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Professional Misfits: “You’re Having to Perform . . . All Week Long”

Brenda L. Beagan
Dalhousie University – Canada, brenda.beagan@dal.ca

Kaitlin R. Sibbald
Dalhousie University – Canada, kaitlin.sibbald@dal.ca

Tara M. Pride
Dalhousie University – Canada, tarapride@dal.ca

Stephanie R. Bizzeth
Dartmouth General Hospital – Canada, stephanie.bizzeth@dal.ca

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Abstract

Background: Occupational therapy professes commitment to equity and justice, and research is growing concerning the experiences of clients from marginalized groups. To date, almost no research explores the professional experiences of therapists from marginalized groups. This qualitative study explores how exclusion operates in the profession among colleagues.

Method: Grounded in critical phenomenology, semi-structured in-depth interviews were conducted with 20 occupational therapists who self-identified as racialized, disabled, ethnic minority, minority sexual/gender identity (LGBTQ+), and/or from working-class backgrounds. Iterative analysis was conducted using constant comparison and employing ATLAS.ti for team coding.

Results: Across identity groups, four processes of exclusion were identified: isolation, abrasion, presumptions of incompetence, and coerced assimilation. Garland-Thompson’s (2011) concept of “misfit” is employed to analyze how therapists are constructed as not-quite-fitting the professional space delimited by occupational therapy’s white, able-body-minded, Western, heterosexual, middle-class, cisgender norms.

Conclusions: Misfits are constructed by contexts, by expectations and material arrangements that assume particular bodies. Misfits make visible the inequities built into business-as-usual, an illumination that comes at often-painful cost. Yet there is possibility for change toward equity and justice for therapist colleagues: we can all choose to do differently, enacting change at micro and macro levels.

Keywords

professional exclusion, racism, heterosexism, ableism, classism, ethnocentrism, misfits

Cover Page Footnote

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Credentials Display

Brenda L. Beagan, Ph.D.; Kaitlin R. Sibbald, M.Sc., OT Reg (NS); Tara M. Pride, M.Sc., OT Reg (NS); Stephanie R. Bizzeth, M.Sc., OT Reg (NS)

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Individuals from socially marginalized groups may continue to experience marginality when working in the health professions, including occupational therapy, despite professed commitments to equity and justice from professionals in the field (CAOT 2018a; 2018b). Professional status alone does not transform social marginalization, the experience of systematic social, political, and economic exclusion resulting from structured power inequities (National Collaborating Centre for Determinants of Health, n.d.). In this cross-Canada qualitative study, we drew on interviews with 20 occupational therapists who self-identified as racialized, disabled, ethnic minority, minority sexual/gender identity (LGBTQ+), and/or from working-class backgrounds to explore the processes that convey professional exclusion. Intentionally and unintentionally, colleagues shape and convey normative expectations that signal not-belonging to therapists from marginalized groups. Yet these interactions are amenable to change and carry the potential for movement toward a professional culture that better meets its professed values of inclusion and justice.

Oppression Despite Commitments to Equity

Oppression is a central aspect of inequity and injustice, concerning situations where harms or benefits accrue to members of different social groups through systemic interlocking social structures grounded in history (Pooley & Beagan, 2021). The power relations of oppression perpetuate domination and subordination. In Western liberal democracies like Canada, people tend to profess a strong commitment to equality. At the level of discursive consciousness (Giddens, 1984), that which we are able to articulate with reason, most people deny that some groups are inferior or deserving of ill-treatment (Young, 1991). Yet, at the level of practical consciousness (Giddens, 1984), where we act and react without thinking, people experience unconscious or barely conscious aversions and prejudices and perceptions of inferiority and superiority (Young, 1991).

People are usually unaware when we display such aversions and prejudices, such as when we express condescension or stereotypes or enact discrimination or avoidance (Young, 1991). At the same time, a pervasive belief in equality at the level of discursive consciousness means those at the receiving end of such behaviors (or who witness and comprehend them) cannot name the behaviors as inequities without calling into question socially dominant beliefs and values, thereby situating themselves outside of the unspoken rules for social inclusion.

