

Experience Report

Is occupational therapy an ableist health profession? A critical reflection on ableism and occupational therapy¹

Terapia ocupacional é uma profissão da saúde capacitista? Uma reflexão crítica sobre capacitismo e terapia ocupacional

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Abstract

Introduction: There is a need to engage in critical reflection and reflexivity to deconstruct ableist conceptualisations and practices in occupational therapy.

Objectives: 1) to discuss ableism as a social construction within a practice system, 2) to deconstruct ableist mechanisms employed within occupational therapy practice, and 3) to propose inclusive and justice-oriented practices that can improve patterns of practices within the occupational therapy profession. **Method:** Online discussions and reflective writing, producing critical reflections, were done to curate our experiences and insights based on our personal and professional experiences, thoughts, and observations as Filipino occupational therapy practitioners. Critical reflexivity was seen both as process and output to address the research objectives. **Findings:** Despite the efforts of scholars, educators, and practitioners in employing inclusive and justice-oriented occupational therapy practices, ableism continues to proliferate through overt and covert mechanisms within professional practices. **Conclusion:** As the occupational therapy profession continues to evolve, practitioners are expected to be critically reflective and reflexive to mitigate discriminatory practices and promote inclusive and participatory practices today and beyond. This article hopes to serve as an eye-opener for occupational therapy practitioners and reconsider their doings, knowings, and sayings in their present and future practice.

Keywords: Disability Studies, Professional Practices, Health Personnel, Philippines.

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Resumo

Introdução: Há uma necessidade de se engajar em uma reflexão crítica e em reflexividade para desconstruir conceituações e práticas capacitistas em terapia ocupacional. **Objetivos:** 1) discutir o capacitismo como uma construção social dentro de um sistema de prática, 2) desconstruir mecanismos capacitistas empregados na prática em terapia ocupacional e 3) propor práticas inclusivas e orientadas para a justiça que possam melhorar os padrões de práticas dentro da profissão de terapia ocupacional. **Método:** Foram feitas discussões *online* e escrita reflexiva, produzindo reflexões críticas, para selecionar nossas experiências e *insights*, pensamentos e observações pessoais e profissionais como praticantes de terapia ocupacional nas Filipinas. A reflexividade crítica foi vista tanto como processo quanto como saída para abordar os objetivos da pesquisa. **Resultados:** Apesar dos esforços de acadêmicos, educadores e profissionais em empregar práticas de terapia ocupacional inclusivas e orientadas para a justiça, o capacitismo continua a proliferar por meio de mecanismos abertos e encobertos nas práticas profissionais. **Conclusão:** À medida que a profissão de terapia ocupacional continua a evoluir, espera-se que os profissionais sejam criticamente reflexivos para mitigar práticas discriminatórias e promover práticas inclusivas e participativas hoje e além. Este artigo espera contribuir como um alerta para terapeutas ocupacionais reconsiderarem seus fazeres, saberes e dizeres em sua prática presente e futura.

Palavras-chave: Estudos sobre Deficiências, Práticas Profissionais, Profissional de Saúde, Filipinas.

Introduction

Critical reflection is defined to be “[...] a form of criticality concerned with critique of oneself, one's internal dialogue, performance, cognitive biases and development” (Robertson et al., 2015, p. 68). Doing critical reflection allows a practitioner to ask questions like “Why did I do that?”, “How do I feel after doing that?”, or “How could I do it differently the next time around?” On the other hand, critical reflexivity allows us to take a step back and appraise the unquestioned and dominant philosophies embedded within our lives and our professional practices (Laliberte-Rudman, 2021). A practitioner who practises critical reflexivity asks questions like “How did I learn to do things this way?”, “Am I doing these things out of my privileged position?”, or “Was I being biased in thinking or doing this way?” Engaging in critical reflection and reflexivity brings about transformative actions by assessing and understanding our experience, assumptions, and practice (Fook, 2015) toward a socially responsible and ethical practice (Bolton, 2010).

Health and service professions, including occupational therapy (OT), need to engage in both critical reflection and critical reflexivity as they interact and deal with people from all walks of life, including those who identify as part of the minority and marginalised population. OT practitioners are expected to be aware of their biases and preconceptions, especially when interacting with disabled people to avoid letting these biases cloud one's professional judgement and to effectively collaborate with clients and communities. Without critical reflection and reflexivity, a profession's

conceptualisations and approaches may be a conduit to reinforce ableism. Ableism is defined by Lewis (2022) as

[...] a system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness... This systemic oppression leads to people and society determining people's value based on their culture, age, language, appearance, religion, birth or living place, 'health/wellness', and/or their ability to satisfactorily (re)produce, 'excel' and 'behave'.

