We Are OT

A Brief History and Personal Narratives of Diversity within Occupational Therapy

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First Edition

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Dedication

To each and every diverse occupational therapist - you make our profession better!

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Why We Are OT?

Featuring narratives from Occupational Therapists from a range of ethnic backgrounds, sexualities, disabilities and other diverse identities. Inspired by the Black Lives Matter movement, publishing in ADHD Awareness Month and on World OT Day - 27th October 2020. It also precedes this year's UK #OTWeek - 2nd - 8th November 2020 which has the theme "Securing the future workforce and increasing diversity within the profession".

Presented in a range of formats from poetry to occupational analysis, personal career narratives and fiction, to a game of spot the job advert discrimination.

Answers the question: What are the benefits of diversifying the Occupational Therapy workforce for the populations we work with?

With reflective prompts after each entry this is designed to engage critical reflection of your practice and support you to engage in diversifying the Occupational Therapy Profession.

People are encouraged to share their own narratives and reflections on their blogs and social media using the hashtag #WeAreOT.

Because Occupational Therapy is only as good as the people delivering it.

We Are OT!

Why Now?

2020 has been… a year!

Firstly who would have predicted a pandemic? Actually quite a lot of people, but moving swiftly on. Our lives have well and truly been disrupted and inequalities have been thrust into sharp focus once more.

Secondly the Black Lives Matter protests following the killing of George Floyd. We all knew police brutality happened but, seeing the video and then hearing the denials from others, made it more urgent to act than ever before. Especially frustrating was the - 'well it's not like that in the UK' - comments. Maybe it's not as blatant, though to those experiencing it, it certainly is. But actually structural racism, institutional racism can be more difficult to overcome, because it's hidden, it gaslights and it helps maintains the status quo. I think Ed Sum's poem on Viewpoints sums this up brilliantly.

Finally my own personal experience. I am a white, middle class, heterosexual woman, but I also have a number of health conditions and I do tick that disabled box (though it took a while for me to accept that I did). I believe I have experienced discrimination as a result, though I acknowledge my privilege too. Experiencing even a small amount in comparison to those who experience injustice on perhaps a daily basis has forced me to wake up.

It's not enough to not be racist, ableist, sexist, transphobic, homophobic. You must be anti these things and actively work to challenge such attitudes and behaviours no matter the size of them. I wanted to move from being a keyboard warrior and take some more direct action, but as you will see in my narrative I have my own struggles so I needed to help in a way that made sense to me and that led me to books and reflective practice. I definitely did not want this to be a white saviour moment but the BLM movement forced me into speaking up against all discrimination. As my lived experience is only as someone with a disability, so I sought input from people from other disadvantaged groups. Together we co-hosted a series of twitter chats. Please find the links to the introductory blog posts below (the chat transcripts should

also have been added). I think of these as an appetiser to this book.

Improving Representation in Occupational Therapy series of #OTalk

BAME [Black, Asian, Minority Ethnic] (21/07/2020) - https://otalk.co.uk/2020/07/13/otalk-21st-july-2020-improving-bame-representation-in-ot-otalk-diversity-in-ot-series-uk-focus/

Disability (25/07/2020) - https://otalk.co.uk/2020/08/23/otalk-25th-august-2020-improving-disability-representation-in-ot-otalk-series-uk-focus/

LGBTQIA+ [Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual] and Gender (27/10/2020) - https://otalk.co.uk/2020/10/20/otalk-27th-october-2020-improving-lgbtqia-and-gender-representation-in-ot-otalk-series-uk-focus/

Please do add 8-9pm GMT on 15th December in your diaries and join us on Twitter for an update on our individual and collective progress so far and a to take a look at Key Priorities for Action in 2021. Follow and join the conversation using the hashtag #OTalk.

I hope to see you there,

Kirsty

A Brief History of Diversity in the Occupational Therapy Profession in the UK

Some key dates from https://www.rcot.co.uk/about-us/our-history

1932 The Scottish Association of Occupational Therapists (SAOT) is founded.

1936 The Association of Occupational Therapists (AOT) is founded for England, Wales, Northern Ireland.

1974 The British Association of Occupational Therapists (BAOT) is formed from a merger of AOT and SAOT. The British Journal of Occupational Therapy is launched.

2017 HM The Queen grants COT a Royal charter to become the Royal College of Occupational Therapists.

In this section I'd like to have been able to add in detail of when the first BAME OT qualified, etc, and then add figures on how diverse the profession is now. So that we could have seen how far we've come, and how far we have still to go.

I sent the following request to HCPC and RCOT requesting data on the diversity of the Occupational Therapy Profession.

I'm putting together an ebook to launch on World OT Day "We Are OT" to explore Diversity in the Profession.

I am hoping someone could help with facts and figures around this in terms of registered OTs. If you have historical information this would also be appreciated to explore how the make up of the profession has developed over time.

We are exploring diversity in terms of BAME, LGBTQIA+, OTs with disability and gender differences so any information you have that could be useful in relation to these aspects would also be appreciated.

Thank you for your time and help with this.

Kirsty

Response from HCPC

Thank you for your email of 11 June 2020, sent to our Registration Department, in which you ask for information on diversity of occupational therapists. Your email has been passed to me for reply.

Your request has been handled under the Freedom of Information Act 2000 (FOIA).

We are unable to provide ethnicity data as the HCPC does not hold any statistically significant ethnicity data on any of the professions.

Regarding your request for the number of occupational therapists who have declared LGBTQIA+ or a disability, we are unable to provide you with this information. This is because the information is not held in an easily accessible format. To provide you with this information would require us to manually review each occupational therapist's registration record and extract the information you have requested. This would exceed the appropriate cost limit under Section 12 of the FOIA.

Staff time can be charged at £25 per hour, this equates to 18 hours before the limit is met. On 1 June 2020, there were 40,162 registered occupational therapists. We estimate to access each record and extract the information you have requested would take approximately 2 minutes per record. 40,162 multiplied by 2 minutes equates to 1,338 hours, therefore exceeding the cost limit.

The gender breakdown of occupational therapists is as follows:

Female = 36,949
Male = 3,202
Unknown = 11

My Reply

Thank you for your reply. I find this quite shocking and wonder if perhaps you could feed back to the council a need to start collecting data in a way that it can be analysed and explored. I have been to our professional body, who I know do collect more meaningful data on ethnicity, but it isn't complete as not every OT is a member, whereas every OT has to register with yourselves to practice.

As you are aware, in the wake of the current #BlackLivesMatter Movement and the unequal affect that covid has had on BAME members of health and social care this will rightly be gaining more attention. How can we address inequality in how members of the public are represented in the staff that provide their health and social care, if we have no accurate statistics on this representation, and in terms of other protected characteristics such as gender and sexual identity and disability.

Thank you for your time and I hope in future this sort of data will be more easily extractable.

Their Response

Thank you for your email of 15 June 2020. I raised the matter with our Policy & Standards team, who ask that the below response is sent to you.

Many thanks for your helpful comments with regards to the collection of EDI data of our registrants. I would like to assure you that this is an important area of focus for us in our work.

Overall, the HCPC intends to garner a more holistic and transparent picture of the EDI profile of its registrants, employees, and partners as a whole, in order to identify and take action to address any potential discrimination, harassment, and/or unconscious/conscious bias.

In December 2019 we launched our first annual, voluntary survey of our registrants to establish a stronger base of data on registrant's EDI information (including ethnicity). The responses to the survey mean we hold contemporaneous EDI data for 5.4% of all of the professions on the Register. However, it is important to note that the response rate varied quite a bit by profession and by gender. So far, we have undertaken some initial, high-level analysis of the EDI data collected to establish if there is a sufficient sample size to be considered representative of the wider registrant population and to assess the feasibility of commissioning external research on the data. We will publish the research brief calling for proposals from external researchers within the next month on our website and plan to report on findings to HCPC's council in December 2020 (which will be published on our website).

We are concerned 5% isn't a high enough proportion of the Register to be truly representative and so have asked professional bodies to support

us in encouraging registrants to complete the survey. We have also engaged other regulators to establish what other methods might assist us in increasing this figure to a reasonable level in future annual surveys. This has included learning from the NMC's and GMC's approach to data collection and supporting communications campaigns. We plan to undertake a targeted campaign with registrants later this year, to boost participation in the survey which will be launched in late 2020/early 2021.

I hope this provides some reassurance that we recognise the importance of this and are committed to improving our work in this area.

Response from RCOT

Unfortunately I did not receive a response from the general email address that I sent the request to, however I did not follow it up or make an official FOI request, though I know others that have, and have briefly caught sight of the data they hold on ethnicity. It shows we need to do more.

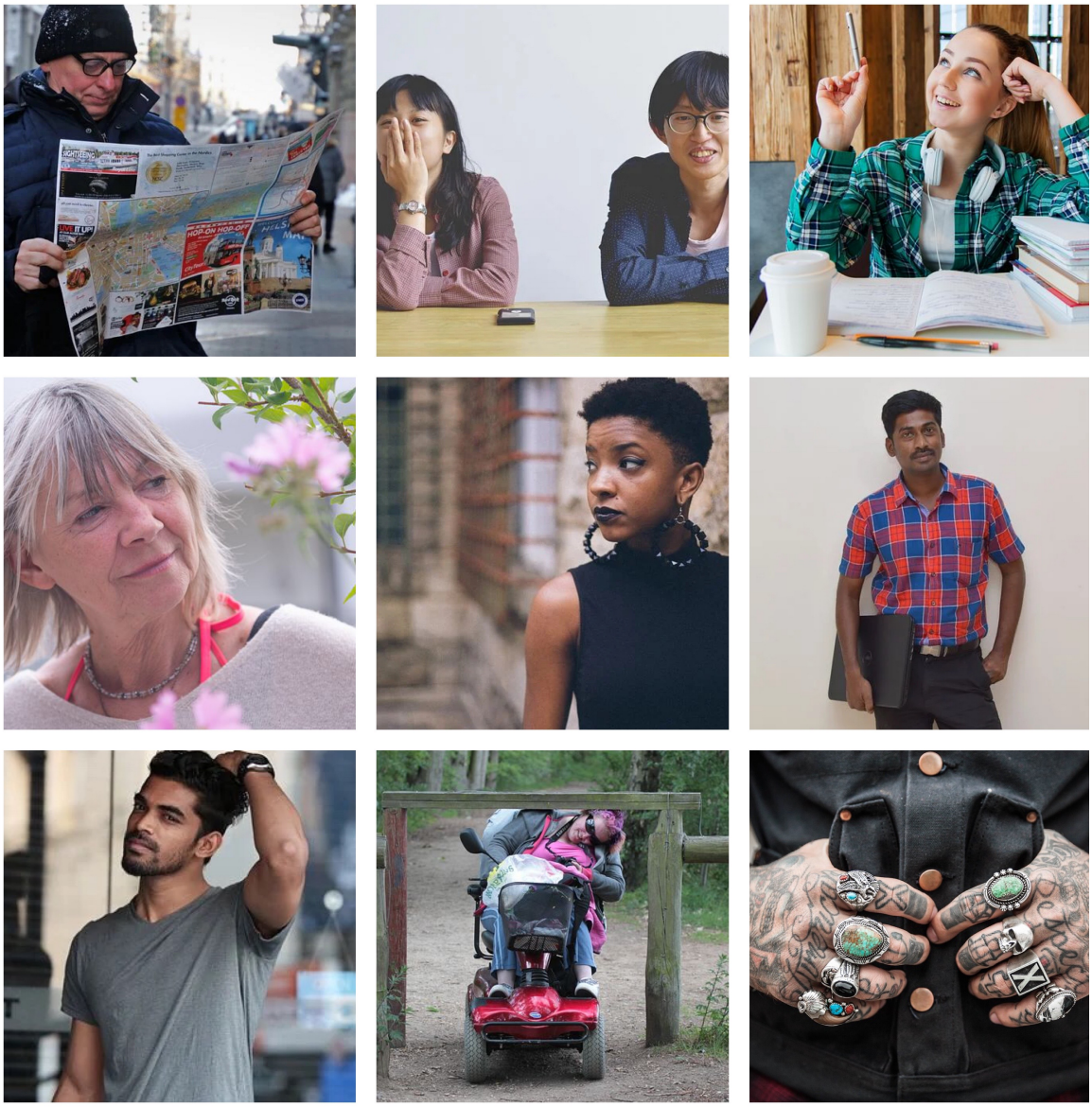
RCOT held the BAME big conversation on 6th July 2020, and on their Equality, Diversity and Inclusion webpage you can see their response to the Open Letter they received from a group of OTs. Sadly I now can't find the page on any of the top level menus on the website but it does exist and can be found here. **https://www.rcot.co.uk/equality-diversity-and-inclusion.**

So in short, this history is very brief. If anyone knows of any other data that would help us build a better picture of the diversity of the profession in the UK then do send it my way.

Or, when that survey arrives from the HCPC please make sure to complete it.

Where Am I Now?

Look at the picture below (Image of a range of different people). Who in this picture could be an OT? Are there any that couldn't? If any of them turned up to work with you what would you think? Be honest with yourself. This reflection is for your eyes only.



Attitudes and Unconscious Biases

Free write your thoughts on the following topics in relation to the OT workforce:

Ethnicity Disability Sexual Orientation Gender Identity

Neurodiversity Polyamory Obesity Mental Health Religion

How to use this book

I have tried to create a story through the book so I do think it is best read in order however you should also be able to dip in and out of sections as you want.

You could read it through fully, jotting down very brief responses to the reflective questions and then go back and explore each in more depth.

Or you can take each narrative in turn and take time to respond to the reflective questions in detail, referring to other resources to increase your understanding.

A Note on Privilege

When you ask someone to 'check their privilege' there is a tendency toward defensive responses. Usually that the person in question isn't racist, ableist, sexist, transphobic, homophobic, etc.

All 'to check your privilege' means is to consider the following: does any part of your personal make-up or identity give you preferential treatment or access to certain parts of society, over someone that does not have that identity or characteristic.

It doesn't ask if you are complicit in enacting that privilege but just gets you to acknowledge that it exists, and can therefore disadvantage some people.

Intersectionality is the idea that these aspects intersect to create someone's lived experience and acknowledge that some people can be doubly or triply oppressed within society purely through the circumstances of their birth.

You may find this resource on Privilege and Intersectionality helpful: https://guides.rider.edu/privilege

Visible differences

You will see in some of the accounts that follow, that disclosure comes up as an issue, but being able to choose whether or not to disclose certain information about ourselves could in itself be considered a privilege, although people with 'hidden' or 'invisible' differences talk about the concept of masking, that is, hiding one's true self to 'fit in'. But this often comes with a psychological toll, including burnout. This is often referred to by neurodivergent people such as those with autism. https://boren.blog/2017/01/26/autistic-burnout-the-cost-of-coping-and-passing/.

Be Aware of Microagressions

Those throw away comments that aren't necessarily intended to cause harm that highlight someone's membership of a disadvantaged group. See https://www.vox.com/2015/2/16/8031073/what-are-microaggressions.

Personal Accounts from UK OTs

Where Are You From? Will They Want Me? - *Ed Sum*

Where Are You From?

"Where are you from?"

Four simple words;

Four short words;

A simple, short question…

How do I answer?

What do they want?

Are they being racist?

Just interested in me?

Is it my accent?

What do I say?

How do I answer?

Parents from Hong Kong?

From the health service?

The community rehabilitation team?