> When the more bold of us do complain of these mundane signs of systematic oppression, we are accused of being picky, overreacting, making something out of nothing, or of completely misperceiving the situation. The courage to bring to discursive consciousness behavior and reactions occurring at the level of practical consciousness is met with denial and powerful gestures of silencing, which can make oppressed people feel slightly crazy. (Young, 1991, p. 134)

In short, having been socially disparaged for naming inequity, marginalized therapists are excluded from the dominative social consensus and, therefore, from normative society.

Established social structures and hierarchies that display a group's practical consciousness come to reside in institutional practices, but they also become the internal, socially inherited "memory traces" of individuals (Giddens, 1984). Inequitable social structures and systems are maintained (or dismantled or transformed) through the everyday routine actions and inactions of human agents at micro, meso, and macro levels. Both social stability and social change are produced through the tiniest and grandest of human actions and utterances, as well as inactions and silences. Multiple forms of oppression, such as racism, ableism, sexism, heterosexism, gender binarism, colonialism, ethnocentrism, and classism, coexist

and intersect in complex ways, becoming indiscernible because they are so normalized, built into the business-as-usual of myriad institutions. Their existence, and the denial that oppression is operating, are as common in professional contexts as elsewhere.

Oppression in the Professions

The professions have long been bastions of exclusivity, sites of power and authority traditionally occupied by heterosexual, cisgender, white, able-body-minded, upper-middle-class men (Martimianakis et al., 2009). Professions such as occupational therapy and nursing, though founded by women, remained places of privilege and exclusion in every other way (Grenier, 2020). This exclusion occurs by creating contexts reinforced through systems of power, which those from marginalized backgrounds are unable to enter, or, once inside, are unable to fit comfortably.

Exclusion has been named in many ways across identity groups and the spaces that shape professional education and practice, yet there are similarities. Higher education, which is required for entry to the professions, remains steeped in upper-middle-class values and expectations, rendering those from working-class backgrounds "cultural outsiders" even when present in academic spaces (Waterfield et al., 2019). In the same vein, disabled people have been described as "unexpected workers" in higher education, those who were not really intended to be there in the design of the social institution (Stone et al., 2013). Sara Ahmed (2012) argues that in the context of institutionalized whiteness, racialized professionals are positioned as "unexpected guests." Pitcher (2017) also uses the phrase unexpected guests in describing the experiences of transgender people in higher education. The language surrounding these experiences is strikingly similar; a guest, an outsider, those unexpected, and those unintended require an invitation from the rightful occupant of a space, the host. As gracious guests, they are required to adapt to the existing space. The welcome offered to guests is temporary, contingent, and discretionary; they do not belong, nor do they take up residence or necessitate changes to facilitate a better long-term fit.

From critical disability studies, Rosemarie Garland-Thomson's (2011) concept of "misfits" has a particularly strong resonance with the experiences of health professionals from oppressed groups. For her, misfits result from an incongruent relationship between two things: "a square peg in a round hole" (p. 592). Individuals are not inherently misfits; they are socially produced as misfitting by contexts made to fit other people: "The discrepancy between body and world, between that which is expected and that which is, produces fits and misfits" (p. 593). As such, the various types of "worlds," the spaces and norms in which misfits are produced, warrant critical examination.

In the professions, education acts as a gatekeeping space determining who is allowed into the profession and deemed to belong there (Martimianakis et al., 2009; Sullivan, 2004). The workplace is the day-to-day space in which boundaries are produced and reproduced by those present, in part through interactions with colleagues (Fournier, 2000; Jain, 2020). In addition, Price (2011) introduces the idea of professional kairotic spaces, "the less formal, often unnoticed areas . . . where knowledge is produced and power is exchanged" (p. 21) that include a "strong social element" (p. 61), which results in exclusion beyond what is typically defined as the professional space. These informal spaces, because they reside on the edges of what would typically be considered a professional space, often remain hidden sources of power exchange that enforce professional boundaries. As such, understanding the misfit experience illuminates where social institutions, like the professions and those who comprise them, draw the line of belonging, the distinction between hosts and guests, and produce social exclusion in educational, professional, and social spaces.