Ableist micro- and macro-processes can reinforce injustice to an already unjust society. Although engaging in critical reflection and reflexivity is seen as a threat to dominant approaches and power relations, such practices must be enforced because they contribute to professional development and galvanise our social accountability (Bolton, 2010). In this article, we seek to 1) discuss ableism as a social construction within the practice system of OT, 2) deconstruct ableist mechanisms employed within OT practice, and 3) propose inclusive and justice-oriented practices that can improve patterns of practices within the OT profession.

Approach

This article did not go through the traditional way of collecting and analysing data. Whilst data-free, we, the authors, worked together through online discussions and reflective writing to curate our experiences and insights based on our personal and professional experiences, thoughts, and observations as Filipino OT practitioners. These produced critical reflections that contained qualitative data and allowed us to generate proposed strategies to enable inclusive and justice-oriented practices underpinned by critical reflexivity.

Moreover, each of us is coming from different points of analysis. All authors are Filipino occupational therapists. DPGY (first author) is a Ph.D. student in disability studies, an occupational scientist, and had a clinical background in physical rehabilitation; MPS (shared first author) is an associate professor of health professions education and an occupational scientist who does full-time teaching in a national university; PGVM (co-author) is a Masters student in International Health and an instructor of OT with a clinical background in children care and mental health services; and, ECL (co-author) is a clinical instructor of OT with a clinical background in children and mental health services.

Whilst the reflections were based specifically on OT service delivery in the Philippines, we envision this paper to be of benefit to both local and international occupational therapists. To validate the content of this article, we invited feedback from three external reviewers coming from various backgrounds and countries—an American OT, an American disabled self-advocate, and a Filipino sociologist.

Occupational Therapy: The Profession Under Scrutiny

OT first emerged in the year 1917, a time when eugenic philosophy had been gaining global support. The American eugenic movement was formed in the early nineteenth century and continued up until the 1940s. An aspect of eugenics aimed to eliminate inferior genes including impairments (Carlaw, 2019). It was a time when violent medical interventions seeking to cure impairments became rampant. OT pushed forth for the humane treatment of disabled people using daily activities that occupy time (Meyer, 1922). Over the years, the profession transitioned to become an integral part of the healthcare system. The OT profession is thereby defined as a client-centred allied health profession that seeks to promote health and well-being through the therapeutic use of activities—occupations (World Federation of Occupational Therapy, 2012). A critique, however, to the uncritical application of client-centredness is the tendency to have a narrowed lens that focuses merely on the client thereby failing to see the system that oppresses the client as a problem.

The etymology of occupation stems from the Latin word ‘occupare’ meaning ‘to seize’. Reed et al. (2013) explained that multiple meanings have been associated with occupation across history depending on societal values, religious beliefs, philosophy, government, technology, gender, class, and geography. Ableist values are traced back to the ancient Greek and Roman times when social structure influenced the type of occupation people engaged in, physical labour for the poor, and freeing time for contemplation for the elite. The Industrial Revolution instilled the value of productivity, which led to ‘occupations’ being subjected to logical, rational, and objective measures. Simply put, the activities that society has historically valued required a certain threshold of physical, cognitive, and emotional ability to be considered useful or worthy. The action ‘to seize’ entails power and ability and thereby can be associated with how performance, participation, and experience of occupation must involve ability.

Ableism: a Pattern of Knowing, Feeling, and Practising

OT caters to a broad range of audiences across the lifespan, from infants to elderly people. Moreover, the profession has a role to play in the promotion of health for individuals with physical, mental, sensory, cognitive, and developmental conditions. As the profession grew, the professional practice has been subjected to regulations imposed by legislation, policies, and standardisations that shaped how services are delivered and funded. These conditions allow for the concept of ableism to take root. Ableism constitutes beliefs, attitudes, processes, and practices that project a particular kind of self and bodyminds as the species-typical, essential, and perfect human (Campbell, 2001). Ableism perceives disability as an inherently negative condition in need of amelioration, healing, or elimination (Campbell, 2009). Whilst not overtly, such manners of knowing and doing can result in stereotyping, prejudicing, discriminating, and oppressing disabled people (Bogart & Dunn, 2019). The manifestation of ableism may typically be hostile, benevolent, or ambivalent in nature. Among these, ambivalent ableism, specifically paternalistic ableism, was found to be the most frequent form of prejudice wherein it can take the form of general pity, unwanted help, infantilisation,

overprotection, and invalidation (Nario-Redmond et al., 2019). We outline in Table 1 the different experiences of ableism from the works of Nario-Redmond et al. (2019).