The Occupational Therapy team?

"I am from Nottinghamshire."

Will they want me?

I am gay. I am an Occupational Therapist.

My parents didn't want either.

I am a gay, Chinese, cis-male Occupational Therapist.

Will my service users want me?

Questions to prompt reflection on Ed's poems

1. 'Where are you from?" sounds like such a simple question but think about how it could sound to others who have experienced this question before as a microagression. What alternatives could you use?
2. What do you need to consider when a supporting colleagues in situations where they experience discrimination from service users?
3. How do these poems make you feel?

Occupational Therapy and Me - *Somia Jan*

This is Me

My name is Somia Elise Jan and I am an Occupational Therapist.

It's June 2020 and I am absolutely devastated by the current events around the world with regards to race. I simply cannot comprehend how, in this day and age, you can still be brutally murdered or targeted and bullied, all because of the colour of your skin. Unfortunately though this is not a one off incident. It is just one that has fortunately been caught on camera, and I do say fortunately, because I think it is forcing the world to open their eyes to racism that is happening EVERYWHERE and EVERYDAY.

During this period of the #BlackLivesMatters movement I have been forced to reflect on my own experiences of coming from a minority background, I am of a dual heritage, English (my mother's side) & Pakistani (my father's side). I must stress at this point I do not want to take anything away from this powerful and overdue movement, however it has forced me to identify with some of my own experiences that I have perhaps suppressed, both the positive and negative. I think that this

suppression is part of the problem minority's face, and an important aspect of this movement. We often accept that in some situations we will be treated a little differently, but why? Why do we accept this? I'm sure if we are more open with our experiences we'd be welcomed? Or maybe not! But, if we aren't, we can address this and challenge and implement change.

I have made the decision to push myself out of my comfort zone and share my journey into becoming an occupational therapist as an attempt to spread awareness of both a culture and a profession I am immensely proud to be a part of. I hope sharing my story will reach others who are struggling on their journey and to remind them they are not alone. I hope it helps attract more minorities into this wonderful profession because we need you and your uniqueness more than you know.

The Journey

(Please note this is just my experience and I am not generalising a whole culture)

Choosing a university degree: During my time at college, whilst undertaking my A levels like my peers, I was studying with a view to attend university. However the path I was 'supposed' to take was not that of Occupational Therapy. Originally I was meant to study Pharmacy, I know what you might be thinking, how did you switch from Pharmacy to Occupational Therapy?

The dream of becoming a pharmacist was not my own but more of my father's (he meant well). Culturally there is an unspoken pressure within the Asian community that the women either stay at home, or go on to become successful. However successful is only recognised in limited forms such as a Doctor, Pharmacist, Lawyer etc.… I remember writing my personal statement to apply for pharmacy courses, and even volunteering in a pharmacy to get experience. One day it hit me, I did not want to do this for a living, whilst I respect all that our pharmacist colleagues do, and this just was not a job I could enjoy getting out of bed for.

I had personal experience with an Occupational Therapist which is how I knew about the profession. I decided to seek further voluntary experience to ensure this was the path for me. Spoiler alert - it was! I fell in love with the profession instantly. I loved everything it stood for, person centred, goal orientated, and just an overall feeling of wanting to make a difference for people within their everyday lives. So I made the

decision to sit down with my father and tell him I was no longer pursuing pharmacy as a career. It was not as simple as sitting him down, I was anxious and delayed this for as long as I could. I felt like I was letting him down somehow. Unfortunately when I sat him down and had the conversation about MY future my fears were confirmed. He did not support my decision and could not understand why I would want a job that is unheard of and not as well paid. Despite my efforts to sell my decision to my dad it was not well received and he believed I was making a huge mistake. The reason I am including this in my story is not to blast my father because he is an amazing man, and he now sees the reason behind my decision and whole heartedly supports me and is proud of me. But the culture he was brought up in created this idea of what my life should be like. Before I'd even begun my course I felt I was in a battle against this expectation, as I was also the first female from my dad's side of the family to go to university.

*During the summer before I started university I made the decision to wear a Hijab (headscarf) for religious reasons.

First day of university - September 2013: I remember walking into my first lecture, my heart was racing so fast - I was so nervous, although I'm certain this was a shared feeling. I remember looking around the room to see my new cohort (of around 60). I distinctly remember seeing a range of ages, but not a range of colour within my class. This instantly left me feeling isolated. As the morning continued I felt myself naturally drawing towards the 3 others students of colour (note: one of these students left at the end of first year to pursue a different career). Although I got closer to other students over the course of the year, I would be lying if I said I didn't spend the majority of my time with the other students of colour. Honestly I don't recollect any negative experiences from either fellow students or lecturers, which I know is fortunate from speaking to others. I think in my first year I was my own biggest oppressor, in terms of not stepping outside my comfort zone, and I don't entirely know why.

My first placement: When it came to my first placement, which was in a high secure male unit, I remember feeling physically sick and genuinely petrified around how service users might react to me wearing a hijab. Would I be safe?

I remember going on my pre-placement visit and sheepishly asking "Will the patients try to strangle me with my own scarf?"

I think this was a combination of anxiety around being in the

unfamiliar setting of a high secure unit and my own anxieties about responses I might get for wearing a scarf. My educator was lovely and reassured me where she could. She was not aware of any other staff members who wear the hijab but, advised I tucked my scarf in as a precaution. Again, fortunately I went through the placement with no problems from staff or service users, and in fact my hijab sparked off some nice conversations with both staff and service users about Islam. Mainly around the purpose of wearing the Hijab, which is around one preserving modesty and privacy. There were also some questions around my name and the meaning (Somia is an Arabic name with the meaning ‘reserved; skill; truthful; divine’). No-one within the service to my knowledge was Muslim and until recently I was not aware of any impressions I may have left on the service users. But I recently dug out my old placement books and read the following feedback ‘’Somia has been able to establish good rapport with clients and the immediate team. She has always appeared open and honest in her approach and is willing to work with a variety of clients from various backgrounds without discriminating’’. Reading this back has made me smile because this is everything I strive to be now, and I guess at the time this was written I did not fully appreciate this skill I had developed.

University experience continued: During the summer of 2014 I made the personal decision to remove my hijab. I did this for many reasons but, primarily I felt I was not doing the hijab justice as I was not practicing all elements of my religion. So for me personally it did not feel right to wear it at that time. Therefore during the remainder of my time at university I was not wearing a hijab. But no one really asked about this, and this is not something I really addressed, other than with my closest friends and family. Looking back I am surprised this was not brought up in passing conversation, but this perhaps links into people being scared to ask personal questions.

Whilst I had no negative experiences wearing it, I felt a sense of relief, almost like I fitted in more with my cohort. I spoke to more people in the remaining years. I don’t think this was because others could approach me more easily without the hijab, or maybe it was. I can only comment on my feelings at the time. Without my hijab I oddly felt I was able to speak out more freely and have more conversations.

This has left me feeling uneasy as I have gotten closer to my religion. I realise I should never be ashamed of my religion, in fact I should be

proud, and I am. This is something that has come to me over time and through personal growth.

Throughout the rest of my time at university or on placement, particularly after removing my hijab, I wasn't really asked about my religion/ culture. I'm not sure if this is because, on the surface, I do not look like I am of mixed ethnicity as I am quite pale skinned. My name however would generally spark some conversation. Mainly discussions around how to pronounce it (so-mee-aa or so-mia, if that's easier). This brings me on to another subject; in some situations I have shortened my name to Mia. For whatever reason, people generally struggle with my name and I have found it really difficult to continually correct them. Somewhat ridiculously, I feel I am being rude if I do, so I just either let people pronounce it wrong or shorten it. Unfortunately this is still a problem for me even today, although I feel I make more of an effort to correct people I am meeting for the first time, but if after a few attempts they still say it wrong I almost just allow it. I can be in a group of people who all say my name differently which then sparks the ' am I saying it right?' question to which my reply is always the same 'no, BUT I will answer to anything' and then an awkward laugh. I should make more effort to correct people but it sometimes feels like people are not really that interested in hearing how to say it properly.

Life as a qualified Occupational Therapist: Since qualifying in 2016 I have worked in a range of settings across physical and mental health, and I have worked with some amazing colleagues. But like during my university experience I have barely come across other Occupational Therapists of colour. Reflecting further I think within the physical areas I have worked in there has also been less diversity across other professionals. Within mental health I feel I have observed more diversity however I still feel within healthcare as a general, where I have worked, the staff have been predominantly of a white background.

Some days I find myself asking, why? Why are we few and far between? But then when I reflect on my journey, I think about how I found myself conforming for a lot of my educational and professional journey. I didn't really bring any attention to my uniqueness, which makes me wonder how many others are struggling with integrating their personal and professional identity. I am sure this isn't simply limited to just aspects of race or religion.

I have always taken pride in my ability to engage service users by

using their unique qualities, asking them about their cultures, beliefs and values. So important because they all impact on our occupational performance. If we do not ask these questions we are missing essential parts of these wonderful service users. How can we begin to understand what is meaningful to them if we aren't exploring this?

I love when people ask me about my religion, I love sharing that side of me, and now I offer information without being asked as I finally put an end to my self-oppression! I think the more I have grown professionally the more confident I have become in speaking up on behalf of my service users which has given me further confidence to speak up topics that feel important to me. Being qualified comes with a responsibility to raise concerns on behalf of our service users who might not be able to do so for themselves. This is something I personally found difficult to do confidently as a student as I did not want to appear 'cocky'.

I also think if we speak out more about our experiences, both positive and negative, we will attract a more diverse audience to our profession. To me, it is crucial that no one should feel like they can't do something because of culture or skin colour or beliefs. We can do anything we put our minds to! I think the more diversity within our profession the more approachable we are to a range of service users.

The present: My recent post is in Perinatal Mental Health. I believe I have been able to successfully support a number of mothers with my interventions using meaningful occupations that incorporate religion and culture. An example of this was a mother I had begun working with felt like she had lost her identity since becoming a mother and struggled to do things that were meaningful to her. By listening to her story and unpicking her interests I learnt reading around her religion was important to her, but she felt she had no time to do so whilst looking after a new born. We took what was meaningful to her and incorporated this into a co-occupation (something she could do with her baby), this was done by finding children's books that she could read to her baby. This left mum feeling like she was still connecting with her religion whilst sharing this with the baby, which were both important occupations to her. This led to her adapting many other aspects of the religion into co-occupations, such as praying and cooking. Upon completing our intervention she stated she felt like a newer version of herself.

I also think my background has helped me reach out to people who I believe would not otherwise have accessed services. Boldly, I assert that

this is because I am readily able to identify with their cultural needs. An example of this is within the Pakistani culture mental health is somewhat frowned upon and some families believe mental health conditions do not exist at all. The belief is that the person must have been given the evil eye from someone else (a gaze believed to cause harm a bit like jealousy), or that they have a Jinn inside them (spirit). Traditional interventions for both the above involve going to an Imam (Muslim leader) for support which can range from prayers been read to the person affected or advice on how to change their daily life, normally to incorporate the 5 pillars of Islam (1. Profession of faith. 2. Prayer (x5 daily). 3. Charity. 4. Fasting. Pilgrimage (Hajj)). Having this knowledge of my own culture has allowed me to enter homes and acknowledge the above but also to widen what the service user can access in terms of interventions. To see an Imam is not always available quickly and I often will say “why don’t we try some of X interventions alongside praying” for example and that has always been welcomed. I’ve used activity analysis on many occasions to support and enable someone to pray, and for some that connection with God is so powerful that this is enough, and where it is not by this point the family have built their trust in me and the service and are more open to seeing the wider MDT.

I’m still not wearing the hijab at work fully right now, but I’m working toward this by practicing my religion more, praying 5 x a day, learning about Islam and reading the Quran. I feel that by doing all of this when I do make the decision to wear it again I will be doing it justice as I will be practicing my faith fully.

I’m not sure if this has been helpful for others to read as I guess my experiences have been a little bit self-inflicted, but actually I believe the world around us has influenced me into thinking this way. It is easier to blend in than stand out. I share my story with the hope it reaches either professionals or students experiencing similar hardships. To those sat in a room full of people feeling completely alone, I say reach out. You aren’t alone in this and I believe together we will get there. It’s time to be open and share our experiences and to spread awareness of diversity in occupational therapy! Through this we can inspire others to join us in doing the same.

Thank you for reading. If anyone wants to share their stories or reach out I can be contacted on the following:

Twitter: @SomiaOT

Email: somiaelise@hotmail.com

This is also me

Questions to prompt reflection on Somia's story

1. Whilst training or working as an OT have you ever felt the pressure to conform? What did this look like and how did this make you feel?
2. How much do you ask clients about their faith, culture, religion and spiritually and how this affects their occupations?
3. What steps will you take to make sure you find out about these in future?
4. Think about your own views held on women wearing the hijab - how has Somia's story affected these?

5. Somia very clearly describes her therapeutic use of self here - her own intimate awareness of her faith has helped her connect to others and meet them in understanding where beliefs may initially provide a barrier to effective care. Can you see the benefit of having diversity within the profession to enable us to better serve the diversity within the population?

You're an OT! - *Michael Osborne*

I am a British born black male I have been a practising occupational therapist for fourteen years. I currently work in an inner city borough that boasts of a diverse population in that more than 55% of the borough is made up of ethnic minorities. This was not a primary factor in my decision to work there. That was purely based on geography and travel distance. The Trust I work in covers four London boroughs and I felt it was better to work in a borough different from where I live as I work with clients with mental health. I did not want to view my borough through the lens of mental health and wanted to maintain a boundary, which was a personal decision.

When I was exploring my career options I was drawn to the philosophy base of the profession and it seemed to organically align with my own core values and principles. My career journey started when I volunteered for a foreign exchange programme called "Camp America" where I secured a summer position working at a special needs camp. These camps offered respite and rehabilitation using a daily activity therapy programme in rural areas. I enjoyed the experience so much as a counsellor that I returned to America for the next five summers working in different special needs camps. I progressed my role to Head Counsellor with responsibility of managing a cabin with a different weekly cohort. In retrospect it was the equivalent of managing an in-patient ward. Whilst gaining these practical experiences I wanted to learn more about mental health and physical disabilities and applied to do a BA in Psychosocial Studies. Whilst I learnt to study I was still unsure of my career path. I had been fascinated by the story of Diane Fossey who was a primatologist and her story was told in the movie "Gorillas in the Mist". I had no interest in her career but was intrigued by the diversities of careers and knew that I wanted to work overseas, helping a minority population and not be in a standard 9-5 job. I was still intrigued by the work she did with gorillas but did not understand it at the time. I went to a Voluntary Service Overseas exhibition (VSO). I was fascinated by the amount of positions available to work overseas and instead of sending money and food, they strive to send people and experience. I wanted to replicate the summer experiences I already had and so I looked at the positions that were in demand and seemed instinctively drawn to occupational therapy. I then read an article they

had called “Introducing occupational therapy to Bolivia” and immediately knew this was what I wanted to do. I did further research into profession and visited several services. Unfortunately I had discovered this whilst I was in the second year of my first degree. So I completed that and then decided that I would study part time whilst employed in a relevant field. So I worked as a rehabilitation assistant completing two NVQ’s in Health and Social Care Level 1 and Promoting Independence Level 2, before starting my OT training. I later read an OT article about Diane Fossey who it turns out was an occupational therapist, and then it all made sense why I was drawn to the movie and it affirmed that this was the perfect career choice and I was meant to do this. I felt like I spent a long time searching for the exact career and knew what I wanted to do but did not know the name. Once I found out about it I surrounded myself in environments and situations where I was fully supported and encouraged by work colleagues

It wasn’t until I started my training that I noticed that the profession was dominated by white middle class females but this did not deter me or affected my view of the profession. I ironically would listen to comments that I was in a unique position because I am a black male and therefore would be an asset to the profession and some would say it would give me certain advantages afforded to me because of my male privilege and if such a thing exists in today’s climate – black privilege.