While misfits may be cast as ill-suited for a particular context, that unique vantage point of being "outsiders within" (Collins, 1986) can also illuminate the everyday operation of institutions and social spaces that otherwise remains invisible to those who fit in smoothly. Misfits become "agents of recognition who by the very act of misfitting engage in challenging and rearranging environments" (Garland-Thomson, 2011, p. 603). Just as a fish in water cannot perceive the water, those who fit readily may struggle to see the limits on belonging built into the professions. While those who fit may experience professions as open and committed to diversity, those who constantly come up against the institution may feel the abrasiveness of institutionalized whiteness, upper-class-ness, able-body-mind-ness, and heteronormativity: "We all know the experience of going the wrong way in a crowd. You have to become insistent to go against the flow, and you are judged to be going against the flow because you are insistent" (Ahmed, 2012, p. 186).

Health professions have begun documenting the ways their racialized members experience institutionalized whiteness (Beagan, Bizzeth, et al., 2022; Beagan, Sibbald, Bizzeth, et al., 2022; Beagan, Sibbald, Pride, et al., 2022; Kristoffersson et al., 2021; Mpalirwa et al., 2020; Vazir et al., 2019). There is some evidence that health professionals from lower-class backgrounds may experience deep ruptures in embodied ways of being and knowing, becoming misfits in their new contexts (Beagan, 2005; 2007). Similarly, though formal curricula in the health professions may address LGBTQ+ health in positive and equitable ways, informal curricula may convey intense heterosexism, persuading queer students that it is not safe to be "out" in professional contexts (Murphy, 2019). Finally, disabled people face intense marginalization in the health professions, with doubts about their competence often framed as concern for patient and client safety (Bulk et al., 2017; Jain, 2020). Similarities in processes of professional exclusion across identity categories remain underexplored.

Occupational therapy in Canada is a profession committed to inclusion and enabling the person-environment-occupation fit of clients (Townsend & Polatajko, 2007). In this paper, we ask how exclusion happens in the profession itself. While negative experiences with clients certainly warrant examination, this paper focuses on how exclusion operates in the profession and its spaces: with colleagues, coworkers, and supervisors in the social and institutional spaces that characterize day-to-day occupational therapy practice. Our focus is less on explicating experiences of exclusion and more on the processes through which exclusion is constructed. This is an arena where professional commitments to inclusion might be most readily translated into action because change relies solely on changing our own everyday practices.

Method

Three university research ethics boards approved this qualitative study. Twenty participants were recruited across Canada through snowball sampling among the professional organizations and networks of team members and circulating recruitment information via provincial professional newsletters and social media. Participants were required to have at least 5 years of Canadian occupational therapy practice experience in any context and to self-identify as disabled, of working-class origin, racialized, ethnic minority, and/or minority sexual/gender identity. (Experiences of Indigenous professionals will be the next research phase.) Those who responded were emailed the study information and consent forms, and eligibility was confirmed.

The study was grounded in critical phenomenology, a qualitative approach intended to explore interpretation and meaning, especially of those aspects of everyday life usually taken for granted (Moustakas, 1994; van Manen, 1997). It is critical in its commitment to interrogating the roles of power relations that structure the conditions, institutions, and assumptions of everyday life (Ahmed, 2006).

Commitment to social change is inherent to "critical" research. An in-depth phenomenological study would typically include multiple interviews with each person to unpack layers of meaning and experience. This was not a time commitment we were able to request from busy professionals; thus, we say "grounded in" critical phenomenology.

In-depth interviews were conducted by phone or in person and explored belonging and marginality, the toll of oppression, as well as coping and resistance. The interviews were recorded and transcribed verbatim, then coded using ATLAS.ti software. Iterative analysis moved between compiling coded data and re-reading full transcripts. Quotations were organized and reorganized as sub-themes emerged, then cleaned by removing false starts and filler words like "um," "ah," and "like." Themes and subthemes were developed iteratively. For example, initial coding included items like overt hostility, microaggressions, vicarious oppression, belonging and not belonging, assumptions and stereotypes, undermining and disrespect, and sabotage and betrayal. Those were eventually blended into a theme about direct and indirect hostility, which later was altered to focus on our final theme about what others did to convey hostility, which we termed abrasion. The data coded undermining/disrespect no longer fit and became the basis for a final theme, presumed incompetence.

The larger research team and the smaller author group included individuals who identified with all of the social groups in the study. Lived experience thus informed every aspect of the study, from its inception through the construction of interview guides to analysis and writing. We met weekly throughout the study, which allowed for reflexive discussion and analysis, challenging and building on each others' interpretations as they emerged. While "insider research" has both strengths and limitations (Collins, 1986), in this instance, by triangulating views with researchers from differing identity groups and researchers from in and outside the profession, we strived to mobilize our "biases" and perspectives to enrich our analyses.