Table 1. Different forms of ableism.

Experience	Description	Specific Experiences
1. Benevolent ableism	An assumption wherein disabled individuals are vulnerable, weak, and dependent. This tends to romanticise acts of ‘overcoming their limitations’ resulting in the objectification of disabled people as they are perceived as ‘specimens of wonder and amazement’	<ul style="list-style-type: none"> • Being an inspiration when in: <ul style="list-style-type: none"> ○ Public ○ School/work ○ A medical context • Being depicted as ‘heroic supercrips’ in stories
2. Hostile Ableism	Negative forms of ableism in which other members of the society exploit or attack disabled individuals	<ul style="list-style-type: none"> • Verbal abuse • Physical assault • Sexual assault • Bullying • General harassment
3. Ambivalent ableism	A combination of both hostile and benevolent ableism, shifting from one to the other depending on the situation and circumstances	
a. Paternalistic	Patronising speech and behaviours	<ul style="list-style-type: none"> • Unwanted help • Infantilisation • General pity • Invalidation • Overprotection
b. Jealousy/ envy	An attitude of desiring things that a disabled person receives/gets	<ul style="list-style-type: none"> • Jealousy over a disabled person’s: <ul style="list-style-type: none"> ○ Accommodations ○ Perceived privileges • Accusation over benefit exploitation
c. Dehumanising/ objectifying	Behaviours that fail to respect the inherent right of being human	<ul style="list-style-type: none"> • Depersonalisation • Invasion of privacy • Abandonment/ neglect • Delegitimisation
d. Fear-based	Behaviours ruled by fear	<ul style="list-style-type: none"> • Existential concerns over life • Fear of catching or passing a disability • General avoidance

Despite the recent efforts of scholars, educators, and practitioners in employing inclusive and justice-oriented OT practices, ableism continues to proliferate through overt and covert mechanisms within professional practices. A glaring issue has been the economic changes that affected the OT profession in recent years. As OT services are being adopted into the insurance system, ‘objective outcomes’ are desired (Doucet &

Gutman, 2013). This obsession with quantifiable, objective results within the Global North has impacted the Global South despite some countries' out-of-pocket payment schemes. The integration within the healthcare system's hierarchy and the adoption of medical language polarised the profession to being seen as subordinate to medical practitioners. This subordination espouses the idea that one should 'follow doctor's order' and be adherent to the biomedical model of disability and all its tenets. The reliance on a biomedical, impairment-focused perspective harbours an ableist viewpoint (Campbell, 2009; Borowsky et al., 2021). Moreover, health professionals within rehabilitation sciences, when guided by the biomedical model of disability, are prone to perceive disability as a problem requiring intervention as it is widely, yet erroneously, assumed that function is an integral influencer of health (Reynolds, 2017; Janz, 2019; Mosleh, 2019). The biomedical paradigm depoliticises disability as a societal issue of stigma, injustice, and inaccessibility.

Ableist Practice Patterns in Occupational Therapy

Janz (2019) argued that an ableist mindset within the healthcare field is so dangerous and insidious as it often presents as 'common sense'. For instance, the area of practice of OT is heavily influenced by the medical language and is classified based on dysfunction (i.e., physical dysfunction, cognitive dysfunction, and psychiatric or mental dysfunction). Moreover, common sense established within the education and practice of OT includes patient case formulations which can unintentionally reinforce ableist discourses in OT education (Grenier, 2021) and the premium given to 'health-related quality of life' and 'leisure', which is argued by Janz (2019) and Hammell (2009) to be stemming from ableist notions and ideals as the former relates quality to functioning and the latter is class-bound, privileged, and non-universal.

The concept of ableism perpetuates because of how these actions are covertly practised, which later becomes systemic and structured. In the following subsections, we present how ableist practices are espoused across the OT process based on our personal and professional experiences, thoughts, and observations as OT practitioners in the Philippines. We actuated critical reflections on the practice process that begins with evaluation, followed by intervention, and usually ends by measuring set outcomes. Within these processes, ableism can be demonstrated unconsciously, unintentionally, or even without reflection and reflexivity.

OT Evaluation

Evaluation denotes curating the person's occupational profile through document reviews, interviews, and direct observation (American Occupational Therapy Association, 2020). The evaluation process includes the assessment of skills through standardised assessment tools, observation of the client's performance of an occupation in simulated and actual settings, and determination of goals.