However this was not my experience when it came to entering the competitive employment and rightly so I feel I was judged on my ability as opposed to my skin colour or gender. I have chosen to specialise in mental health and have been mistaken for every other profession but my own. When I entered the OT department on my first day and introduced myself, I was asked if I was the barber. I later learned they had a black man offering a barbering service for mental health clients who was due in that day. Hence the mistake but I often found on the wards that I would be asked if I am a nurse, or support worker, or social worker or carer and these are by colleagues and family members

I have often found myself in situations where I am the only person of colour but this does not make any difference to me as it is what I have experienced my whole life from being the only black child in my primary school to the only black member of staff in a working environment.

I often can see the surprised look on people’s faces when I introduce

myself as an occupational therapist and few have the "courage" to mention this directly expressing an agreement that it is nice to see a person of colour in the profession. The only time I have been able to positively use this to my advantage was to volunteer as a health ambassador, a scheme provided by Health Education England which requires a commitment to visit local schools and give a presentation on my career journey.

I have volunteered in a variety of capacities and each provided a unique experience. There were some schools that operated a kind of speed dating approach to learning about careers. In that environment a group of eight pupils would come to my table and I had about ten minutes to answer their questions but to tell them about my profession. Most of these pupils were from ethnic backgrounds with limited knowledge of the careers in NHS with many citing nursing, or doctors. However I was able to relate my profession to them personally by asking them about their hobbies and how they would be able to do them if they sustained a physical or had a mental impairment. By making it an interactive session I was able to get across my role in a way that was meaningful to them in a simple way they could understand as each pupil represented a different year group, which meant tailoring my presentation to meet their needs. When I was growing up this would have been exactly what I needed to learn about the profession and seeing someone like me would have made that easier. When I left school based on my grades the only options that was offered to me was to work in a shop. So that is why I feel passionate about this volunteering role because it is about providing pupils with the vast array of careers that are out there and being able to give them a chance to learn what they have to do to gain access.

The importance to a client is obvious but is not openly discussed. It seems that people of colour are able to align themselves and build rapport very quickly but this is often inferred and unspoken. I have had occasions where a black client did not want to be seen by me and requested a white therapist. I realised that for many white people in these positions represented the status quo so being black it came across to some clients that they did not believe in your skills or ability and so you would have to prove you were equal to white counterparts

This sends an indirect message that I am a black occupational therapist and I am introducing a profession to students who might not have considered this as a career or even heard of the profession. I have even

had students of colour who I have had on placement later confide in me that they felt immediately more comfortable and relaxed when they saw that I was black. The reasons for this can be inferred. It was never a situation where it was discussed at great length but there was an understanding which we both knew. The inference is that we could eliminate any cultural encounters by not having to explain behaviours and attitudes associated with people of colour unless it came up as a particular area of discussion in relation to discussing assessments and how to address cultural needs.

I had very supportive supervisors on placements who openly seemed to embrace and welcome me into the profession both as a male and by being black. Sometimes I would be with my educator who would be white female and clients would speak to only me thinking I am the doctor and ignore my educator.

The caseloads had a large proportion of clients who were black so I was easily able to identify with them but also address issues in a way a white therapist may miss. One example I can think of was working with an OT from Australia who assessed a client making rice. She was about to score him poorly as having deficits in many areas until she asked me how I would make the rice. When I told her which was exactly how her client made it, it then made her re-evaluate her assessment.

I will say for the most part it is what it is. My client group reinforces to me why it is important that they see themselves reflected in the professionals who are treating them. This does not seen that it does not come with its share of challenges and discrimination but for the most part it is a profession that I am very proud of and should continue to welcome diversity in the profession. Given the history of the profession being founded by white female, it seems to have inherited through the ages the stereotype of “basketweaving”. The majority of interventions are around meal preparation and cooking which are predominately female tasks based on stereotyped roles so I have had to face challenges in relation to justifying my interventions but challenging the stereotype by making activities more relevant to patient experience. I think when I look at the assessments that are used, there is very little that provide an opportunity to explore diversity and I have found that a skilled person of colour would be able to highlight the concepts in the assessment and expand based on who they are whether they be a

therapist who has a protected characteristic.

Questions to prompt reflection on Michael's story

1. Michael says people have "courage" to point out his colour in relation to being an OT. Do you have the courage to raise discussions of diversity, or the lack thereof in your department? Could you add this to your next meeting agenda?
2. "It is what it is"/I am used to being the only one - in 2020 do you think that our colleagues of colour should have to simply accept the status quo?
3. If you are a white therapist have you considered how students of colour might feel coming on placement with you? How could you help to allay any fears they may have?
4. Michael makes a very useful point about the message that we give out to schools, young people and wider society about the make up of our profession. Can you review your promotional material to make it more diverse/representative?

Michael actually reflected on these points himself too and I thought his

response made for interesting reading.

The recent black lives matter has prompted debates and encouraged conversations and these have been difficult because it forces people to think about notions of white fragility and white privilege which may be unknown concepts. People do not want to be seen as racist but it is about demonstrating anti-racist practices. I use the word courage as I feel people skirt around the issues in an effort to not offend. I am offended when I'm told by people that they do not see colour, they see me. Whilst I understand the sentiment, you have to acknowledge my colour. (While working in America, I worked in the kitchens of another camp with a staff of black American males and Eastern European staff. One black male had an altercation with a gentleman from Poland. He came downstairs where we were all eating breakfast and when we asked him what was wrong he said "He can't stand these f********** blacks" Everyone was shocked because he was ranting and raving while I was at the table and I could feel the sideways glances in my direction. He looked me right in my eyes at one point scanning the table and carried on. In that moment I realised he did not see my colour because I am from Europe and he saw Michael and afterwards when we had a conversation it was confirmed and he was horrified trying to apologize saying he meant it towards the American blacks. Was I supposed to feel better?

It is what it is?

It sounds defeatist but growing up a minority and seeing subliminal messages where you are seen as a stereotype or you are nor represented, made me feel powerless to influence or make any change. Where I have found I am making a difference is by simply being the best version of myself using all the resources available to me as my right as a British citizen and I often used OT as a personal journey in that I fit many roles and identify with many groups so being in places and doing things that no other black person does means that I am representing and making a difference.

Your third learning point I am trying to imagine if it was said the opposite way. How would I allay the fears of a white student on placement with a

black therapist? I tend to think that I come into contact with students from all over England and therefore have a different background to me. For me it is about introducing them and helping to establish the OT identity. They may have fears that relate to a stereotypical black man in mental health with psychosis so that would be a very specific piece of work that would be an excellent learning opportunity in understanding narrative, and history and trying to find commonality

I think promotional material should be representative of the profession but localised so….and I give a very random example e.g having a white woman lead a black minority strategy may not be received well in the same way as men making decisions about women's rights

Where Are My Role Models? - *Roslyn Walcott-Cumberbatch*

I started my career as an Occupational Therapist in 1998, however diversity was on my mind long before then. On my journey before becoming an OT I started by training to be a general nurse in the early 90's. I remember being asked by a group of African international students where did I come from? When I replied that I am English and was born in the UK, the response was "how can you be English when you are Black?…"

Moving from Coventry (my home town) to London for nurse training was a huge transformation for me at 17, but was also so exciting. One of the things I did love about London was the increase in diversity, seeing so many more people of colour. Nursing did not work out for me and I went in search of another career option. By chance I discovered OT whilst working as an agency nursing support worker on a mental health ward. I researched the profession and decided that was what I wanted to do.

OT Training

When I applied to complete my OT training I had wanted to stay in London, however that did not happen but, I got into Canterbury which was close enough. My first accommodation was in a place called Herne Bay, at that time the locals were all Caucasian (from what I could see). I remember people staring at me as I walked down the street, pointing at me like they had never seen a black person before. I stayed strong and kept my goal in mind.

On my OT course, there were two of us from a BAME background,

however my colleague decided to defer a year which left just me. When it was time to think about my dissertation I chose to look at cultural awareness in OT students. I guess it was because, when finding out about OT and starting the course, I was not aware of how white middle class and female the profession was. During my placements, I only met one black OT, who happened to be s senior clinician. I began to wonder what was ahead for me and wondered about the service users from a BAME background. I was often told that it doesn't matter if the OT was not culturally aware because the OT would ask the questions, however I was intrigued to find out what level of the knowledge the students had. The results from my research showed that of the OT's that took part in completing a questionnaire, knowledge of other cultures and religions was low. However, as I mentioned previously the response was it does not matter as we will ask.

In the workplace

I started my OT career with Lewisham and Guys Mental Health Trust, no surprise that I never saw any other OT's who looked like me. In 2000 the Trust merged to form the South London and Maudsley NHS Trust (SLAM). At that stage I came across a lead OT who was male and from an Asian background. In the OT department where I was based I met a black female locum OT, after that it would be several years before the OT profession in SLAM became more diverse.

When I started work I never imagined that I would end up in the position I am today. Maybe that was because I saw no role models so therefore felt like this would not be a possibility. As a basic grade (band 5) on rotation I preferred working in multi-disciplinary teams, this was mainly

as there was more opportunity for working with BAME staff from other professions, whom I could relate with. Again, working in inpatients felt better as there were many nurses from a BAME background, however I also became aware of the disproportionate amount of service users from a BAME background. Cooking sessions in the OT department were interesting as this was often when the difference in culture would became apparent. Examples were during food preparation when a client would want to wash their meat with vinegar and salt before seasoning it. Or washing their rice before boiling it. My white colleagues would often question why they were preparing the food in that way and look quite shocked.

As a service we were always looking for creative ways of engaging the local community. There was a time when we discovered a chef who happened to be a young black male. He was paraplegic and in a wheelchair. He had experienced mental ill health as a result of the accident which resulted in his physical disability. However over time he rediscovered his passion for cooking, after seeing how this helped him through his difficulties he decided to support others in his local community. As well as opening a small catering business he also developed workshops specifically aimed at young black males to motivate them and encourage them on their journeys. He came to the OT department at the Maudsley and facilitated food preparation workshops with male inpatients on the ward. Attendance from the young black males on the ward was high, which was not usually the case for attendance at OT groups. The feedback was positive as he was inspiring for the young men.

Support for staff from a BME background

I joined a black reference group which looked at inequalities and how we might tackle them. I had a growing desire to support other OT's and staff from a BAME background and of course service users. I presented my undergrad research at an OT mental health conference which was received well.

Recruitment

Over the years there was an increasing number of students from a BAME background who had placements in SLAM, and this was encouraging to see. However, the students did not seem to be coming through into the band 5 OT roles. As this was a concern to me I asked if I could be involved with the recruitment process. This ranged from being an observer on the assessment centres and then as I became more senior, sitting on the interview panel and chairing on occasion. As a BAME person it can be even more daunting at interview when you do not see anyone that looks like you. Having someone of colour on the panel can help with someone's confidence and let them know that the organisation is diverse. Professional language can be difficult for those whose first language is not English, sometimes how the questions are worded can impact on a person's ability to understand what is being asked of them. This still remains an issue across different professions and I have often provided coaching to support staff with answering interview questions.

I now have the pleasure of interviewing and recruiting many many OT's from a BAME background which is great to see. As an organisation we

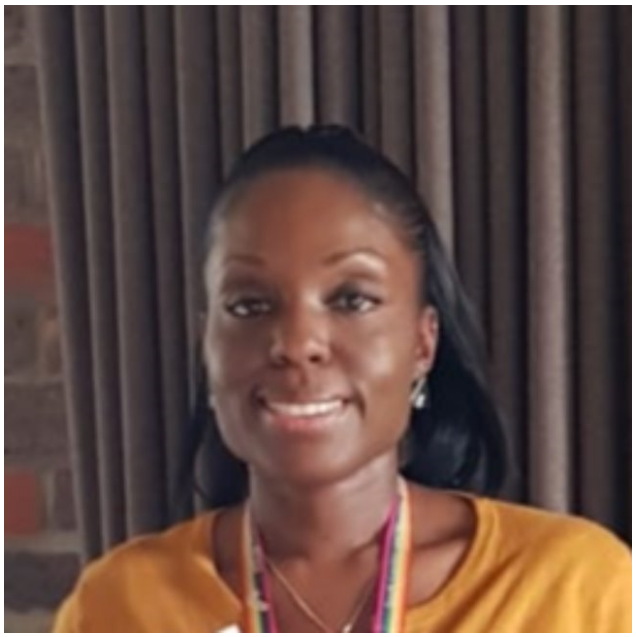
now have a significant number of BAME OT's within SLAM which feels right. We still have a way to go with BAME representation from senior leadership within our profession.

Progression

In 2016 I was the first black female OT to become an 8a within SLAM, I know that by achieving this I became a role model for many other BAME OT's who felt inspired and felt there was hope for achieving promotion.

I am an active member of the BME network forum, I mentor junior staff, I am a diversity in recruitment rep who sits on the interview panel for posts at band 7 and above, and most recently I sit on the executive leadership programme board to ensure equality is considered at all times.

I am currently on a secondment in an operational role overseeing promoting recovery teams in the community. A role which I am loving, I am in a position where I can influence decisions and still keep my OT hat on. I never thought I would reach the position I am in today and feel a real sense of achievement. I know as a profession and certainly within my organisation we still have a way to go with increasing the number of BAME OT's at band 7 and above. This has been acknowledged and hopefully plans will follow to address this.



Questions to prompt reflection on Roslyn's story

1. Who are some of your OT role models, and why?

2. What was the make up of your OT course? Was there someone like you, amongst fellow students, in the academic staff or as your placement educator?

3. What is your awareness of other cultures and religions? Is it enough to say 'we will just ask' the person? What examples given above show that might not be sufficient?

4.The story of the chef shows how we could work with others to meet that need for understanding where we don't possess it. Can you think of any situations in your service where you would benefit from this type of cultural input?

5. That's a few times we have heard about the perception that OT is full of white middle class women. How can we break free of that perception? What steps can we take to make recruitment and progression opportunities more inclusive?

Infatility - *Alice Hortop and Kirsty Stanley*

A conversation in poetry between Alice and Kirsty on fatphobia and infertility

Slight *Kirsty Stanley*

When you don't eat in front of others
"I don't want to have to order you a larger uniform"
When you know what they say isn't true
"Have you lost weight?"
When you haven't got the breath to speak out
"Let's do the stairs shall we?"
When there's much more to it than food!

Wearing Grief *Alice Hortop*

It surrounds me, inches pad my broken body,
As the fruitless years pass, the padding grows,
A physical barrier, consciously and uncomfortably worn.
Visible grief, heavy on my bones,
Heavy with judgement,
And the irony?
The unwanted padding of grief,
Traps you into the childlessness that caused it,
Fat people aren't allowed to be mothers.