We report demographics yet deliberately keep details vague to minimize confidentiality breaches (see Table 1). For example, we use the term Asian to refer to East Asian, West Asian, and Southeast Asian participants, collapsing important cultural, ethnic, and national distinctions. The 20 occupational therapists all identified as members of at least one of the socially marginalized groups included. Most were women, and most worked in community or private practice, with some in academia, hospitals, and other institutions. Ages spanned from 30 to 50 years of age, with the participants distributed across years of practice, from 5 to 25 years.

Limitations and Trustworthiness

The study was limited by having a relatively small sample that was also heterogenous, which may have resulted in glossing over important differences in experiences by social identity, geographic location, years in practice, and so on. The biggest risk of a heterogenous sample is a lack of saturation. Despite recruitment being hindered by COVID-19, saturation was deemed to have been reached on most themes, as narratives were increasingly familiar. At the same time, the heterogenous sample added strength in that it allowed exploration of experiences across multiple groups, enabling us to tease out similar processes of marginalization. We did not employ member-checking, as our previous experience has shown that professionals rarely respond to preliminary analyses circulated. The increased participant burden was deemed not warranted by the quality of feedback usually received. A conference presentation of preliminary analyses indicated the interpretations resonated strongly with marginalized therapists.

The study was limited because only one interview was conducted per person, which is scant to examine such a complex topic. This was intended to reduce participant burden, as past experience

suggested busy professionals would be unable to commit to more. In fact, even getting an hour of the participants' time was challenging, with some of the therapists having to curtail the interview to return to clinical duties. We employed triangulation of researchers (as discussed above), sources, and theories (Lather, 1991). With our interest in the processes of exclusion, beginning to hear similarities from those experiencing racism, heterosexism, ableism, and so on strengthened the trustworthiness of our interpretations. We employed queer theory, disability theory, class theory, and theories of whiteness and anti-Black racism to interpret the data.

Table 1

Demographics

Characteristic	Category	N =
Age	30s	12
	40s	7
	50s	1
Years in practice	5–9	7
	10–14	7
	15–19	3
	20–25	3
Location	Rural/town	3
	Small city	9
	Large city	8
Practice setting*	Hospital	7
	Private practice	6
	Community	7
	Academia	4
Race/ethnicity	Black/African	3
	Asian	5
	Other minority**	4
Disability	Disabled	5
Sexuality/gender identity	LGBTQ+	6
Class background	Working class/poverty	6

Note. *n > 20, some people worked in multiple sites.** includes linguistic and religious minorities.

Finally, the relevant lived experience of team members brought a particular bias to our analyses, though, of course, no more so than had the research been done by "outsiders" (Collins, 1986). The fact that we were all insiders in some ways and all outsiders in other ways enabled rich reflexive team discussions. We interviewed one another at the outset for personal reflexivity. If we think of "bracketing" preconceptions and assumptions less as stopping them and more as making them explicit to understand their effects, we engaged in bracketing mainly through "transpersonal reflexivity" (Dörfler & Stierand, 2021). Perceptions, experiences, and beliefs became sources of insight as team members engaged in thinking together, holding a reflexive mirror to one another (p. 788). Probably the most limiting common factor remained that we were all insiders to the profession of occupational therapy, to some degree, with that bias least likely to have been challenged.

Results

This paper focuses on experiences with professional colleagues, including in occupational therapy education. Some of the participants had as little as 5 years' experience, others 25 years or more; yet, we did not find experiences varied markedly, despite dramatic changes in the profession in discussions around equity and justice. The participants with many years of experience nonetheless described incidents that had just occurred or were still occurring.

Regardless of the particular form of oppression, the processes of exclusion were similar, including isolation, abrasion, and presumed incompetence. Isolation was the sense of being the "only one," not

fitting in, or being left out. Abrasion was the sense of "rubbing up against" professional boundaries and expectations in ways that conveyed hostility. Presumed incompetence was a recurring message that these therapists were less credible. The resultant exclusion constituted these therapists as misfits in professional contexts, subsequently requiring them to engage in extra work, including coerced assimilation, to survive and thrive in the profession.