In child-focused services, it is almost second nature for therapists to speak to the parents/caregivers to gather information about the child. At times, even when the child is at an age where they can speak for themselves, therapists may easily take for granted the child's preference because they are oriented to communicate with the

parent/caregiver mainly. Similarly, in physical rehabilitation, geriatric care, adolescent care, and mental health settings, therapists tend to be paternalistic by focusing on caregivers speaking on behalf of the person, which may make the disabled person feel invisible during the evaluation process. These situations convey ableist assumptions that tend to put a lesser premium on the thought, needs, wants, and circumstances of a disabled person by silencing them when therapy services should be about and centred around the disabled person.

Another, when screening or evaluating a new client, there is a tendency to prioritise the assessment of activities of daily living (ADL), as if a hierarchy of occupation exists and dependence in ADLs equates one to having substandard health and quality of life. This tendency to assess ADLs because of an implied protocol is something that we experience even in teletherapy. This is the backdrop of moments wherein OT practitioners frame occupations, most often the ADLs, as something ‘expected to do’. When their needs and capacity are not recognised for the sake of complying with protocols or templates, it can be argued to be dehumanising. According to Haslam (2006), dehumanisation is the relative denial of mind, complex internal life, and overall humanness to an individual or group. Therapists need to acknowledge that expectations are shaped and dictated by an ableist society and should not take precedence over what is meaningful to the person.

Rating clients based on their performance is prone to ableist approaches as well. The dominant use of quantitative measures to determine ability from disability potentially reduces the disabled person to a myriad of numbers. Through the years, OT has developed standardised tools that examine specific client factors (e.g., pain, range of motion, strength, and balance). The measured performance is always made with reference given to the performance of nondisabled individuals (labelled as the ‘norm’), thereby suggesting that the disabled person is incapable of doing certain activities or that their performance is deviant from the doings of so-called ‘normal’ people. To illustrate, a person with cerebral palsy should not be measured on the same balance scale as an athlete with an injury, yet we still see that being practised. The creation and use of standardised tools can be useful in practice when employed in the right situation and purpose (i.e., to objectively quantify pre- and post-intervention). However, the issue here is how occupational therapists tend to have this desire to categorise their patients into the spectrum of ability/disability even to the point of using assessment tools and instruments that may not be the most appropriate for the person’s needs and goals.

There is also an unconscious practice of measuring disability and the client’s prognosis based on severity (e.g., ‘mild’, ‘moderate’, or ‘severe’) or based on the therapist’s subjective perception (e.g., ‘good’, ‘fair’, or ‘poor’) solely based on the physician’s diagnosis. Sometimes, these labels were generated from a person’s performance within a single context alone such as the clinic or hospital. Nevertheless, therapists need to be cognisant that individuals may not perform their best, especially if they are anxious due to the new physical and/or social environment, if they are exposed to a new experience, or if they feel overly conscious when being observed. For instance, children presented with unfamiliar toys unavailable at home may struggle playing with it or may not be motivated to play. Similarly, adults assessed through simulated activities may have difficulty adapting to a task typically done at home. Whilst the use of medical labels and diagnosis (even OT diagnosis) is statutory, it tends to enclose the person to a

category and, as argued by Clare (2017), can deorient and devalue people, eventually positioning them into a space of oppression and stigmatisation. In terms of evaluation, we argue that whilst using standardised tools and clinical observation are expected, needed, and useful, we also want to acknowledge the viewpoint of the client in the assessment process to triangulate the assessment information being documented.

The use of language-concordant care enhances the trust between clients and carers, optimises health outcomes, and promotes health equity whilst providing health care services (Molina & Kasper, 2019). Within OT practice, the term ‘able to’ has largely influenced the formulation of goals for clients and groups. A typical OT goal’s syntax proposed by Gateley & Borcharding (2012, p. 58) is as follows, “Client will be *able to* button shirt using a button hook with 2 or fewer verbal cues by the tenth treatment session”. Whilst not necessarily discriminative, the term ‘able to’ implicitly suggests how a disabled person is compelled to adhere to species-typical physical, mental, neuro, and cognitive abilities without intentionally recognising that ‘disability’ is part of the person’s identity, which needs to be embraced rather than conquered (Wolbring & Chai, 2017). Moreover, there is a compulsion to set goals relating to independence, performance, and efficiency to adhere to the ‘norm’, without realising that the norm was established with nondisabled bodyminds, underpinned by the conceptual frameworks of capitalism and individualism, without proper representation of the disabled population, and is stemming from a eugenic origin (Davis, 2013). The goal of eradicating cues and prompts to achieve independence and be more efficient may not always be meaningful. For instance, in cultures where interdependence is more valuable than independence, when an elderly person with a disability is being assisted to stand up or walk to participate in a church service, this could be seen as something virtuous and respectful without thinking that the elderly is disabled or dependent.