Not Me *Kirsty Stanley*

"No, don't sit in that chair, everyone that does gets pregnant!"
Not me
"Who needs half-term off?"
Not you
"I'm not sure you understand, you don't have children."
Not you

Platitudes *Alice Hortop*

I know of a woman, 78, who had her first child recently,
All she did was relax.
I know of a woman, 84, who had her first child recently,
All she did was relax.
I know of a woman, 92, who had her first child recently,
All she did was relax.
I know a woman, a virgin, who had her first child recently,
All she did was relax.
If only you would stop wanting your heart's desire,
The child you imagined and hoped for over a decade.
Can't you just relax?
It's all your fault.
Relax. Stop trying, but keep trying.
… But I was relaxed at the start,
I even enjoyed trying once.

Be Careful What You Wish For *Kirsty Stanley*

You don’t want a boyfriend, they are more trouble than they’re worth

But what about the love and laughter

You don’t want a husband, they never help around the house

But what about the times they hold you tight when your world is crumbling

You don’t want a baby, they never sleep

But what about having something to wake up for

You don’t want a toddler, they are into everything

But what about the joy of exploring something through fresh eyes

You don’t want a teenager they act like they hate you

But who do they come to when their world is crumbling

Be careful what you wish for…

I know, I might never get it!

The Disney sell Alice Hortop

Like Cinderella's little mice sweetly singing,
"We will fix it".
You can have the dream,
.... If you can endure it.

There's no dignity in the cold clinic.
Baby pictures on the walls.
For the compliant and the patient.
… the ones who endure most.

Broken body clinically explored.
Lose weight.
The weight is my baby grief,
Heavier with recrimination.

There's no dignity in the warm conference.
Stories of available unwanted children.
For the compliant and patient.
… the ones who endure the most.

Broken life clinically explored.
Lose weight.
The weight is my family grief,
Heavy with recrimination.

All paths explored.

All paths failed.

They didn't 'fix it'.

No Disney 'happy ever after'.

Thin Magic

"Bibbedy Bobbedy Boo

an inch or 5 off for you!"

"Oh fairygodmother,

You've given me my heart's desire"

The scales strike target weight

"Back again I see

with a little more to thee"

"It turns out thin wasn't the panacea,

for a baby you need to grow."

Please come along to our #OTalk on 17th November 2020 where we will be exploring Fatphobia along with Sarah Merton.

Questions to prompt reflection on Alice and Kirsty's poems

1. My experience of infertility has shown me the need for positive discrimination and equity over equality, e.g. expecting people going through fertility treatment to be able to schedule time off for appointments in advance is ludicrous, when you are at the whim of your hormones. What is your understanding of the terms: equality, equity and positive discrimination?
2. Obesity and fatphobia is rife within society, just look at the war on obesity during the pandemic, without an acknowledgement of the understanding of the complexities that lead to it. What's your experience of fatphobia?
3. How do these poems make you feel? What have you learned from them? And is there anything they will make you do differently in future?

Different: Not Yet Diagnosed - *Kirsty Stanley*

I am pretty much an open book and have spoken about much of this elsewhere online but I thought I'd bring it all together here.

I've always been a little bit different and I've had my fair share of healthcare appointments.
Thank you NHS.

Thought some tablets were sweets when I was two. Panicked the parents.

Had whooping cough despite having the vaccine.

Developed asthma. Was good at swimming, but I never got the job as a lifeguard because I couldn't hold my breath for long enough underwater. Also got disqualified doing butterfly because my hands never entered the water at the same time.

Got called Kirsty cry baby by a teacher in primary school.

According to a school report was clumsy with scissors and glue.

Tight hip tendons as a teen. Had physiotherapy.

Bloody periods!!

Can sleep for days and then..

Wrote my dissertation in 48 hours with no sleep! I am excellent at procrastination, seriously, I could win medals. In fact I'm writing this with only a couple of days to go before publication.

Chronically late if I even remember to turn up or if I can find where I'm meant to be (sat nav inventors I thank you).

Displace my ribs by turning round in the car (more physio), get RSI from using my phone too much (though without it I'd be literally and figuratively lost), random bruises everywhere. Back pain if I stand too

long (I literally kissed my dishwasher when I got it).

RTA. Head and arm versus windscreen. Forehead and forearm scars (see image below).
Overactive Thyroid. Radioactive Iodine. Underactive Thyroid. No obvious superpower developed sadly.

Wobbly joints - ever need to see a good example of a swan neck joint deformity ... beep me!

Help identify lots of occupational therapy students with previously undiagnosed additional learning needs. Get to know the head of the service. Realise it takes one to know one!

Diagnosed with dyspraxia at the age of 32

Depression,
Depression
Depression
Anxiety
Burnout

But, mental health still does not get the same acknowledgement as physical health, it's something you can 'overcome' if you try hard enough, right?

Binge Eating Disorder (and by the way when you are overweight this gets blamed for everything).

Fertility issues (only diagnosed because I decided to shun convention and go it alone).

Literally just diagnosed with ADHD (combined presentation) at the age of 42, and I am just learning how that ties in with some of the above. A lack of diagnosis does not mean a lack of challenges, just usually a lack of support.

And last but probably not least, since December, you know, right in the middle of a pandemic, my asthma now flares up, around 8 courses of steroids this year and I need to see a specialist! On the shielding list, shield, don't shield, maybe shield, who knows! Maybe I even had covid

early, wouldn't be able to distinguish it from my asthma cough now.

I love occupational therapy. I believe wholeheartedly in our profession and especially in its underpinning philosophy, and as you can see I've made extensive use of the NHS (I even saw an OT in hand therapy) and know that I do not want to see it dismantled.

Yet ...

I remain unconvinced that occupational therapy wants me. At least not within the structures that currently exist.

I often feel a disconnect with what I believe occupational therapy to be versus what I am enabled to deliver. It's like knowing there's something wrong with you but not having the diagnosis, let alone the cure.

One incident stands out to me. At a multi disciplinary conference, in a seminar, the session leader asks us all to line up across the room. To the far right if you disagree, the far left if you agree. The premise is not important here but what was, was the fact that I was an outlier. I even felt confident enough to express my beliefs. But I struggle with that idea of being different. Does it mean that I am wrong, my opinion worthless or have I just been able to diagnose something before everyone else?

I have left jobs as a result of stress and I have felt stressed as a result of leaving jobs, even though they weren't giving me the occupational balance I need. In fact when the pandemic hit I was thankful I didn't have the job I'd left, because I'm not sure I would have been protected enough. It's a pity that I couldn't have been supported to prioritise my mental health before. And so I stayed too long in a situation that I was trying to mould to fit my difference. Knowing that things didn't need to be the way they were. But the world doesn't work like that, even when it should.

Reasonable adjustments are seen as costly, changing the way things have always been done to how they could be done is a no no. And even dare suggest that there is more than one way to achieve a goal and it doesn't 'meet the needs of the service'. Asking for flexible start times

was seen as me ‘picking and choosing when to work’, rather than working when I can be most effective. If you want me in at eight don’t expect me to make sense until at least ten!

I have had a few extended periods of sickness from work, due to both physical and mental health issues, I’ve also been judged for posting about tidying my house whilst I was off sick with chronic diarrhoea - ironically the side effect of an antidepressant I started to help me cope with stress at work, and the failure of another cycle of fertility treatment. I have an en suite bathroom - believe me tidying was frequently interrupted. Don’t forget that picture of the konmari folded drawer on facebook doesn’t show the whole story. Like the fact that having the motivation to do the tidying had taken forever, and around 18 months after that comment was made tidying still brings that memory back, and so I still live amongst unsorted piles. And there’s the judgement you get when you leave the house if you are off with stress or depression, when that’s the very thing that will get you better and back to work. We know this, but that doesn’t seem to stop the judgement. I get it, it impacts on your colleagues but that judgement makes it harder, if not impossible to go back. That throwaway comment can be devastating.

And, probably best not to get me started on managing attendance processes and phased returns to work. In my experience they aren’t the supportive structure they are meant to be. There’s an all or nothing approach to returning to work, a ‘my way or the highway’ dictat. Having a predisposition to needing to take time off when you get just a ‘cold’ (aka respiratory infection and asthma exacerbation) means that when X works through their cold, I get another black mark against my attendance. There’s only so long that ‘you do a good job when you are here, Kirsty’ feels authentic, when you are told if you have more sickness your job will be at risk. That phrase does wonders for the mental health I can tell you.

But then the pandemic came along, and I’m sure I’m not alone in feeling that covid was my reasonable adjustment. Working from home, with all my home comforts and the company of the dogs. Choosing my working hours to avoid the early starts I can never make and working in shorter blocks of time. Running my own business!

But. Once the virus  has been medicated I fear that the positive aspects of the new normal will be rolled back. One of the challenges I

still have is the lack of financial security that comes with working flexibly to manage a health condition, or many.

But. I will end on what I have bought to this wonderful profession of ours. Patients asking you if you have multiple sclerosis because you ‘get’ fatigue, students opening up about mental health because they know you understand, people feeling heard because you haven’t told them ‘there’s no need to cry’ and have given them time. Sometimes there really is a need to cry and that is okay.

So why then then Kirsty did you have to go back to see that person a second time?

Because I know that sometimes you can’t diagnose what’s going on with someone in just one appointment, or by looking at them, or from that picture online.

Questions to prompt reflection on Kirsty’s account

1. Having experience of health conditions doesn’t automatically make you more empathetic towards other people - if you have always been fit and healthy how do you seek to better understand the lived experience of others that aren’t? If you have lived experience how do you think

beyond your own experience to how others might experience the same ‘condition’?

2. As occupational therapists we don’t necessary need labels or a diagnosis to work with someone. I would love to see us working more in the fields of occupational health where I think we could make a positive difference. Have you ever offered your services to your own occupational health department at work? What do you think we could offer?

3. If you are a manager and you have a member of staff asking for adjustments please take the time to really consider if it is reasonable. Think outcome not process. Can things be done another way?

4. Think Balance. Can we truly be effective employees if we aren’t taking care of our own health? And can your employees deliver the best service if you forget that they have lives outside of work?

The Roads Travelled - *Diana Sheridan*

I'm standing at the metaphorical crossroads that everyone faces at some point in their lives, which has repercussions throughout my life, to the extent that I wonder if I should become my own therapist, be it counsellor or Occupational. It also raises more questions and reflections of the roads that led me to this point in life. I haven't reached the destination that I had dreamed of & expected that I would reach all those years ago as an idealistic teen.

How have I gotten to this point?
Could I have taken a different road or just a different turning at different times in my life – would it have altered the stop offs or detours or avoided the meandering around seemingly pointlessly?
Having reached this crossroad, where do I now go from here?
Should I carry on the same road, re-trace my journey or map a different means of getting to the same goal – although actually my goal has remained the same on reflection – to become a clinical educator and achieve a Masters - the pipe dream would be a PhD and to call myself a Doctor like many of my illustrious ancestors.

The road travelled thus far, involved numerous hospital admissions as a sickly child and acquiring a hearing impairment along the way. I had contact with AHPs (SLT and Audiology), from an early age and finding out what my Aunt did (OT), which inspired me to become one too, despite her attempts to discourage me following in her footsteps. I'm glossing over the negative impact of the limitations placed on me by others because of their perceptions of (dis)ability, because there have been some advantages in building therapeutic relationships with clients/ patients. The road took a long detour of an interesting 10 years, many jobs, a different degree and living in various places around England before it brought me back home to work in the very college I was to graduate and become an OT. The subsequent years have been sometimes frustrating detours around obstacles to find new routes, stop-overs to maintain essential self-care or learn new skills, or slowing the journey to take on new commitments. Rather than a smooth journey towards the mapped out destination at speed, the slower speed has resulted in gaining empathy and connection with fellow travellers from all walks of life, which has been an invaluable pragmatic and therapeutic

resource to draw from when using my professional skills to help others in whatever way I can.

Over the past year or so, I have taken a longer stop-over than usual for some essential repairs and some hesitant self-care due to a new chronic condition and some significant life events that have drained personal and professional fuel sources. Despite professional embarrassment, I've asked for help and support to decide whether to re-think my long dreamed for destination and park it for now, if not for good. At the age I have now reached, I'm not where I expected or hoped to be in life, both personally and professionally. I had added in some activities that resolved unmet needs (local Rotary Club, Church and Guide Unit), but even this hasn't kept me functioning enough to keep moving whilst feeling like I'm standing still.

I'm now re-fuelled and a little refurbished enough to think about getting back on the road, but the "car" is of age and the mileage significantly high enough that the means of transport might need replacing, which doesn't worry me as much. Choice and maintenance of car is very much a reflection of someone's outlook on life: battered bodywork belies a robust and reliable engine in my case! And the destination is still there, albeit with a little less gloss and glitter of dreamed for 5* luxury that might require more spectating than active participation, but enjoyable nonetheless as it can be shared with others.

Questions to prompt reflection on Diana's journey

1. Diana's narrative is the second time this year thatI've seen someone explore the concept of a lifemap that has gone off course. The first was by Dolly Sen - an Ot and mental health activist. How often do you reflect on your own journey and how it has made you the person you are?

2. Glossing over the negative parts of our experience is common amongst those in disadvantaged groups. But understanding where common issues occur can help us help others smash through roadblocks. We do not have the right to force someone to relive their worst journey but if you listen they will share the pin points. For example what common challenges have you heard OTs with hearing impairment speak about? How can we take steps to find an accessible route for all?

3. Self-care is an important and, I would posit an overlooked occupation by many OTs. This is especially important when engaging in activism, although I have interestingly enough recently seen tweet in which someone described their activism as self care. How do you fill your fuel tank?

Readmitted: A Story - *Hunter*

Part 1 - Readmitted

‘Back again?’ The admitting nurse says the second word in a sigh, tuts and adds ‘not even 4 months this time,’ and then laughs as she says, ‘At least you know the drill.’
‘That’s true at least. I empty my pockets and wave goodbye to my phone, my lifeline. How many of you reading this would willingly give over your hand extension to strangers for “safekeeping”. But I know if I don’t that’s when things get messy. If I’m “not compliant” then I’ll be in here longer and I want to stay in here for the least amount of time possible. Nothing ever changes, all my issues are still outside these walls. And none of the staff here have a clue what that’s like. I’m left to settle for two nights on the ward, as I walk along the corridor to get my medications I hear one of them mentioning, ‘another personality disorder admitted two nights ago’. Me, I was admitted then, is there something wrong with my personality? Maybe that’s why I can’t get anywhere with my problems, maybe I’m the problem. I go back to my room staring at the white ceiling, wishing I could go back and wipe my life clean of all the crap I’ve been through.

The next day I’m led down to a room that I know pretty well, to see the OTs. I still don’t really get what they do to be honest, take me to a gym or give me a choice between craft group or cookery. But as I step through the door I immediately notice that something is different. The OT is a dude, like me. First I think oh its probably a doctor, but then he introduces himself…. He steps forward and holds out his hand and when I curl mine into a fist he doesn’t flinch but echos the movement and the dude fist bumps me. I can’t help it, I laugh out loud. An actual LOL. He smiles, come on in… he leaves a space that they normally fill with my name. The one on their records, Marvin, or Mr Owusu. The surname they pronounce with a question as if to check they’ve said it right.
I fill in his gap, “Vin.” The nurse who has accompanied me raises her eyebrows at the new OT who indicates he’s fine and she leaves us to it.
‘Hi Vin, I’m Joseph, the occupational therapist on the unit.’
‘But you’re a dude.’ I can’t help it, they’ve always been women.
‘Is that a problem?’ he chats back, no tone, no offence, just a query.
’Nah. It’s just I thought you was like Santa.’
His eyebrows raise and he smirks, ‘ We exist, even do work more than once a year.’
I like him.
‘So, what’s been going on for you? I see you’ve not that long left the unit. Let’s talk about how we can help you stay away from this place.’