Isolation

Everyday practices that produce isolation of therapists belonging to marginalized groups resulted in experiences of exclusion. Isolation as a mechanism of exclusion, although producing similar effects across identity groups in education, the workplace, and in kairotic spaces, was expressed in various forms. Experiences of isolation resulted in the need to do extra work to either be included in the professional space or to endure isolation.

During education, isolation was most often experienced as being the only one. Across all identity categories, the participants spoke of frequently being the only one or "the first": the only racialized student in their school cohort, the only out LGBTQ+ person in their class, the first disabled student in their program, and so on. During occupational therapy education, those who were disabled commented on the extra work required being the first or only and having to figure out accommodation processes themselves because "there hadn't been anybody like me, going through that program in the past."

This same sentiment held in the workplace where the participants reported, for example, being the only Jewish therapist or the only immigrant therapist. None of the three Black therapists had ever worked with another Black therapist, despite having over 50 years' practice experience among them. One disabled therapist said she knew only of two others in Canada with similar disabilities and had little contact with them. One Asian therapist noted, "It's just something that's always there, that you always are aware of, when you're in your workplace or even just like social settings, yeah, I'm the only visible minority."

Resoundingly, social spaces and the expectations in these spaces were discussed as particularly isolating. Racialized and ethnic minority therapists reported not being asked to join when classmates or coworkers were going out for a bite or a drink. In the same vein, one Asian therapist found when she was included in social spaces, no one seemed comfortable with her: "I tried to fit in. Like, I would go out for drinks with my colleagues [but] people just don't really know what to say to me, sometimes." Similarly, some of the participants excluded themselves from work-related social events occurring in spaces where they did not feel comfortable. For example, some LGBTQ+ therapists felt unsafe joining colleagues at straight bars. Some ethnic minority therapists found gatherings always centered around food unfamiliar to them. Some disabled and working-class therapists simply did not have the resources to join social gatherings, on top of the time and energy expended for school and paid work. Some found they were even excluded in informal conversations in the workplace, as one Black therapist noted: "It's like you're in a group and people are talking to each other not acknowledging you're there and not interested in your own experience as part of a social conversation." Some of the participants learned over time to exclude themselves, keeping work focused solely on work.

This awareness of being the only one conveys who is the expected occupant of the therapist role in a profound way. Being an unexpected presence led to extra work in navigating disclosure, determining safety in the workplace, navigating stigma, and working with their own negative messages arising from years of not fitting in. One Asian therapist from an impoverished family background saw her colleagues as more confident and at ease in professional contexts:

> They come from a better background and language was never a barrier for them, and they're Caucasian, and they would be able to speak without thinking. So I always just doubted myself, and I always try to fit in, but I don't truly fit in. I feel like I have to work much harder.

Even the most frequently raised response to isolation in the profession, finding community, requires extra work from these therapists. Community was described as the one thing that supports people to resist the pressures of professional conformity and marginalization.

> Save yourself. Find community. Keep community. We need community. You need your people. You need to find spaces where you're not behind that glass wall, you're not modulating your performance, where you're just you, and who you are is not just good enough, it's awesome.

Abrasion

Abrasion can be understood as experiences in which the participants reported rubbing up against the boundaries of professional norms in ways that resulted in a consistent wearing away of their sense of belonging or incidents that resulted in feeling raw and exposed. In school, this often took the form of humiliation and/or the threat of, and actual hostility from, colleagues, supervisors, and professors. This involved rubbing up against normative requirements in ways that highlighted aspects of their identity that went against the grain. Marginalized therapists reported needing to ask over and over for their needs to be met, often in front of other classmates or colleagues:

> I can just remember sitting in class and being like, 'Oh my god, I have to do this *again*! Like, I have to ask again!' Just that feeling of my face getting red and being like, 'Oh god, I don't want to have to do this again', make myself stand out again and ask for help. I just want it to be easy! It makes me teary, just thinking about that feeling. There would have been so much less time wasted and so much less frustration on my part and less feeling like 'What the hell am I doing here?'… feeling like I have to drag it out of people. To know when I needed to ask for help, I could ask for help without feeling like I was asking for a favour.