The OT profession prides itself in being holistic, however, the use of ‘able to’, hyperfocusing on caregivers/parents’ perspectives, and an obsession with certain categories and normative performance may stray us away from being the holistic carers that we ought to be. Although it is valid to measure the capacity to perform, careful attention must also be given to environments, contexts, systems, and occupations that influence performance, participation, and engagement.

OT Intervention

Intervention is broadly understood as the implementation of the evaluation plan. It is a process that begins with planning and ends with the reevaluation of the intervention (American Occupational Therapy Association, 2020).

Deriving from day-to-day experience, OT practitioners often already have ideas of what to target and do for a certain population. A pitfall to this situation, however, is the tendency to be less person-centred. Instead of listening and collaborating with the disabled person in terms of planning the program, there is a possibility of coercing them into ‘choosing’ what to target and doing what the OT practitioner thinks. This practice prevails in Asian countries, like the Philippines, that value traditional hierarchical structures that reduce the disabled person into the patient role dependent on the expert. The uncontested and rampant assumption where the therapist is the expert and main problem solver espouses patterns of ableism in day-to-day practice and also galvanizes

an unbalanced power dynamic between practitioner and client whilst, in reality, the client is the expert about their own life, bodyminds, and desires.

When OT practitioners do collaborate with the disabled person in developing a program, it is a common practice across all settings to expect a person receiving services to have therapy goals right off the bat and cooperate with the treatment program. When the goals are not met or when the person is not motivated to engage in therapy sessions, they are labelled as ‘non-compliant’ or ‘unmotivated’. This can be a subtle way of reinforcing ableism in practice. Without recognising that people need to internalise their reality, purpose in life, and socio-economic situation among others (Papadimitriou et al., 2021), OT practitioners may be blindly espousing dehumanising and ableist practices. In connection to such a dynamic is subjecting the disabled person to ‘forced intimacy’. Mingus (2017) defined forced intimacy as the everyday experiences of disabled people of being expected to divulge personal information and accept physical contact/help to survive in an ableist world. This happens within the clinical setting when disabled people lose any sense of privacy for the sake of evaluation/treatment, thereby positioning them as vulnerable individuals as a prerequisite to accessing their needs. Furthermore, it became a professional expectation that clinicians be let into all the private aspects and privy to all the details of a client’s life, sometimes immediately upon meeting them.

During intervention sessions, task completion in a normative manner is a measure of a quality therapy session or a goal achieved. When working with children with developmental disabilities, OT practitioners usually perceive deviant behaviours, such as stimming negatively. Stimming refers to a self-stimulating behaviour characterised by repetitive movements or sounds usually by an autistic child. In some instances, intervention entails lessening or removing the stimming behaviours of a person since it is perceived to be a hindrance to task completion or smooth performance of the activity. To the extreme, physical and environmental restraints could be employed to eradicate stimming. Stimming is discouraged because it is not something a nondisabled person does to complete tasks in a timely manner. Even when stimming does not affect the performance of an occupation, the embodiment or enactment of ‘being different’ is seen as needing eradication since the occupational therapist’s goal is to produce people who do things ‘normally’. We should acknowledge that stimming behaviours are part of the holistic identity of the disabled person as it is an adaptive mechanism they need to soothe and communicate emotions and thoughts (Kapp et al., 2019) and, arguably, to deal with the oppression around them.

Another, the use of ‘time out’ or isolation or dark rooms is a common behavioural management technique underpinned by applied behavioural analysis (ABA) principles and practices. Whilst it is a valid form of negative reinforcement within ABA, the concept stemmed from animal experiments and can dehumanise a person by considering them as a set of observable behaviours that need to be controlled. Unfortunately, behaviour management principles and techniques still predominate the education and training of OT practitioners in the Philippines.

The predominant use of specific frames of reference or specialised interventions may also pose a hindrance in understanding our clients holistically. We become short-sighted of our client’s unique environments and contexts and insist on seeing our clients from a fixed standpoint. Often, we ask the question ‘*Is it behavioural or sensory?*’ but forget

that they are not mutually exclusive and can co-exist at the same time and still make up the identity of a person. Whilst we recognise that OT largely borrows principles and assumptions from psychology and neurosciences, without critical reflexivity, we will continuously promote ableist practices. Drawing from Hehir's (2002, p. 1) words:

Ableism [is] the 'devaluation of disability' that 'results in societal attitudes that uncritically assert that it is better for a child to walk than roll, speak than sign, read print than read Braille, spell independently than use a spell-check, and hang out with nondisabled kids as opposed to other disabled kids'.