My jaw must literally hit the floor because it takes a while for me to gather it back up to answer him. And something in the way he looks at me, really looks, pen not hovering over his paper but twisting round and round, eyes on mine, makes me want to do something I've never done before. Tell the truth. The whole truth.

Joseph gives me two hours of his time, even though I've been here before, even though there's a record of everything I've told them before. He mostly listens too. Usually it feels like pulling teeth for them I reckon. But he makes the right noises, you know. Not that the women didn't, they said the right things, empathised and all that but when Joseph speaks he digs, says a couple of words that uncover what I've been hiding, from myself let alone them. He just gets it.
I explain how there are days I can't even get out of bed, and some days there's so much terror inside my heart is beating like mad, and I try to fake it being fine and people think I'm making it up for attention, and then it explodes and I punch a wall or the next hardest thing…he indicates to my broken fingers and tells me it's okay. I feel my chest pounding and my breathing getting fast, scared that I might hit him. But he just looks at me in the eyes and holds my hand, tells me to breathe deep and copy his breathing.

He tells me we can stop, or take a break and come back to it. I decide, this guy just stopped my chest from pounding, helped me feel I'm there and calm down, I need to carry on. So I tell him all the years of being beaten, the pains in my body, the aches and the constant bad thoughts in my head about myself. I tell him how my partners had never really given any feelings to me, how I'd sacrificed all sorts to them, how I'd moved across the country to be with one partner. I couldn't look him in the eyes in case he asked me about my partners….oh man the dreaded question; Then he asks me "partners? Boyfriend, girlfriend, husband/wife?" no one else had ever asked me this. None of the other OTs had asked me if I was gay or straight, or bi? This guy seemed interested, his voice wasn't all professional or detached, it was kind and seemed to want to actually know. I take a deep breath and look up, he has a small smile on his face and he's kind of warm and caring, so I tell him "boyfriends, I'm gay, my family didn't want me". He takes my hand and tells me it's fine, he understands, and then he explains he's gay too, and he's not judging me, he wants to know all so I can get the right help. I feel exhausted I tell him, he takes me back to my room and tells me to get some rest before lunch and that he'll check in with me tomorrow.

Part 2 – Disclosure

Joseph sat, waiting for his patient to be brought in, he's not had a chance to get on the ward this morning but the staff there were kind enough to bring the patient through for him after medication time.

I'm waiting, thinking about the history, how in the morning meeting staff were saying he's a typical Personality disorder, just wanting attention, we should stabilise and discharge. I sit there thinking about his history, wondering why there's no relationship or social history here, just that he's homeless and moves from place to place, gets aggressive and violent but says he's anxious. I sit there and wonder, how do I approach this young lad. He comes in and straight away I can see he's a bit nervous and feeling like he doesn't belong in the therapy room with so much craft around. I introduce myself, I can see he's anxious, so I listen, nudge here and there with some exploratory questions and take it in. I don't want this to be a clinical experience for him, I want to hear his story. I want to know why he keeps being readmitted. I have to ground him at one point and bring his breathing back to baseline, I offer him a break or for us to stop but he wants to carry on.

I have a feeling about his sexuality being a part of this – he keeps referring to partners and looks away as though he's ashamed of them. So I ask him, are they your boyfriend or girlfriend? He tells me he's gay and I can see the tears in his eyes and his body language switch from being hyperalert to relieved and almost ashamed at the same time. So I tell him I'm gay too, that it's okay, we can help you. I can see he's exhausted, it's such a big secret to carry around. I take him back to his room and say I'll see him again tomorrow.

Tomorrow comes, I have a busy therapeutic craft group and then patients on the ward to see. I share with the MDT the patient's sexuality and ask for some sensitivity with him as I feel this is a big issue of insecurity for him. As I'm walking over to see him I hear a nurse asking Vin if he wants to call his girlfriend or family. I'm furious! After my warning that morning the message still isn't passed on. I walk over and ask Vin if he's ready for my session and remove him from the situation. I apologise to him and explain I will raise this with my seniors.
We sit down and I go over a care plan with him, I explain that what he's been experiencing is the fight or flight response, and he looks relieved. I explain about anxiety and arousal and some ways we can manage it. I talk about how we can help him get a routine together that's flexible and then I ask him when was the last time he really enjoyed any of his hobbies – two

years he tells me. I sit and think to myself no wonder he's not been getting any better.
I come up with a plan – we are going to explore his hobbies, I'm going to teach him about anxiety and teach him how to manage it. Then we are going to do some practice. But most importantly, I give him some material I've printed out, and a filled out referral form to a gay counsellor who does free sessions for low income patients. This kid doesn't need CBT, he needs a safe place to talk about his sexuality in the long term and learn to love himself again. He agrees……
I report to my supervisors about the nursing staff, and they dismiss my concerns and tell me oh they probably forgot. I say forgetful or not, its counter therapeutic and actually traumatising. I'm told I have to understand the nurses work long hours and probably are tired. I feel dismissed and feel like no one here has a clue about how this can impact a gay person. I realise I don't belong here as staff and should just focus on my patients and move on when I'm ready to a more urban area.

…..3 weeks later – I'm in an MDT, the new consultant seems cool, then up comes Vin. So I ask can we get his diagnosis reviewed. I don't think he's a true personality disorder. I think he's a person with traumatic experiences and role loss and what was anxiety had been presented as angry outbursts. He's been doing so well. The consultant looks at me, I present my evidence, my observational assessments then present the MOHOST. His functioning is good, he's getting into a routine for the first time in his life, and he's managing his activities, his self-neglect has improved significantly and he's had no angry outbursts for a week and a half, not needed any PRN medication for a week and has been using psychosocial strategies to good effect. He's even going for walks independently on his allocated time out. The consultant looks at the history and agrees it's time for a diagnosis review. I smile and feel relieved, I feel like today was a win for this patient. I tell the consultant I feel the patient is ready for discharge by end of the week, he agrees to do a four day trial home and then review how he's been and then look at discharge. I glance sideways seeing the nurse just looking at me dismissively.

Part 3….a visit back

It's two years later and I'm back. But this time it doesn't feel like failing. Joseph greets me and we fist bump and laugh. 'How are you doing man?'
'Yeah, good. Just celebrated my year anniversary at work.'
'Ready to talk to them?' He looks at me expectantly.
He leads me into the room and there's about four dudes sat there, heads bowed.

‘Who would like to ask Vin the question they prepared?’
One of them looks me in the eye and says ‘How did you beat it? Joseph says you ain’t been back for two years.’
Is that what they think, that depression is a thing to beat. Isn’t that where I was two years ago.
‘The secret is, you don’t. You learn to live despite it, with it. You learn to be who you are and love your life and enjoy it.’
And that is what occupational therapists help you to do. The ones that ‘get’ you, that is.

Questions to prompt reflection on Hunter’s story

1. Freewrite about how you are feeling after reading this.
2. How often do you assume heterosexuality? Do you use inclusive terms to enable people to open up about their lives?
3. Therapeutic use of self and self disclosure is a contested thing within occupational therapy, with some people believing it to be unprofessional and others believing that it is a fundamental skill that helps us support the people we work with? Think back to a time where you disclosed something personal in order to help build rapport or trust. Reflect on that now.

4. The medicalisation of trauma is far more common than we realise, and in Hunter's story we can see how healthcare can add to that trauma. What steps will you take to support LGBTQIA+ people in your workplace?

Loves, Actually: Personal Reflections on Relationship Diversity - *Clarissa Sørlie*

A Bit About Me

Hi, my name is Clarissa (@GeekyOT on Twitter). My pronouns are she/her and I identify with the gender I was assigned at birth (I'm a cisgender woman). I've been an occupational therapist for eight years, and I've worked in mental health for thirteen. My main professional interests are the dark side of occupation (Twinley, 2021), volition (or motivation for occupation; Taylor, 2017) and sensory processing (Dunn, 2008). I'm also interested in the use of modern board games as a therapeutic tool - I'm a bit of a geek!

As an occupational therapist and a feminist, I recognise the significant impact that roles and relationships have on occupational experiences. Despite this, I don't see my own experience of relationships reflected in the occupational therapy literature. You see, I'm in multiple simultaneous romantic relationships - with full knowledge and consent of everyone involved. I'm also attracted to people of my own and other genders. The British Association of Counselling and Psychotherapy (BACP) recently published guidance on working with Gender, Sexual and Relationship Diversity (Barker, 2019) and since then, I've been thinking about how I'd like to see our profession as one that clearly affirms diversity. When Kirsty told me about this project, I knew it was time to start the conversation I had been waiting for.

I gave a lot of thought as to whether to contribute to this text using my real identity or a pseudonym, especially as I keep personal information out of the public domain due to the nature of my work. It's been a difficult decision - even as I prepare to submit this chapter, I feel a knot in my stomach. But I've reflected a lot on my values (like integrity, authenticity and equity) and on the privilege afforded to me by being cis, white and professionally well-established. The words of Funk (2019) have reverberated through my mind throughout the writing process:

> "In moving toward more freedom, openness, and transparency, they [LGBTQ+ activists] are also moving toward more integrity. In living by their own rules and being exactly and unapologetically who they are, they are helping create a world where other people can do the same.

> Our elders didn't necessarily choose this leadership role. I didn't. But when it was offered to me, I accepted it. I accepted it when I came out as gay, and I continue to accept it every time I make the effort to honestly be and express who I am. Every time I do that, I hope and believe I make it a little easier for someone else to do the same." (pg. ix)

So, after a lot of deliberation, I've decided to give a description of my personal journey through consensual non-monogamy (specifically, polyamory)[1][1]. By sharing this, I aim to provide an example of the occupational experiences of a non-monogamous person. I then situate this account in some of the broader academic literature on stigmatisation and discrimination in healthcare, as experienced by polyamorous individuals and communities. By way of conclusion, I offer some recommendations for clinical practice. As a university-educated white cis woman working in healthcare, my identity carries with it privileges and disadvantages that mean that my account is not necessarily representative of the experiences of all polyamorous people. Regardless, it is my hope that this chapter offers you a resource for working inclusively with relationship diversity.

Re-Evaluating Relationships

I came across relationship anarchy (Nordgren, 2006) while researching non-traditional/alternative approaches to relationships. It provided a clarifying framework for views I already held, and I felt instantly drawn to it. And while I don't consider myself an anarchist in a political sense, relationship anarchy has heavily influenced the way I relate to others:

- Platonic, familial and romantic love are all important to me, and I reject the idea of a hierarchy in which romantic relationships take priority over others. Instead, a person's significance to me is dictated by the quality of our connection and how meaningfully we participate in each other's lives
- I see love - in all its forms - as an abundant resource. This quote, from Shakespeare's *Romeo and Juliet*, resonates with me:

> "My bounty is as boundless as the sea,

[1] Although commonly abbreviated to 'poly', the word 'polyamory' is used in full throughout this chapter to distinguish it from the Polynesian community identifier (Manduley, 2015)

My love as deep; the more I give to thee,
The more I have, for both are infinite." (Act 2, Scene 2)

I believe that loving additional people doesn't take away from the love I already feel for anyone – much like how the arrival of a second child doesn't diminish the love a parent feels for their firstborn. Although I'd like to point out that, as an introvert, this definitely doesn't mean that I have limitless energy or time for socialising!

- My relationships are intentional. Each relationship is negotiated based on our personal boundaries and custom-designed from a smorgasbord of qualities (such as emotional intimacy/support, collaboration, romance or sex)
- Labels like 'friend', 'girlfriend', 'boyfriend', 'partner' or 'joyfriend' (for nonbinary partners) are not descriptive enough to capture the customised nature of my relationships so I prefer not to use them. In fact, relationship anarchy doesn't distinguish between friendships and romantic relationships. This appeals to me because a lot of my relationships don't fit neatly into either category
- My relationships don't automatically follow the 'relationship escalator', the social script that goes something like this: flirt, fall in love, become exclusive/a 'couple', merge living arrangements/ finances, perhaps get married/have children
- I value autonomy - my own, and that of others - and don't see myself as being entitled to anyone's time, support or agreement. I appreciate when people freely give me these things, and when they choose to remain part of my life

For some, the term 'relationship anarchy' conjures an image of chaos and a confusing lack of boundaries. If you've ever worked with me, you will know how much I value boundaries and structure. Being influenced by relationship anarchy (and rejecting the expectations and assumptions that usually accompany romantic relationships) has led me to put *more* thought, negotiation and intention into my relationships - not less.

Polyamory

My approach to relationships can be described as consensual non-monogamy (specifically, polyamory). The term "polyamory" comes from

a combination of the Greek word for “many” and the Latin word for “loves” - “many loves”. Essentially, it is “engaging in multiple romantic relationships simultaneously with full knowledge and consent of all partners involved” (Winston, 2017, pg. 5). The emotional/romantic nature of relationships is key to distinguishing polyamory from other forms of consensual non-monogamy, such as swinging or open relationships (Witherspoon, 2016).

Polyamory is often confused with polygamy (being married to multiple people - something which is frequently associated with some conservative religious traditions) and patriarchal polygyny (men having multiple female partners who are themselves not allowed additional partners). In contrast, polyamory is not linked to a religious or spiritual ideology, nor does it seek to restrict any partner’s freedom to have additional partners (Winston, 2017). Polyamory is also not usually characterised by multiple legal marriages, although some polyamorous people choose to demonstrate their commitment to each other through handfasting ceremonies (Witherspoon, 2018) or legal contracts designed for business partnerships (Winston, 2017). Polyamory just means “we have other partners… and everyone knows and is okay with it” (Creation, 2019, pg. 29).

People practise [1] [2]polyamory for a multitude of reasons. In her fifteen year ethnographic study of polyamorous families, Sheff (2014) distilled these reasons into six themes:

1. Getting more needs met across a range of relationships, rather than placing pressure on one relationship
2. Having the capacity to love more than one person (much like a parent having capacity to love additional children)
3. Potential for sexual variety
4. Building a chosen family
5. Experiencing polyamory as an innate characteristic/orientation, not being able to be any other way
6. Making a deliberate choice to rebel against social conventions

Polyamory is as diverse as the people who practise it. For example, some people adopt a more hierarchical model, where one partner is

[2] There’s debate about whether polyamory is a personal identity, sexual orientation, relationship structure or relational orientation (Jordan *et al.*, 2016). I’ve used the verb “practise” with the intention of allowing space for the breadth of experiences and views that exist

considered “primary” and takes priority over others (who may be “secondary” or “tertiary” and have less relationship rights or privileges). In contrast, my style of polyamory is non-hierarchical: I don’t have (or want) a “primary partner”. That doesn’t mean that I’m militant about dividing my time and energy completely equally. There are some people I spend more time with than others (maybe because of our physical proximity, our emotional intimacy, or because it’s what we need at the time) - and they may not necessarily be the people I’m romantically/ sexually involved with.

I have several ‘connections’ (this is the term I use for people I’m romantically and/or sexually involved with). Each relationship is very different to the next, but they are all deep, supportive and egalitarian. Everyone knows about each other (some have even met each other or introduced me to other connections), and I keep my connections in the loop about changes to other relationships. My connections are also among the people I debrief with when I’ve been on a great (or especially bad) date. Different connections relate to different aspects of my personality and interests - I don’t need to drag anyone to an event they’re not interested in. Whether I’m in the mood for a movie singalong, urban exploration or a deep chat, I know exactly who to call.