Others described experiencing homophobic and racist remarks and behaviors or being humiliated for not communicating in English as comfortably or confidently as their peers, or requests for disability accommodations being met with scorn and derision. When students raising concerns about such experiences in their educational spaces were disregarded, ignored, challenged, or faced additional humiliation, they were led to remain silent: "Being challenged by someone in that position of power over my future, if I'd had a failing grade in the class or whatever, then it would have been the end of my schooling as an occupational therapist." One student remained silent about being gay-bashed on a field placement, never disclosing this to the school. Another student abandoned hope for an international fieldwork opportunity when all placement sites were in countries unsafe for LGBTQ+ people. Such experiences rubbed raw the students who experienced them, as professional expectations were revealed and experienced to be abrasive, rigid, and. immovable.

Humiliation and threats of and actual violence followed marginalized therapists into the workplace. Humiliation in the workplace occurred through ignorance and indirect derogatory comments. When people were open about their LGBTQ+ identity at work, homophobia generally took the form of ignorance, with questions such as, "Which one of you in the relationship is the man?" Vicarious violence was reported across identity groups, with the participants describing hearing coworkers making derogatory

comments that were racist, ethnocentric, anti-Semitic, anti-immigrant, anti-refugee, and homophobic. Though not directed at the therapist, they constitute vicarious hostility, revealing the beliefs of the speaker and the overall lack of safety in the workplace: "I don't react initially, because it's like a slap in the face; it's a shock. So it takes time. At first you just get this autonomic nervous system response, and you can't really think clearly."

While those whose marginalized social identities were less visible had to hear slurs directed at members of their groups (such as Jewish therapists hearing anti-Semitic comments), those who were visibly racialized (including Black and Asian therapists) had to face relentless questions about where they were "really" from, a coded message about not fully belonging in Canada. Those who spoke English or French with the "wrong" accent faced constant critique and dismissal as being impossible to understand. For example, one therapist who had worked in Canada for decades reported that whenever she presented to large groups, her manager would correct her English "in front of everybody."

Bullying, scapegoating, and persecution were also reported in the workplace, which resulted in some of the participants leaving their jobs. These oppressive tactics were also joined by practices of silencing. For the LGBTQ+, disabled, and some ethnic minority therapists, silencing often took the form of not disclosing identities because of fear of repercussions, including physical and emotional harm: "I was completely not out, during my first job, because . . . everybody was so conservative . . . it just was scary to even think about broaching that." Judging safety and making countless in-the-moment decisions about disclosure became a constant undercurrent. The racialized participants, in contrast, spoke of having their ideas ignored or dismissed until they were repeated by someone else: "I gave an idea about something, then even in that meeting, it would be dismissed, and another person would take that same idea that had been dismissed, and they would say wow! (laughs)." Some of the participants whose ethnocultural identities were strongly connected to religion or spirituality found there was little space for those aspects of self in a profession infused with secularism. Conferences are scheduled during non-Christian holy days, workplaces celebrate Christian holidays, and discussion of religion and spirituality seems virtually taboo.

Humiliation, silencing, appropriation, and marginalization in day-to-day practice led the therapists to experience constant abrasion from the boundaries of the profession, which left them feeling raw and wounded: "It's a brick wall. And we're banging . . . banging [our] heads against this brick wall. And so, your nails tear, and you bleed, and you get scratches and stuff." The participants also described the extra work required to attempt to heal from, or live with, the results of this abrasion. Organizing how to take extra breaks, using sick time to emotionally recover from discrimination, and supporting students with similar experiences were all ways that therapists responded. Particularly vivid were the therapists' descriptions of trying to carve out space in the profession, push back at boundaries through subtle and explicit activism, and re-shaping the edges of the profession so the next generation of misfits entering the profession would experience less abrasion than they had: "[So] those that come next can see the traces of the work already done."

Presumed Incompetence

Despite having the same credentials and as much experience as their non-marginalized colleagues, the marginalized therapists reported having their competence and suitability for the profession questioned and invalidated in professional spaces. This was particularly relevant for the disabled, racialized, and ethnic minority therapists.

In occupational therapy educational settings, both students and faculty from marginalized groups were presumed incompetent. One participant thought the perception of disabled therapists as less competent was exemplified when, as a student, some fieldwork preceptors focused almost exclusively on safety issues:

> It was very much like, 'Did you do that safely?' And it felt like, 'Well, what about all the other stuff? Like, can we focus on some of the other stuff?' It's not just about, like, I didn't trip over the IV pole. I should be reviewed based on what I'm actually here for, which is my OT skills!