OT Outcomes

The next phase of the OT process involves the deliberate measurement of outcomes after the intervention process. These outcomes include but are not limited to, engagement in occupation to support participation; occupational performance, improvement, enhancement, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice (American Occupational Therapy Association, 2020). In this article, we chose to discuss outcomes on quality of life, occupational justice, and advocacy participation.

Quality of life is largely described as the standard of health, comfort, and happiness experienced by an individual or group. Although quality of life has nuanced understandings from different professions and disciplines, it is defined as an "[...] outcome measure to indicate the global health, functioning and well-being of a person following illness, injury or disability, and to evaluate the effectiveness of therapeutic interventions" within OT (Liddle & McKenna, 2000, p. 77). This concept, however, is problematic and a barrier to care and participation especially when it is not defined comprehensively considering cultural determinants and subjectivity. There is no standardised meaning of quality of life as it is argued to be a difficult concept to concretize (Spagnolo, 2008). Disabled people perceive their quality of life differently from health professionals and other nondisabled individuals (Goering, 2008). Imposing quality of life definitions or regulations based on Western or biomedical standards can potentially disadvantage disabled people, especially those who live in low and middle-income countries. Individuals from impoverished backgrounds have limited choices in terms of employment, education, housing, and meals, to name a few. In these countries, if a disabled person from a low-middle income social strata's quality of life is shaped primarily by the oppression of ableism, the everyday encounters with stigma, attitudinal barriers, and the backdrop of poverty, then surely the impact of OT services to their quality of life will not be very great despite receiving such services.

Occupational justice is also an emerging concept in OT discourses and practices. Occupational justice is defined as the "[...] access to and participation in the full range of [personally] meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs" (American Occupational Therapy Association, 2020, p. 79). Ableism is reinforced when we assume that all people are 'able' to afford all these opportunities without understanding cultural, historical, and political contexts where occupational justice principles are to be applied. Córdoba (2020) described occupational

justice as a colonising concept by the Anglo-Saxon community of OT practitioners. In other words, underpinned by Western ideas and ways of thinking, when occupational justice is uncritically examined and applied, it can reproduce forms of understanding and practices that deny other worldviews outside the colonising world (Córdoba, 2020). Whilst efforts to bridge occupational justice conceptualisations and OT practice are underway, it is imperative that OT practitioners carefully consider the cultural contexts (e.g., social determinants of health, language use, meaning, traditions, and beliefs, among others) of not only the service users but also the practice settings where an occupational justice perspective is to be employed (Sy et al., 2021).

One of the aims of occupational justice is to promote advocacy and promotion of occupational rights among people and groups. Advocacy participation has been a mechanism used largely by OT practitioners to promote the profession, its values, and its position in the health and social care systems. To do this, OT practitioners gather to celebrate holidays or festivities related to disability. For instance, there is the tendency to use ‘disability’ as a punchline during disability week celebrations (i.e., ‘know me for my abilities, not my disability’, images with the word ‘disability’ but the prefix ‘dis’ are crossed out, and derivatives). To further reinforce the festivities, advocates use inspirational stories through various media to illustrate how a disabled person can achieve ‘great’ things in life, or how a disability can be ‘fixed’ later when one does this and that. This is an example of ‘inspiration porn’, a form of ableism. Without critical reflection, we deny the intersectionality of identities and privileges that made the unfolding of people’s lives different, thus neglecting the uniqueness of disabled individuals (Erevelles, 2011). Although these practices are undoubtedly done with good intentions, they may need to be revisited before advocating and celebrating another disability event.

Inclusive and Justice-Focused Occupational Therapy Practice

If the OT profession is committed to upholding human dignity in our services, then it is expected that the collaboration between practitioner and client promotes non-ableist practices entailing inclusivity and participation. The embodiment of person-centredness should be the essence of the profession—to acknowledge the person as a human with their own identity and lived experiences. Yet, we should realise that to truly be person-centred is to acknowledge and call out the oppressive system surrounding the person. The integration of a justice-oriented lens and the adoption of disability studies perspectives can allow us to be sensitive and critical of the taken-for-granted language, actions, and attitudes within contemporary OT practices (Magasi, 2008; Laliberte-Rudman, 2021). Concretising these principles, we are proposing in Table 2 the following ideas and concepts to rethink and challenge our conventional practice including destigmatising dependency, acknowledging Crip Time, co-creating inclusive curricula, utilising non-ableist narratives, allying with the Disability Justice movement, and promoting critical reflexivity.

Table 2. Proposed practices for a more inclusive and justice-focused OT practice.

