as subservient participants in the rehabilitation process. The routines and procedures that were followed fostered this subservient status. I also noted a disparity in the quality of care delivered to persons with chronic disabilities of low economic and educational status, and from minority groups, as compared to care given to the rich and powerful. Similar discrepancies were apparent within my peer group of therapists. Therapists did not readily connect with their clients. Many therapists professed more of an expert role in their relationships with clients rather than one of collaboration. The shortcomings that existed within the medical model and the role therein of traditional therapists gave me an awareness of what I did not want to do. This realization was a continuation of my confrontation with the symbolic other. I promised myself that I would never treat or interact with a client in an inattentive, depersonalized manner.

My ability to keep this promise was aided by many elegant physicians and clinicians who mentored me through their equitable treatment of all clients. These exemplars always made time to converse with me; they created deep connections with most all persons they encountered; and they delivered a high quality of care wherein their actions matched their words. Inspired by such role models, I began often to interpret information for clients and family members. My hope was to demystify medical jargon and support them in their efforts to secure equitable treatment in a complex system. I also started to ask the clients how they felt about their relationships with their occupational therapists, and found many to be saddened by the detached treatment they had received. As a supervisor I was able to use this information to reshape the behavior of the therapists and improve communication. Through “place integration” I incorporated my clinical professional identity into a New York style based on competency, speed, and directness while keeping my personalized perspective.

The Academic Journey in New York City

The first encounter I had with the academic community in New York was that of substituting for a faculty member on leave. I fell in love with the teaching–learning process and found my first occupational therapy mentor, a wise scholar. Though she was also young, I called this mentor my “NYC Granny,” as shepowerfully influenced my professional development. From her, I learned to develop a strong social skin that protected me from cultural bias and led me to rely on competency rather than social approval. I learned to deal with the fact that power, authority, and leadership roles were limited by gender in the academy as they had been in the clinic: disparities caused in great part by gender differences and cultural bias. Many of the occupational therapy faculty surrounded themselves in their own professional space and language. With the
help of my mentor, I was able to expand my professional identity by working with scholars from various different disciplines and from multiple universities.

One of my most rewarding experiences was mentoring students with scholarly potential and supporting their growth. I taught physical disabilities, kinesiology, and neurophysiology to large, homogeneous groups of middle-class students. These students wanted to learn relevant practical information rather than theory. But I had a passion for teaching and eventually I learned to bridge the gap between theory and practice by using motivational teaching strategies.

The challenge at this point in my career became a tale of two loves—clinician and educator. Which role was the symbolic other? As my educator role developed, my association with the clinic was constantly challenged. My faculty status was frequently qualified as that of a clinical educator. I believed that I had developed uniqueness in the academy similar in many ways to my duality as a bilingual and biracial person. My success as a clinical educator was due in large part to the support of my mentor Granny.

One unusual struggle I encountered in the academy occurred in 1986, when I received a major national Hispanic leadership fellow’s award. This fellowship was structured to provide a high-level, management-training program for academics. The goal was to provide exposure and insight that would enhance growth through the academic hierarchy. However, in one of the seminars, I was told that I could become a more powerful leader if I lost my accent. I gave a very caustic response. I think that my limbic response was triggered by my perceived attack on my Hispanic accent rather than an accent in general. I think that this experience confirmed for me what I already knew: that some higher education institutions had significant disparate ethnic realities. My New York City academic institution and faculty promoted inclusion, cultural awareness, and sensitivity that made me feel welcomed and at home. My New York "place integration" led me to a sense of attachment and belonging among the people in the academic society that represented a strong, culturally diverse, and tolerant society.

The Manager Journey in Los Angeles

In midlife, I decided that I wanted to pursue my dual role as clinician and academic. I went back to school for my doctorate in occupational therapy in order to expand my research capabilities. After finishing my doctorate in New York in the early 1990s, I joined a start-up occupational therapy clinic that was associated with a major university in Los Angeles. The group I joined worked from a different theoretical framework that I supported and from which I learned. This new work journey was supposed to help me to integrate my newly acquired research skills with clinical practice. However, in reality, the position turned out to be a learning experience about how difficult it is to create a research infrastructure in a for-profit environment.