I do my best to make sure that I’m investing enough in all the important relationships in my life, but I don’t always get the balance right. There are times when I feel like I’m spending more time rearranging my Google Calendar than actually seeing the people I care about. While this might sound stressful - and I’ll be honest, it can be - it helps that most of my connections have other partners. That’s perhaps what I find most liberating about polyamory: there is no expectation for me to meet all of another person’s relationship needs. And they don’t need to fulfil all of mine. I appreciate this most on days when I’m feeling emotionally drained and don’t have as much energy or headspace for my loved ones as I would like. There is no expectation for me to be the primary provider of support, and I’m not obligated to be a +1 to social events. I can give emotional energy when I am able to, and prioritise my own self-care when I need to. And that is a huge relief for my Inner Introvert.

There isn’t an obvious overlap between occupational therapy and polyamory but my career has been spent in mental health, where communication, boundaries and reflection are of utmost importance. These are also the bedrocks of polyamory. In fact, polyamory’s unofficial motto (and the answer to most problems brought to the community) is,

“Communicate, communicate, communicate!”. Likewise, my relationship diversity has made me a better occupational therapist. Through practising polyamory, my self-awareness, empathy and resilience are constantly developing. I’m learning how to be more honest with myself, and how to discern what I really need. I meet new people who challenge me to grow as an individual, and introduce me to broader occupational and relationship experiences.

Community-Centrism vs Couple-Centrism

One of my favourite polyamorous terms is ‘polycule’, which describes the network of non-monogamous relationships that includes partners and their partners (referred to as ‘metamours’). When mapped out - with lines delineating connections between individuals - the resulting diagram resembles a molecule, hence the name. I like to include mutual friends in this diagram too, in recognition of the value I place on all types of relationships, not just romantic ones.

Of the many changes that polyamory has brought to my life, perhaps the most significant has been a stronger sense of community and collectivism. This has been driven by a shift in focus from ‘couple’ to ‘communities’ that has accompanied my exploration of relationship anarchy. I first sought out polyamorous communities (in person and online) because I wanted to meet likeminded people. These communities have been a lifeline. The experience of connecting with these groups reminded me of my professional socialisation into occupational therapy - having the support of others while learning new terms, encountering new situations and reflecting on my own values and how they fit with those held by others in the community. The groups I belong to have supported my identity formation, helped me make sense of my experiences and given me advice and emotional support. And because a lot of the people who come to these groups are geeks, gamers and science fiction fans (Sheff, 2014) like me, I’ve even been introduced to new books, games and films.

Witherspoon (2018) recommends that clinicians working with consensually non-monogamous people should support them to connect with relevant communities. Groups exist in person and online and can often be found on Meetup.com or Facebook. However, it is worth noting that these groups vary significantly in the type and quality of support

they offer, and people may need to look around for the community that suits them best. Benson (2016) also points out that, although group members share a 'polyamorous' identity, there can be considerable variations in their behaviours, norms and expectations.

There are many reasons why people might not get involved with polyamorous communities. The influence of race and class is reflected in the attendance of polyamorous support groups and events - which are disproportionately accessed by white, middle class people. Sheff and Hammers (2011) suggested a number of factors that may contribute to this. The privileges associated with being white and having a relatively high level of education, income and job security may buffer against some of the negative consequences associated with being openly polyamorous. It is also possible that people from Black and Minority Ethnic groups who are already experiencing stigma and racism are reluctant to visibly assume an identity that opens them to further discrimination. Alongside this, the disproportionate challenges that women may face when coming out as non-monogamous can be amplified for women of colour or those who are working class (Klesse, 2014). Barker (2019) adds that "people of colour, and working class people frequently feel excluded by the lack of people like them, by implicit norms about the way things are done and the things people are expected to be interested in, and by the financial outlay required to access such spaces". Furthermore, Klesse (2013) argues that the styles of communication generally employed in polyamorous communities are reflective of middle class patterns and may therefore reinforce class divisions.

People who don't attend predominantly middle class white social groups may find their sources of support and community through other means, such as smaller underground queer scenes or online platforms. For example, activist Kat Blaque uses YouTube to normalise and educate on different aspects of her identity (being Black, transgender and polyamorous) and how they intersect, and there are Black-centered polyamorous spaces such as the Black Poly Pride event in the USA and the Black and Poly Facebook group and magazine. These initiatives represent conscious efforts from marginalised individuals and groups to address discrimination within the community. However, the community at large often faces discrimination in institutional contexts due to prevailing stigma attached to non-monogamous lifestyles.

Stigma, Discrimination and Healthcare

When I first started researching polyamory, I knew very little about it. I didn't realise that I already knew polyamorous people (because we hadn't openly discussed their relationship diversity), and I completely misunderstood it.

Winston (2017) summarises some of the most common misconceptions about polyamory:

- Confusing poly*amory* with poly*gamy* or poly*gyny* (as discussed in the 'Polyamory' section above)
- Assuming polyamory is a sexual fetish
- Believing polyamory is casually 'playing the field' until the 'right' person comes along - this was my view!
- Equating polyamory with cheating/infidelity

We live in a mononormative society - one where monogamy is promoted as the only acceptable type of relationship (Jordan *et al.*, 2016). Sheff (2020) refers to a culture of 'compulsory monogamy', where monogamy is "the default and only legitimate form of relationship" (pg. 883). Polyamory can elicit strong reactions from people, and Sheff suggests that this may be because its existence challenges the status quo of normative monogamy.

Given this culture of mononormativity, and the dearth of professional training in relationship diversity, it is perhaps unsurprising that polyamorous people experience discrimination when accessing healthcare. In Witherspoon's (2016) study of 1,582 self-identified consensually non-monogamous adults in the USA, over half of participants reported experiencing at least one type of discrimination, harassment or violence. Over a quarter reported three or more types. In addition to verbal harassment (29.1%), sexual harassment (19.7%), and internet harassment (23.7%), participants also reported experiences of discrimination by a medical doctor (16.5%), discrimination by a mental health practitioner (14.2%) and loss of child custody (2%). Of note, participants had significantly higher levels of education and income compared to the general US population, and the majority were white - factors which, arguably, may be protective against discrimination.

Drawing on focus groups with 20 participants accessing an American polyamorous non-profit organisation, Vaughan *et al.* (2019) report healthcare experiences that were stressful and left participants feeling

embarrassed and ashamed. Examples included, "'raised eyebrows' and 'dirty looks' directed at them and their partners, avoidance of eye contact, and a condescending tone" (pg. 46) as well as judgmental language and unsolicited relationship advice.

Polyamorous families in a recent Canadian study reported a range of healthcare experiences that showed a lack of acknowledgement of their other partners during pregnancy and childbirth (Arseneau *et al.*, 2019). For example, they spoke about partners being prevented from attending births and not being given access to information. They also mentioned not having physical space in hospital rooms or on forms to include more than one partner.

Participants in Arseneau *et al.* (2019)'s study described not feeling comfortable enough to honestly answer questions posed to them by professionals (for example, about social support). Similar experiences were reported in Vaughan's (2019) study, as a direct result of stigmatising healthcare experiences. This is significant, as concealment of aspects of one's identity can have a negative impact on mental health (Witherspoon, 2018) and may also lead to an incomplete clinical picture. Flicker (2019) recommends that professionals should give explicit messages of inclusivity, to counteract experiences such as these. Actions could include asking questions about relationship structure, ensuring that language is inclusive, and inviting multiple partners to be present. Other practical suggestions include providing the option to list multiple partners as emergency contacts (Vaughan *et al.*, 2019).

Implications for Occupational Therapy

In her discussion of the dark side of occupation as including "the daily or regularly-experienced occupations that remain under-addressed", Twinley (2021, p191) sites polyamory as part of sex, dating, and intimacy occupations. I believe that, as a client-centered and holistic profession, occupational therapy is well placed to work affirmatively with relationship diversity.

Used alongside inclusive actions (such as those listed above), our existing models and assessments can support us to collaboratively explore the interplay between relationship diversity and occupation. For example, Kielhofner's Model of Human Occupation (Taylor, 2017) may

provide a useful starting point for acknowledging the occupational needs of polyamorous people. Clinicians can draw on concepts such as occupational identity, occupational competence, occupational adaptation, values, interests, volitional processes, roles, relationships and social environment to build a comprehensive occupational formulation. And, while many of our assessments can be used to elicit this information, Atler's Occupational Experience Profile, with its focus on lived experience and explicit consideration of the social environment, stands out as a particularly useful tool.

Based on their research into the impact of stigma on the healthcare experiences of polyamorous people, Vaughan *et al.* (2019) recommend that healthcare courses include training on consensual non-monogamy and implicit bias. A further recommendation is for training to be underpinned by a framework of cultural humility, which values the patient's expertise, acknowledges power imbalances in healthcare and encourages self-reflection from clinicians. I'm keen to see greater recognition of relationship (alongside gender and sexual) diversity in our teaching programmes, as well as our textbooks and journal articles.

Top Tips for Occupational Therapists

The tips below have been informed by the BACP's good practice guide to working with Gender, Sexual and Relationship Diversity (Barker, 2019). The section on relationship diversity is very useful, however the guide also covers gender diversity and sexual diversity, and is well worth reading in its entirety.

- Reflect on your own assumptions and values about relationships and what you bring to clinical interactions
- Cultivate awareness of the language you use, particularly during initial interviews. Are you making space for the possibility that your service user has more than one partner? Are the pronouns you're using in your questions communicating heteronormative assumptions about sexual orientation or gender identity? Opt for gender-neutral language (for example, "partner or partners" rather than "boyfriend" or "husband")
- Be curious and ask questions, but remember that it's not your service user's responsibility to educate you - do your own CPD. I've included a list of resources below that I hope you'll find helpful
- Don't assume that an individual's relationship diversity is at the root of problems they are experiencing

- As always, it is important to be aware of the limits of your knowledge and your scope of practice. Pink Therapy, an independent therapy organisation, has a searchable directory of therapists who specialise in GSRD, and the organisation also provides online training

Please feel free to contact me to share your reflections, questions, or if you'd like to collaborate on a piece of work. I can be reached on Twitter, LinkedIn or ResearchGate.

Resources

Books/Publications

- Barker MJ (2019) BACP Good Practice across the Counselling Professions 001: Gender, Sexual, and Relationship Diversity (GSRD)
- Hardy JW and Easton D (2017) *The Ethical Slut*. Ten Speed Press
- Sheff E (2014) *The Polyamorists Next Door*. Rowman & Littlefield
- Winston D (2017) *The Smart Girl's Guide to Polyamory*. Skyhorse
- Weitzman G, Davidson J, Phillips RA, Fleckenstein JR and Morotti-Meeker C (2009) What Psychology Professionals Should Know About Polyamory

Magazines/Comics

- Black and Poly magazine
- Kimchi Cuddles webcomic by Tivka Wolf. Here are some of my favourites:
    - Types of connection
    - Different relationships nourish me in COMPLETELY different ways...
    - Jealousy

Videos/Podcasts

- 'Monogamy Explained' documentary on Netflix
- 'Multiamory' podcast
    - Polyamory: the Most Common Questions
    - Relationship Anarchy 101
    - Intersectionality and Polyamorous Communities (with Ruby Bouie Johnson)
    - Polyamory, Family and Children (with Dr Eli Sheff)

- Kat Blaque videos
    - Why I Don't Date Monogamous People
    - How I Knew I Was Polyamorous

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Questions to prompt reflection on Clarissa's chapter

Clarissa has highlighted some questions already so I will just add a few additional thoughts.

1. Clarissa shares some common misconceptions of the term polyamory. How has your understanding developed after reading this analysis?

2. As a 'chronically single' person I definitely identified with the aspects raised in this chapter around different types of relationships and how different needs are met. Thinking about 2020 and the challenges of

loneliness how can this understanding of relationship diversity help us support those at risk of loneliness?

3. Along with the ‘white middle class’ presentation of the profession I think there is a certain prudishness around sex and relationships. They can be an important part of someone’s occupational experience as is shown in this chapter. What steps will you take to ensure this is an area you address with sensitivity when needed?

Boundaries and Opportunities *Kosiwa Lokusu*

The importance of diversity within Occupational Therapy allows all of us; staff, patients, family members alike to see each other as equal.

I have never seen the colour of my skin as an obstacle to getting to where I want to be. I am lucky enough to be able to say this and to have the experiences that I have had, which encourage me to pursue whatever I want to do despite how others may interpret me or my situation.

However not everyone has this luxury. This is not to say that I haven't had my own challenges, but what I have always had is someone behind me pushing me to be the best that I can be. I have had fantastic role models from different backgrounds, gender, ages etc defying the status quo and choosing the path that they wish to achieve.This alone, shows me the importance of diversity and being aware of the experiences of others and how we can learn from this.

Occupational Therapy is a predominantly white female career - however this did not stop me. A young, loud, black girl from Croydon - I was going to do exactly what I needed to do to get to where I needed to be. I put myself forward for positions that people may not have expected me to. I attended conferences and made sure I was in spaces where I may have been the minority. But I was still there, and this is what is important.

Having someone with a likeness to you is important.
Seeing that someone like YOU is able to achieve is so important.
This is why I will continue to enter the spaces that perhaps people feel I shouldn't, or look slightly out of place.
I will continue to push the boundaries that are there but need to be broken and continue this with a smile on my face and a passion to do what is right.

Questions to prompt reflection on Kosiwa's reflection

1. What boundaries have you found still exist within the profession?
2. What boundaries have you broken down?
3. What opportunities have you taken for granted versus which have you grasped?
4. What opportunities can you offer to others?

Viewpoints *Ed Sum*

Viewpoints

Standing on the hill

you get a nice view.

It changes with the passing seasons,

but it essentially remains the same;

that is why they want to stay on the hill.

When you don't belong, you don't get to join them on the hill.

You see them when you look up and think how amazing it would be to be one of them.

If you work hard to fit in then you can be invited to join them.

Standing on the hill

you get a nice view.

It changes with the passing seasons,

but it essentially remains the same;

that is why you want to stay on the hill.

When you don't belong, you don't get to join them on the hill.

You see them when you look up and when standing from other hills and think how amazing it is to be free to admire the landscape of hills.

Questions to prompt reflection on Ed's poem

1. How nice is the view from the hill you are on?
2. What concerns you about challenging the status quo?
3. What excites you about it?

Personal Accounts from Worldwide OTs

What's It Like Being a Minority Male Occupational Therapist? - Jason Gonzales

It's not bad at all, actually. To clarify, I used the word "minority" instead of Asian because some people assume that I'm Mexican, Indian, Hawaiian, or Middle Eastern.

Being a male OT in a predominantly female occupation has its pros and cons. Only about 10 percent of occupational therapists are male, which I soon realized at Ohio State University when I was 1 of 7 males in a class of about 55. What I didn't know is that Asians are the second most common ethnicity in the OT profession at a measly 6%. This doesn't surprise me because I've only worked with one occupational therapist that was an Asian male in 5 different states (NY, MA, NJ, HI, and CA) and 13 school districts. Now that may sound pretty specific but he was 1 of only 7 BroT (a term I never heard of until last week BROT Movement) that I have ever worked with in 18 years.