Proposed practice	Description
<i>Destigmatising dependency</i>	It is in the very nature of humans to be interdependent. It has been the core of civilisations and society since time immemorial. We depend on others such as farmers and fishermen for food, janitors and street sweepers for cleanliness, and factory workers for our daily commodities as much as other people depend on us for healthcare services, consultations, and to be confidants. As the saying goes, no man is an island. As such, we have to position the dependency of certain forms of impairment within the inevitable dependency of being human and reimagine society whilst centralising the disability experience. When we recognise that dependency is an aspect of humanity, society can begin to confront our biases against dependency and disability (Kittay, 2011). As such, it is fine for a person to not necessarily need to learn independent activities and can be dependent on a caregiver (i.e., after a fall, an elderly person does not need to meet an OT goal of being able to cook independently on their own because they have a caregiver to help them with that task).
<i>Acknowledging Crip Time</i>	Time is experienced differently by disabled people. It takes a lot of time and effort to do something in this ableist world with an ableist way of doing. Rather than pressuring and bending the disabled person to fit the ableist time, we need to understand how time and timeliness are associated with the social construction of ability (Ljuslinder et al., 2020). We need to acknowledge that people, especially those disabled, need more time and flexibility – this is crip time (Kafer, 2013). Crip time applies not only to physically disabled people but to all disabled people such as neurodiverse individuals.
<i>Co-creating inclusive curricula</i>	Curriculum review in the health sciences, including OT, must be performed through team editing with service users (Grenier, 2021). Webinars, small-group discussions, further readings, and other participatory activities (i.e. privilege awareness, student-led discussions, brainstorming interventions to overcome barriers) may be conducted to tackle “[...] ableism, social model of disability, disability history and culture, and health disparities” (Borowsky et al., 2021, p. 2). More importantly, curriculum and fieldwork placements shall be made flexible and provide the necessary support for disabled people to facilitate their entry and successful completion of OT programs (Phelan, 2011). At present, it’s hard to become an OT practitioner if you’re disabled, and often discouraged by the university and department administration.
<i>Utilising non-ableist narrative</i>	Stories and narratives have been used as part of advocacy and are an integral part of positioning disabled individuals as experts. However, rather than the narrative of ‘fixing’ and presenting inspirational narratives of the few disabled individuals who are privileged to cope and integrate with the ableist society, we propose the use of narratives that are highly contextualised and highlight the personhood of the disabled individual. An example of this is to allow other disabled people to tell their tales rather than letting ‘outsiders’ speak for them. This can be through looking at the works of disabled writers, self-advocates, and qualitative studies where disabled people are made experts of their stories. When narratives of disabled people are geared towards highlighting their humanity - disability is regarded as part of their identity instead of a lack. Meaningful relationships are formed and maintained in life when ableist notions of our society are brought to light - thus, helping the disabled person unpack and tackle their internalised ableism.

Table 2. Continued...

Proposed practice	Description
<i>Allying with the Disability Justice Movement</i>	<p>The Disability Justice movement acknowledges the intersectionality of identities, uniqueness of all bodyminds, that all bodyminds are essential and have both strengths and needs that must be met, and that disabled people are powerful because of the complexities of their bodyminds (Berne, 2019). To ally with the movement is to acknowledge our privilege and to resist the ableist society with disabled people by living in a manner that's sensitive to those deemed least by society. We advocate with disabled people through espousing love as envisioned by Mingus (2012). By espousing love, it means being committed to one another by investing time, energy, and action. If we are committed to standing with disabled people, we cannot stay silent when we know they are dealing with inaccessibility beyond the four walls of the clinic/hospital and they are being excluded by society.</p>
<i>Promoting critical reflexivity</i>	<p>Critical reflexivity can be developed by encouraging students and practitioners to think about how they construct realities and identities (Cunliffe, 2004). Inculcated during education and early training, critical reflexivity exercises may be given through storytelling, journaling, interdisciplinary service-learning programs, and cultural safety guidelines among others (Landy et al., 2016). Beyond monitoring and analysing one's thoughts and actions, it is necessary to recognize the presence of oppression through overt and covert ableist practices, the role of social power structures that influence our actions and interactions, and the urgency to change certain practices. Exploring and challenging one's assumptions, actions, beliefs, and biases are part of the process as students and practitioners work with disabled people who may also be unaware of ableist practices imposed upon self and/or others. OT students and practitioners can be guided by the <i>seven-step framework for critical analysis</i> by Nixon et al. (2017). The framework follows an iterative process consisting of the following: 1) name the specific aspect of practice being analysed, 2) identify the intended purposes of this aspect of practice 3) uncover the assumptions that support these intended purposes, 4) identify who benefits, 5) identify who is disadvantaged, 6) link these specific ideas to society- level patterns, and 7) conceive of alternatives that mitigate actual or potential harms. The intentional exercise of looking into the overall context and recognizing the presence of oppression through ableism shall be established as early as fieldwork education.</p>