I was hired to start a managed-care-driven occupational therapy department grounded in occupation-based practice in a brand new hospital. What a challenge! To survive, I worked closely in a team with two other departmental directors for long hours and delayed vacations in order to meet the bottom line. I was required to put my scholarly activities and research endeavors on hold due to the high clinical and administrative workload. There was constant pressure to increase productivity and reduce cost. Knowing that adverse work conditions are associated with health risks, I learned about stress management, and coped by creating a supportive and trusting environment for staff. I also used a systematic reward system and promoted quality care. I learned to manage the fluctuation of service demands by using per diem staff. I was fortunate to have worked with a great staff of highly intellectual and devoted clinicians and academics who were able to develop new models of practice that were based on holistic rehabilitation (Wood, Abreu, Duval, & Gerber, 1994).

Ultimately, I emerged as a successful manager; yet I did not have time to pursue my research identity. In the mid 1990s, I was offered a clinical/academic position in Galveston, Texas, that allowed me to integrate my three goals of direct care, education, and research. What followed was indeed the emergence of another identity—the collaborative research scientist.

The Researcher Journey in Galveston

Research is one of the most important factors in my professional development. I believe that quality research contributes greatly to the development of all individuals. Quality dissemination and implementation of research is known as knowledge translation, and I wanted to become a translator. Situated in Galveston, I am fortunate enough to work in an institution that fully supports my research efforts as promised. I have the opportunity to work with a group of brilliant scholars and researchers who serve as my mentors in occupational therapy and rehabilitation science. Clearly one is never too old for mentorship. In turn, I have been able to serve as a mentor for doctoral and postdoctoral fellows. This relationship is mutually beneficial and enhances my skills and increases my participation in research and teaching at the impairment, disability, and participation levels. In addition, I have learned to name and frame my practice beyond the medical model by using confluent education principles and to voice my concerns about diversity and about the need to build bridges between academic and clinical worlds (Abreu & Peloquin, 2004, 2005; Peloquin & Abreu, 1996).

Based on institutional support for research and the mentorship process in my current setting, we have been able to create a collaborative research team devoted to expanding the current understanding of persons with acquired brain injury. My research journey has helped me clarify and understand questions about client and therapist collaboration that I first asked at the beginning of my work journey in New York City. For example, in a qualitative descriptive case study, our research team found that, in our facility, exchanges among persons with brain injury and treatment teams were not client centered (Abreu, Zhang, Seale, Primeau, & Jones, 2002). We were mortified that, in spite of an inclusion of clients in interdisciplinary meetings and our best efforts, we had not achieved our goal of a client-centered treatment program. In
other studies, our team has challenged the idea that a natural environment is always the best kind of therapeutic environment. For example, we have found that young clients from a virtual generation are familiar and proficient with technological interactions that go beyond actual reality into virtual environments. Our research supported the assumption that a computer-simulated, virtual kitchen environment is a reproducible tool that can be used to assess cognitive function and supplement traditional rehabilitation assessments (Christiansen et al., 1998; Zhang et al., 2001).

Given the solid research support afforded by this institutional place, I have been able to facilitate the creation of a research infrastructure in clinical practice. With institutional support, I have emerged as a clinical researcher, and I continue to grow and polish my skills.

My Future Identity
Like many occupational therapists, I have lived through a fascinatingly complex interplay of identity changes, expressing the consequent rewards and stressors of the work journey. My sense of identity has emerged from my sense of belonging, and commitment, and my adoption of social and cultural traditions. Security in my sense of identity has allowed me to change and grow. After 40 years of practicing occupational therapy, I feel that I am still searching for a better balance and for another new identity. Who knows what lies ahead? I continue to reflect and celebrate what every new “place integration” has added to my life. My challenge is to find new and challenging ways for self-motivation and continued improvement.

The relationship between workplace and professional community is complex, as is the full integration into spaces or places of work. I hope that other professionals will have success in forming their own professional identities while finding more diversity and fewer disparities in their work journeys. I have candidly shared my professional identity, drama, stress, and success to help others reflect on the development of their identities. ▲

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References