That being said I had only heard one racist comment which happened to come from a student. It was not like being raised in the midwest in the early 80's where people were constantly asking me if I knew karate, which I did, or if I played the piano, which I did, or if my parents were doctors, which they were, or if I ate dog, which I wasn't aware of. To be fair, for a long time I thought all Filipino adults were doctors when I was growing up. But I digress.

There are definitely benefits to being a male occupational therapist. Apparently men get paid about $11,000 more per year than women. I have not personally seen this, because this does not typically occur in the school setting since many districts have steps that they follow based on education and experience, not on gender. I did get a lot more compliments on my clothing and at times my tan and even my arms! Most of the women that I have worked with were much harder workers than me, but they were also more stressed than me. I actually had a coworker complain that I was **too** relaxed, so my supervisor at the time explained that I just moved there from Hawaii.

There is one part of being Asian that's a pro and a con at the same time, which is that I apparently look much younger than my age. For example, I was mistaken for a hall monitor in an elementary school that went to grade 5. Now that I'm 40 years old, I take those as compliments and now I wear my fluorescent green hall monitor sash with pride.

As several other male OT have posted, we often enjoy the wonderful baked goods in the staff lounge. I'm a foodie and I enjoy socializing around eating. At one school, I used to schedule my days based on the fact that a teacher made chocolate chip banana bread, on Wednesdays we had salad club (which I helped start), and Thursdays was pastrami Thursday at the local deli. One day, I think I got 15 people to order Indian food. One of my good friends mentioned that he lost 10 pounds after I left.

But by far the most important benefit to working in the school setting with so many women is that overall I believe my female colleagues have made me a better person. I learned how to be a better listener, more compassionate and empathetic, and better worker, which has made me a better husband, father, and therapist.

Now I'm not saying everything was all hunky dory. There are plenty of things that I (and I'm guessing other men) carefully consider, especially when working in pediatrics. First, I try not to close the door of the OT room especially if it's only me and the child. I don't think that is something women have to worry about, at least not for the same reasons. I don't have kids sit on my lap for story time and when kids want a hug, I don't refuse, but instead "side hug" them.

Being a male OT also makes it difficult to make friends at work. Guys are easy: we talk about some sports and the next day we're practically chest bumping in the hallway. Women can be tricky. I have to be careful about how I invite a teacher or fellow therapist to a social event after school with a group without it sounding like I'm asking them out. With that being said, the women that I have worked with have become close friends and have helped me a lot throughout my life and I definitely appreciate all of them.

(This piece was originally published on the Double Time Docs blog on 2nd April 2019 - https://blog.doubletimedocs.com/2019/04/02/whats-it-like-being-a-minority-male-occupational-therapist/?fbclid=IwAR2ntisjmBdwx5y8kLFM5B7Py0wAfo0HE880dhO8LAcWlKJK2wrAkol3EQ0)

Questions to prompt reflection on Jason's account

1. Jason makes some useful comments about stereotypes in his account, even showing how many of them he ticked off when younger. How can you treat everyone as an individual and stop yourself reverting to stereotypical assumptions?
2. What have you learnt from working with OTs who have different backgrounds to yourself? Has this then changed the way you live or practice?
3. As I learnt when preparing the LGBTQIA+ #OTalk, and despite taking on this project, there is a tendency to just think about gender in the binary. Can you make a pledge to recognise our trans and non binary colleagues when discussing gender diversity in OT.

The Diversity Jackpot - *Bill Wong*

If one were to look at my 8 year career as a qualified occupational therapist so far, many would say what I had, or have, the opportunity to accomplish is the result of hard work and perseverance. However, I also know I am becoming a poster child for the three minority groups I represent in OT - as an Asian, a male, and an autistic individual. I am not going to stop my pursuits of my goals and dreams just because I feel this way. Instead I think of a more productive way - using whatever power or influence I can to promote more opportunities for OT students and practitioners from diverse backgrounds in order to make positive differences for the profession.

The first question people who don't know me well would ask me is - why do I think I am a poster child? I graduated from a top program in the USA in University of Southern California. I started my OT education when the department's associate dean, Dr. Florence Clark, was about to step into her role as president elect of the American Occupational Therapy Association (AOTA). Also, as my career progressed, I have become highly recruited to attend CAOT, RCOT, and OT Australia conferences. Finally, I have over 10,000 followers for my LinkedIn and Twitter.

In terms of career accomplishments, I have experience serving in two important bodies within AOTA - the Representative Assembly and Volunteer Leadership Development Committee. I regularly present at OT conferences. I also contributed to Autism Across the Lifespan: An Occupational Therapy Approach by AOTA Press and the Autism Opportunities Roadmap in collaboration with AOTA's Community of Practice group. Last but not least, I am the only OT student or practitioner to present at more than one TEDx event.

I sensed that my autistic OT peers would look at my career two ways. On one hand, my accomplishments showed them the importance of perseverance and hard work in their development as future and present OT practitioners. On the other hand, my social status within the OT profession appears almost a polar opposite of their own personal experiences in the profession. Although they knew my social status was

hard earned, many of them still said to me, “You can do a lot of the things that I do not find as easy. You can network well at busy conferences and on social media. Public speaking is now a piece of cake for you. You obviously know how to play with the big boys and girls in our field - not only from your leadership experiences, but also the people you have connections with. I am jealous of that. At least you took advantage of the privileges you are given and tried to do it for the greater good of the profession.”

Because of that, I often wonder if what I have been doing indirectly promoted ableism in OT. On one hand, I know I should not stop my aspirations just because I recognise this. After all, it is my career and it is important to strive to improve as an OT practitioner. Moreover, I am capable to make positive differences for the OT profession. On the other hand, while it has been great that I have opportunities to achieve great things in the OT profession, I have a responsibility to advocate for my autistic peers and provide them opportunities to make differences in OT in meaningful ways that they are comfortable with. I also have a responsibility to be a resource to my autistic peers who are not as privileged.

The second question I am sure many people would ask me is - why am I open with my autism diagnosis? This answer evolved since my student days. I had nothing to lose as a student. I could not afford to fail another placement when I found out my diagnosis. I knew I needed extra support to complete my student journey. Then, when I became an occupational therapist in 2012, I did not want another autistic OT student or practitioner to feel alone again. After all, I was lucky to have the luxury of only one year before being able to connect with another autistic occupational therapist. However, one year in an OT student’s journey can mean the difference between staying in the program versus dropping out. One year can mean the difference between an OT practitioner staying in the field versus pursuing other careers.

2014 was a critical year in my professional journey. My first professional development mentor, Terry Olivas De La O, passed away. I wanted to continue her legacy because she had done wonders in mentoring me as an OT practitioner and future leader in the profession during our short

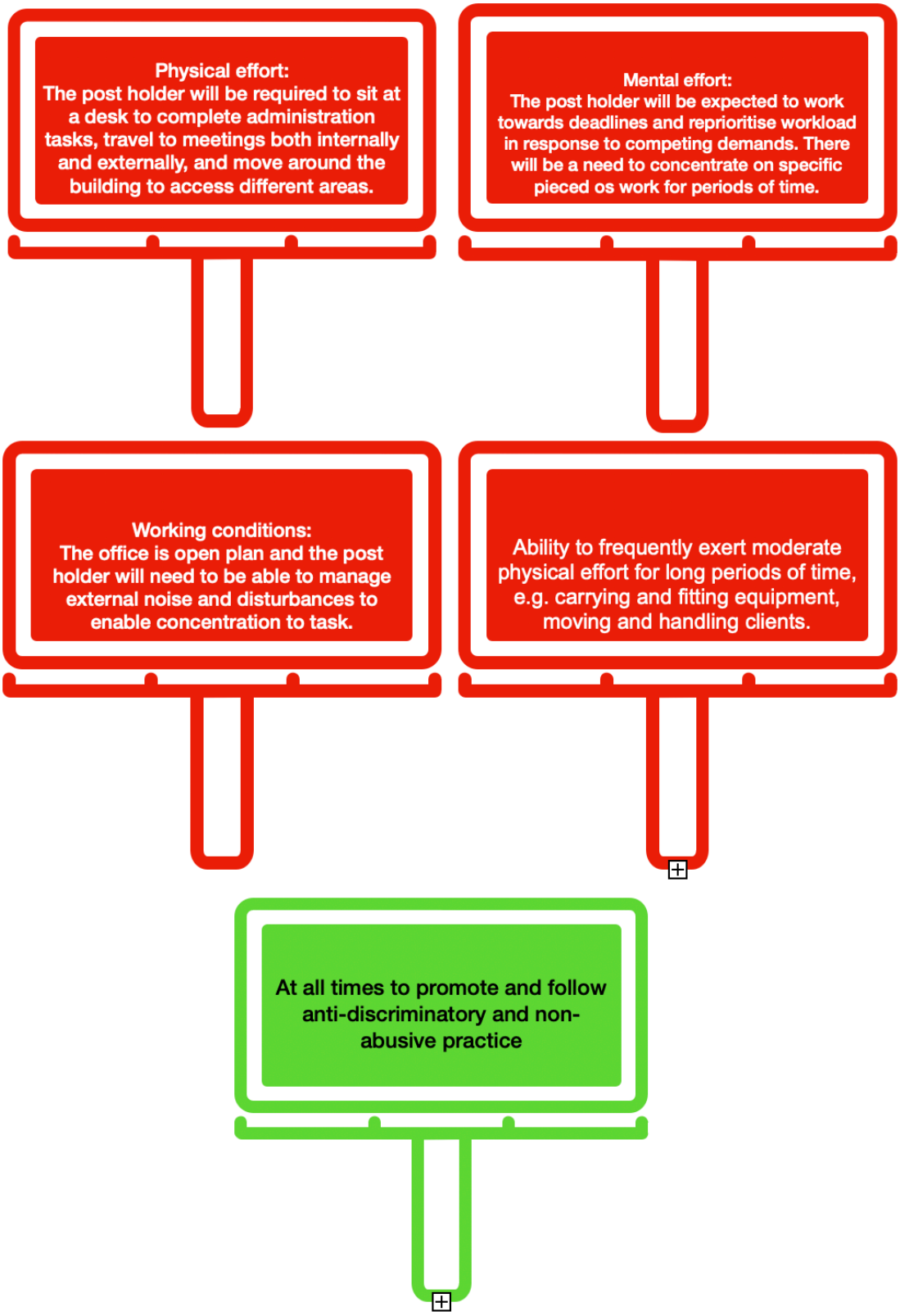
two year relationship. I also did not want to let Terry down. So, I wanted to continue her legacy by mentoring others, particularly autistic OT students and practitioners who came to me for advice. I also wanted to challenge myself as a leader and contribute to OT in similar ways to Terry, but with my own twist. After all, I felt it was important to redefine what are possible for autistic OT students and practitioners as CPD goals.

The last question I will answer is - what do you think your impact is as a classroom instructor? First, I think I can be a living example to my students to work hard and not give up. I was by no means a straight A student. Accepting a life changing diagnosis in the middle of OT school was difficult. I had to work hard to prove people wrong about my capabilities as an OT practitioner and a leader in the field. Second, I changed my students' perceptions about autism. They often were amazed because autistic OT practitioners are part of a rare breed. Moreover, they were amazed by what I have achieved in my career. Finally, the leadership positions I am involved in AOTA would hopefully show to my students that there are pathways to make a difference in the profession, too. After all, many of my classroom students are from diverse backgrounds.

Questions to prompt reflection on Bill's account

1. How can we make a real commitment to diversifying the profession without risking that image of having a 'poster child' to tick the 'we have diversity in the profession' box.
2. Bill obviously feels a huge responsibility to support other autistic OTs with opportunities however how can we all support Bill with this?
3. Bill has capitalised on the opportunities he has been presented with, and made use of mentorship from leading therapists. In the UK how can we provide support and mentorship to a wider range of therapists?
4. How can we support more diverse OTs into leadership roles in our professional associations and in health and social care institutions across the country. What might some of the barriers be and how can we break them down?
5. And lastly - because I know Bill is passionate about this, and it's a perfect forum to highlight what OTs can bring to the table. What could you present on at a TEDx event?

Job Adverts or Advertising Discrimination



With thanks to Holly Sprake-Hill @HollytheOT for highlighting the job advert that some of these came from. Take a look at the signs in red. (Please note there is a text based version further down the page). Which groups might be disadvantaged by this requirement? What could be done to the environment or occupation to make the role more accessible. For the sign in green note down what steps you can take to make sure you follow this with respect to service users AND colleagues.

Text based version of signs image above.

Red Sign 1 - Physical effort: The post holder will be required to sit at a desk to complete administration tasks, travel to meetings both internally and externally, and move around the building to access different areas.

Red Sign 2 - Mental effort: The post holder will be expected to work towards deadlines and reprioritise workload in response to competing demands. There will be a need to concentrate on specific pieced os work for periods of time.

Red Sign 3 - Working conditions: The office is open plan and the post holder will need to be able to manage external noise and disturbances to enable concentration to task.

Red Sign 4 - Ability to frequently exert moderate physical effort for long periods of time, e.g. carrying and fitting equipment, moving and handling clients.

Green Sign - At all times to promote and follow anti-discriminatory and non-abusive practice.

And don't forget the catch all phrase that's used on every job description:

Flexible to the needs of the service

When in reality that flexibility only bend one way!

I like this alternative spotted on a current job description:
The post holder will be expected to adopt a flexible attitude to the duties which may have to be varied, subject to the needs of the service and in keeping with the general profile of the post.

Review the job descriptions and person specification you have access to, are there aspects you might like to change to promote inclusivity?

The Lives of BAME OTs in 2020 - Explored Via CMOP-E

I was invited by @LecturerMish to follow @DLafayette411's example and conceptualise BAME (Black and Minority Ethnic – UK Term) lives through an OT Model. Now being unable to stick to one tweet and not go overboard I've written this.

CMOP-E – Canadian Model of Occupational Performance and Engagement

This model describes the relationship and influences between these elements (Spirituality, Person, Occupation and Environment) which enables occupational performance. That is the ability of a person to perform occupations and daily engagements.

Analysis

Spirituality

Entered the profession to make a difference. Core identity as a member of a BAME community, family and the OT Profession. May feel incongruity with core values and beliefs and current situation.

Person

Cognitive – Mind can't switch off, memories of past injustice mix with current situation. Need space to process. Emotional reasoning does not equal illogical reasoning.

Physical – Added concern about the increased physical health risk of covid to BAME populations. Bombarded by sensory images of racism.

Affective – Tired and worn down, frustrated and angry, upset by being asked to relive past trauma. May also be energised by the momentum for change. Additional anxiety created by pandemic.

Occupation

Self-Care – Possibly neglected or may not be being prioritised. Need to focus on mental health and safety.

Leisure – I would imagine fairly limited especially in terms of enjoyment. Constantly engaging in debate, reading news/social media. Favoured

occupations may be sidelined.

Productivity – If still working the form of this will have changed placing extra demands on the person to work in different ways. Engagement in activism as a productive co-occupation.

Environment

Physical – Lockdown has removed access to certain parts of society where people may have sought support. May feel like there is no sanctuary as home has become where everything takes place.

Institutional (includes Economic, Legal, Political) Possibly feeling unheard by professional and regulatory bodies and workplaces. Wanting to affect change but having little power to do so within current structure. Finance may be difficult at the current time meaning less able to act on needs. Political environment is a mess compounded by Brexit – feels unsupportive. People also appear to be conflating politics with human rights. #BLM movement driving impetus for change.