Table 2 advances the view that therapy practitioners should acknowledge our privilege and resist the ableist society as exemplified in at least two ways. First is by embracing a genuinely intersectional lens in challenging OT practices. It is fundamentally important not to lose sight of the client's multiple and intersecting identities. By necessity of OT practice, disability is the starting point of evaluation, intervention, and outcomes. We can operationalise 'being holistic care providers' by appreciating the fact that varying forms of disadvantage and privilege based on sex, gender, sexual orientation, age, education, and income impact the client's lifeworld and intersect with their conditionalities. Second is by recognising that the dynamics of the therapeutic relationship between the occupational therapist and client must go beyond individualistic practice approaches (Laliberte-Rudman, 2021). This implies the activation of social transformative practices where inequities in occupational participation are seen as social and contextual rather than individual issues requiring the disruption of oppressive structures through emancipatory and participatory OT practices. Countering ableism can commence only when we fully appreciate how OT

practices can be socially and contextually situated and when we intentionally integrate justice-oriented lenses in our knowings, doings, and sayings.

Implications to Occupational Therapy

After discussing the conceptualisation of ableism within OT practice, we also need to recognise that OT is an evolving profession. As we enter the twenty-first century, our profession is acknowledging more challenges, and is warranted to promote the consideration of pluralistic viewpoints before enacting professional policies and local practices. The practice examples that we have outlined are non-exhaustive and personal. It is not our intention to generalise or impose our thoughts and experiences on other practitioners. Rather, we hope to initiate a discourse on this intersecting area of study (ableism and OT) to inform and aid the OT profession in its evolution. Hence, we synthesise how OT practitioners can transform their day-to-day knowings, doings, and sayings framed by the OT process:

1. (Evaluation) Listen to the disabled person. See the larger picture, not just the stereotypical disability by assessing beyond the client factors and their occupational participation. Yet, in doing so, acknowledge and conscientiously assess their environment and context, including their family and community;
2. (Intervention) Provide services that can conform and accommodate to the needs and time of disabled people such as having a flexible goal that positions their interests. Maintain an open communication with the client-partner and promote flexible time management;
3. (Intervention) Allot protected time to pause and reflect on the interventions performed, client-therapist interaction, and the overall service delivery. Be mindful that context can change over time, so regular communication with the client and family is crucial. Keep a personal journal to jot down your thoughts, experiences, realisations, and questions. Process them as guided by the seven-step framework for critical analysis. Furthermore, bring awareness and discuss with your colleagues that ableism can take many forms. Discern and challenge when ableist practices are evident in one's practice and/or workplace. It can be helpful to discuss this with a trusted colleague/mentor. However, depending on the gravity of the concern, concerns can also be communicated through the ethics committee. Communicating concerns to proper channels may facilitate how these can be translated into actionable items for the improvement of service delivery;
4. (Intervention) Reimagine occupational participation beyond social and normative conventions such as promoting disability art, dance, and sports that can be available in the community, disability affairs offices, and non-profit organisations;
5. (Intervention) Create linkages with the community, professional services, and other opportunities that the disabled person can benefit from. This also includes having a social group virtually or physically;
6. (Outcome) Refocus outcome measurements from mere efficiency and independence to personal meaningfulness and subjective acceptability of performance and participation in occupations;

7. (Collaboration) Position disabled people consciously as experts on things concerning them by including them to be guest lecturers in OT courses, co-planning with them in program development, and co-working with them in developing a research protocol;
8. (Collaboration) Co-advocate with disabled people when it comes to raising consciousness about ableism and ableist practices and how these can be disrupted and dismantled to promote inclusive and justice-oriented practices.

Conclusion

OT is an evolving profession. Without critical reflection and reflexivity, OT can potentially reinforce ableist practices that become practice patterns shaping the profession away from the holistic and person-centred principles that it promotes. In this article, we discussed the concept of ableism within the OT context and provided various forms and examples of how ableism is demonstrated across the OT process. Based on the authors' experiences and insights, although limited and personal, a curation of proposed non-ableist practices is presented to instigate micro-transformations towards a more inclusive, participatory, and transformative practice for occupational therapists locally and globally. We aim to illuminate these ableist practices to raise consciousness and invite scholars, practitioners, and policymakers to engage in an ongoing discourse regarding the topic.

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