Cultural – Conflicting cultures. Family, ethnicity, professional. May struggle with the professional or overarching British cultural attitude of stiff upper lip, keep calm and carry on. Focus is on connecting more to culture around ethnicity at present – that's where attention is needed. Family may or may not support this depending on familial make-up – do family members share BAME backgrounds and understand concern?

Social – Usual support groups not as accessible, experiencing tone policing online from those who aren't used to discussing racism. Seeking social support from allies to take on some of the load. Co-workers may not 'get it' especially where you are the lone OT from a BAME background.

In this model the environment is recognised as an underused resource and one that we need to capitalise on.

Not included in the model but I'd add in the Historical environment here too. This isn't about what has just happened. It's about all the things that have come before, all the personal microagressions, all the injustices. They aren't blaming others for the past environment but it still impacts massively on the present and needs acknowledgement (and yes even if you/they weren't alive when it all happened).

Synthesis and action

Spirituality

Reaffirm core belief of self and validation of the person as a their member of their BAME heritage. Help articulation of goals and desires for this period.

Person

Support strategies to manage stress and switch off. Prioritise sleep, nutrition etc. Person needs to be healthy to be most effective. Examine reasoning and explore thoughts and feelings. Risk assessment re physical well-being in workplaces. Recognise that everyone is individual. Some BAME OTs may not want to/feel able to engage at the moment and that is their right.

Occupation

Refocus on self care and restorative leisure occupations. Recognise that energy will need to be spent differently during this time though. Respect that activism is a valid occupation – explore different forms of activism. Possibly reduce demands of some occupational areas to compensate at this time, eg. Housework. That's always the first thing to go with me at least!

Environment

Locate a safe space, a place or time where can just be themselves.

Find a social support network of like minded individuals to bounce ideas off and share the load. Include white allies to support this.

Challenge structural and institutional inequalities and demand change. Allies need to do this too. Professional body/workplace could take more responsibility for leading change allowing BAME OTs to contribute as able without feeling burdened.

As a white OT I have aimed to use the model to empathise with the lived experience of my BAME colleagues. Any mistakes are entirely my own. Do feel free to comment if you agree or disagree with anything I've written. I will listen.

This was originally written for my blog and can be found here - https://occupation4life.co.uk/2020/07/12/the-lives-of-bame-ots-in-2020-explored-via-cmop-e-canadian-model-of-occupational-performance-and-engagement/.

Where Do I Want to Be?

Look again at the picture below (Image of a range of different people). Have any of your views changed after reading the book? Who in this picture could be an OT? Are there any that couldn't? If any of them turned up to work with you what would you think? Be honest with yourself. This reflection is for your eyes only.

Attitudes and Unconscious Biases

Free write your thoughts on the following topics in relation to the OT workforce now, after having read the book:

Ethnicity Disability Sexual Orientation Gender Identity

Neurodiversity Polyamory Obesity Mental Health Religion

Note which areas you need to find out more about. Accept the pain of challenging deeply held views. Once you've read around topics you may find you still have certain values and beliefs but they will come from a more informed position, and hopefully alongside a sense of empathy and understanding of difference.

How Will We Get There?

Although there are things we can take individual responsibility for, such as reflection and education there are also potential group actions we need to take as a profession to increase the diversity of occupational therapists so that we better serve the populations we work with. This section looks at both individual and group actions that we can take.

Allyship

If you find yourself in a position of privilege be an ally to those who don't have the same voice as you. https://www.england.nhs.uk/about/equality/allyship/

Show Humility

We are human. We will get things wrong. If someone criticises you thank them for pointing out your error and then do better. For example, it is likely that you may get a persons pronouns wrong. If this is pointed out, or you notice yourself, simply correct yourself and move forward. If there is anything that makes you uncomfortable in this point, send me an email and I will listen and learn.

In-Service Training

We are very good at focusing on practice skills in in-service training but in 2021 - Think diversity! Here are some suggestions of activities you could incorporate.

Diverse Book Club

Pick one of the books listed under further reading and host a book club.

Offer Your Unique Insight

If you've noticed some behaviours and attitudes informed by stereotypes amongst colleagues offer to share your insight on a topic. Challenge views.

Empathy Library

Pop that corn and watch a film https://empathylibrary.com/. Remember to watch with a critical eye. See if you can find any critical

reviews of it from people from the group it depicts. What do they think of the representation?

Service User Insights

How often do we take the time to learn directly from the people who use our service. Invite them to feedback on your service, listen and learn.

Challenge, Critique and Change

If you hear people saying, or see people doing racist, sexist, ableist, transphobic, or homophobic things challenge them. If there are processes in place that clearly disadvantage one group share your critique and work with others to make change.

Unconscious Bias Training

If you are involved in recruitment at any level, from students to practitioners then do consider arranging unconscious bias training.

We need to think about occupational therapy education and the admissions process and the interview and career progression process, to make them more inclusive.

A few words of caution

Don't fall into the trap of thinking that one token diverse candidate absolves you of a wider responsibility to improve diversity.

Don't assume that having a diverse staff member means that you can give them all of the people that 'match their diversity'. How can you learn from each other for you all to better meet the needs of the population you serve.

Don't expect people from diverse backgrounds to share their trauma. Whilst there are elements of people's negative experiences in the stories they share we aimed to look to the future. Don't force people to re-live past ills just focus on the solutions.

Get Political

It is time for occupational therapists to get political and stand against discrimination and to enact equity and inclusion. We need a stronger political voice. Where disabled populations are being disadvantaged we need to back their action.

Engage with the Professional and Regulatory Body

Actively seek out and uplift diverse voices within our profession. When the HCPC and RCOT ask us about our identities tell them. We are starting from a point of not truly knowing how diverse our profession is. Stand up and be counted, and then demand a recount!

Show RCOT that you are engaged with the issue of equality, equity and diversity.

#WeAreOT Call To Action

I would like to express my huge thanks to each and every OT who has shared their story in this book. It takes courage to speak up and that is something that every contributor has my respect for. Like the emblem of our profession, the Phoenix, these narratives describe a continual rising from the ashes, the drive to overcome, but also the toll that can take. It also shows how that has led to benefits to the populations we serve, through extra empathy, therapeutic use of self and the breaking down of boundaries.

The narratives included by no means reflect the complete diversity of people within this profession and so this is a call to action to you to share your OT story.

What has your diversity bought to your practice?

Share on your own blogs and social media. Please use the #WeAreOT hashtag when sharing. And if you can share during UK OT Week (2nd - 8th November 2020) that would be wonderful. If you would prefer to remain anonymous you can email your account to occupation4life@gmail.com and I can share on Occupation4Life.

Please do share the link to this book with your colleagues, especially those who don't venture online. I would ask that you do not share the file with others. I have kept the purchase cost low (£1.99) to enable everyone who wants one, the opportunity to purchase a copy that will contribute to the scholarship fund, and support their reflective practice. If you know anyone who can't afford a copy, buy it for them as a gift for coping with 2020. If you are happy to donate extra, any additional amount will be gratefully received toward the scholarship, but I appreciate that funds may be tight for many of us this year.

#WeAreOTScholarship

All profits from the sale of this book and any additional donations will be put toward the 2021 We Are OT Scholarship.

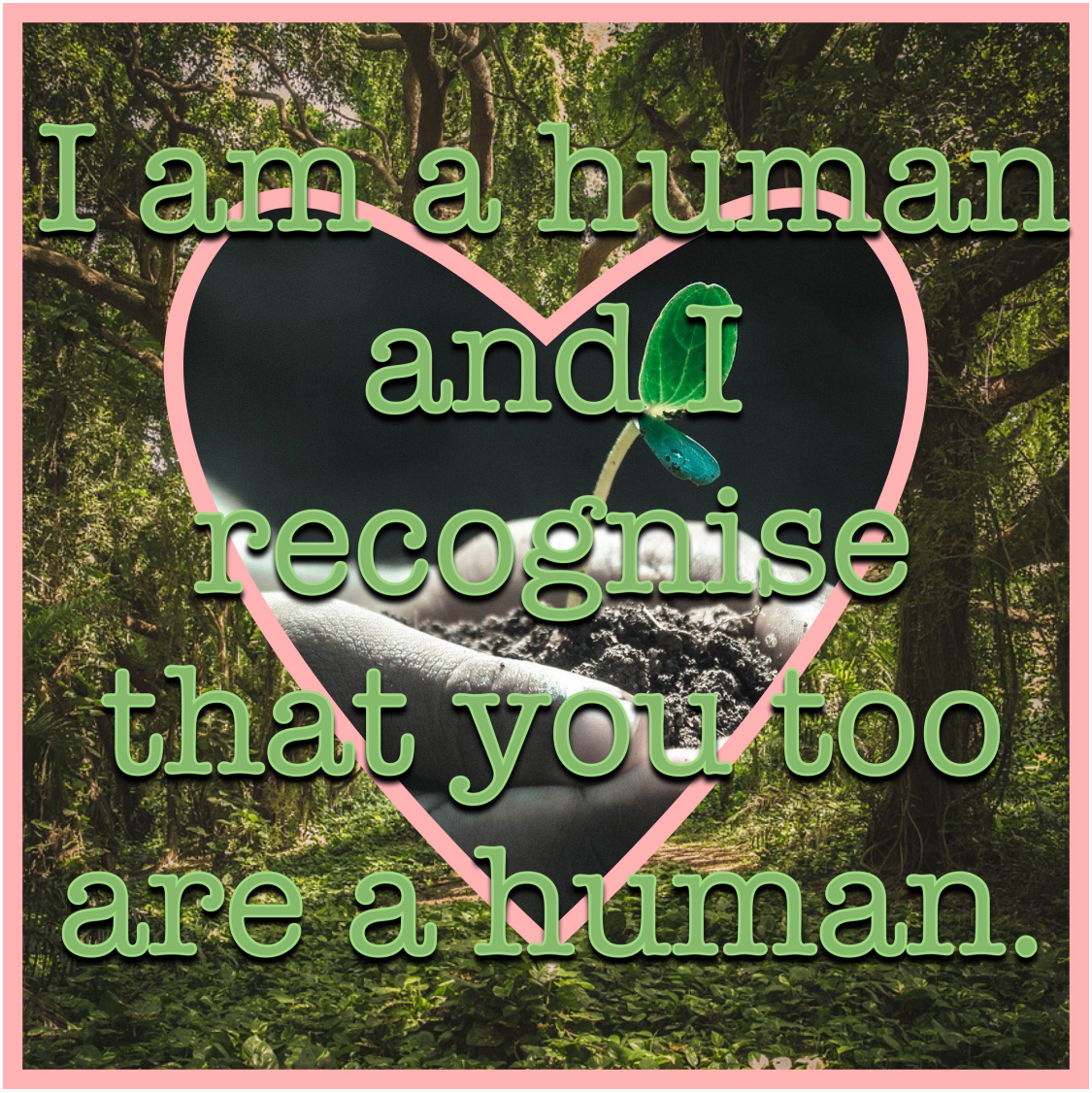
In January I will announce how much has been raised and invite applications from Black occupational therapy students in the U.K. to the Scholarship fund. Likely requests will be for a contribution toward additional training, or for the purchase of relevant books to enhance their studies.

Because this book was inspired from the righteous outrage displayed by the Black community and their allies, this is the reason for offering this scholarship only to Black students. No contributors have received payment and the only money that won't go directly to the fund will be the cost of the PayPal fees.

Head to http://www.occupation4life@gmail.com where you will find the links to follow me on my business social media. I will announce the scholarship application details on my blog.

Above All Remember This

Inspired by a Quote by Cassandra Clare



(Image Above Reads “I am a human and I recognise that you too are a human.”)

Further Reading

Non exhaustive list of further resources

OT Journals/Books/Blogs

Abson, D (2019) Therapeutic use of self https://www.theothub.com/post/therapeutic-use-of-self

AOTI (2019) LGBT+ Awareness and Good Practice Guidelines for Occupational Therapists https://www.aoti.ie/file_downloader.php?file_id=536

Lavalley, R. and Johnson, K. R. (2020) Occupation, injustice, and anti-Black racism in the United States of America. Journal of Occupational Science https://www.tandfonline.com/doi/full/10.1080/14427591.2020.1810111?journalCode=rocc20

Twinley, R,. et al (2020) Together, we are all kinds of minds. OT News August 2020, pp.32-37. Also available as text only from: https://thedarksideofoccupation.wordpress.com/neurodiversity/

Twinley R. (2021) Illuminating the Dark Side of Occupation: International Perspectives from Occupational Therapy and Occupational Science. Oxfordshire: Routledge

Social Media

BAME OT Network @BAMEOTUK - https://twitter.com/BAMEOTUK (Twitter)

DisabilOT - OT's with disabilities https://www.facebook.com/search/top?q=disabilot%20-%20ot%27s%20with%20disabilities (Facebook Group)

The Accessible Education For All Initiative https://www.facebook.com/groups/3498484543537937/about (Facebook Group)

OT Practitioners and Students of Colour/Color https://www.facebook.com/groups/372160100410754 (Facebook Group)

Occupational Therapy Practitioners for Solidarity - https://www.facebook.com/otpractitionersforsolidarityWebpages (Facebook Page) https://www.facebook.com/groups/otpractitionersforsolidarity (Facebook Group)

Not So Terrible Palsy https://notsoterriblepalsy.com/ (Blog by Georgia Vine)

Pd2ot - My journey from service user to professional **https://pd2ot.wordpress.com/** (Blog)

Books

The Self-Care Project - Jayne Hardy

Natives: Race and Class in the Ruins of Empire - Akala

Why I Am No Longer Talking to White People About Race - Reni Eddo-Lodge

How to be an Antiracist - Ibram X. Kendi

Me and White Supremacy - Layla Saad

How to Argue With a Racist - Adam Rutherford

It's Not About the Burqa - Mariam Khan

Meant to Be - Lisa Faulkner

Fattily Ever After - Stephanie Yeboah

Quiet: The Power of Introverts in a World That Can't Stop Talking - Susan Cain

Reader, I Married Me! - Sophie Tanner

Stim - An Autistic Anthology - Lizzie Huxley-Jones

Queer - A Graphic History - Meg-John Barker and Jules Scheele

She Called Me Woman - Azeenarh Mohammed, Chitra Nagarajan, Aisha Salau

Beyond the Gender Binary - Alok Vaid-Menon

Sorted - Jackson Bird

The Gender Games: The Problem with Me and Women, from Someone Who Has Been both - Juno Dawson

A Quick and Easy Guide to They/Them Pronouns - Archie Bongiovanni

Watch/Listen

Dr Karen Whalley Hammell WFOT Congress 2018 keynote 'Building globally relevant occupational therapy from the strength of our diversity' https://www.youtube.com/watch?v=9WipUPXx_Kk&t=7s

Hey White Therapist! Here's where we start! https://courses.clearlyclinical.com/courses/free-ceu-racial-awareness

LSBU BAME Allied Health Professional (AHPs) talk about allyship https://youtu.be/uY58kNLTyqI

The OT & Chill @ot_chill podcast, Episode 11 – L . O . V . E – Let's Talk About Race #BLACKLIVESMATTER: https://open.spotify.com/episode/4sPh0qghwAiozaXLSM0re2
The School That Tried to End Racism https://www.channel4.com/programmes/the-school-that-tried-to-end-racism

White Occupational Therapy Practitioners for Racial Justice (learning space) https://tinyurl.com/WhiteOTs4RacialJustice