Some of the racialized instructors reported being directly challenged by students, their authority and expertise questioned and disrespected. Those with accented English reported that they were deemed less professional, both as students and as instructors. The fear of appearing incompetent and unprofessional in learning environments often led marginalized students to remain silent during group work and learning activities and to avoid identity disclosures.

The presumed incompetence attached to marginalization particularly affected transitions from education to occupational therapy practice. Doubts about competence hindered job prospects for therapists. One participant thought she was screened out of most jobs at a pre-application stage because she did not drive because of disability: "I wasn't even getting past that initial electronic screen, because basically every job that came up, if you're an OT, they say you needed a driver's license, even if you didn't really need a driver's license." One therapist described not getting an interview for a position when everyone else in their class who applied got an interview:

> Why would I not get an interview for this job? Why did everybody else? I have exactly the same training. We're graduating at the same time. I graduated top five in my class. I could not figure out what would have made me less capable or less appealing to even interview.

Similarly, several of the participants thought being racialized/ethnic minority had hindered their job prospects: "I applied to, like, forty-some jobs and only got maybe one interview." One Asian participant thought race had helped in getting community-based jobs, working mainly with Asian clients, but otherwise reduced job opportunities:

> I was in the community for a while. And at one point, I felt very helpless. I felt like, I don't think any hospital or major company would hire me. Like, this is what I'll be doing for the rest of my life, in the community? Maybe is it because I'm [Asian]? Or because they have certain assumptions about me? Is this why they're not willing to hire me?

Attributions of incompetence followed marginalized therapists into the workplace. While not always direct, discussions of incompetence about people "like them" made therapists feel excluded and avoid disclosure, if possible. A therapist who had migrated to Canada noticed that colleagues often spoke of other internationally trained therapists (including those from her country of origin) as if they were inferior therapists; she assumed they also thought this of her. Another remembered hearing others talk of the incompetence and untrustworthiness of someone with a background similar to hers, which led her to avoid workplace disclosures.

Constantly confronting presumed incompetence resulted in extra work for these therapists. Managing fear and shame during learning experiences, navigating the double-bind of responding to

students' inappropriate remarks while knowing students would be reviewing their teaching, applying to numerous jobs and recovering from numerous rejections, and managing a typical workload regardless of barriers, were some of the ways therapists put in extra effort to navigate presumed incompetence. Others described ensuring that their professional identification was always visible to avoid having their competence questioned. A disabled therapist described putting in numerous unpaid extra hours after work each day to complete documentation because asking for assistance might confirm presumed incompetence. As one therapist put it:

> In my work life, probably, I work harder than others, and the recognition I got, and even the position I have now, I think it has been through merit, which is through hard working. Because I have a feeling, if I was just working as hard as everybody else probably I wouldn't have the position I am in. (African-heritage therapist)

Coerced Assimilation

Therapists discussed feeling coerced to mask pieces of their identity to fit in the white, able-bodied, Western, heterosexual, middle-class, cisgender norms of the occupational therapy profession. Across spaces, many of the same strategies were used, indicating the same professional norms in which therapists are supposed to live and exist across educational and professional spaces.

In educational and workplace settings, therapists reported monitoring and adapting their physical presentation to approximate as closely as possible accepted norms, including not being too religious; not dressing too flamboyantly; making sure their hair was not too curly; not speaking too informally, accented, emotionally; or not using adaptive equipment that was too obvious. One therapist reported profound and deliberate class assimilation: "You sort of learn to adjust your language, the way you speak, the way you dress, the way you move. Just mannerisms, often through emulation, looking at the people that are respected around you, and trying to emulate that."

In kairotic spaces, such as the lunchroom or breakroom, the therapists reported feeling coerced to assimilate to the norm in hesitating to bring traditional foods for lunch, as that tended to make them the center of unwanted attention. They "toned themselves down," modulating their voices, their emotions, anger, laughter, grief, and sorrow, which were seen as "too much" for professional respectability: "That was another thing that I had to shift and change . . . all aspects of my speech and nonverbals." This was described by one therapist as needing to "bend [her]self into a pretzel" to fit within the boundaries delimited by a profession that was designed without therapists like her in mind.

Monitoring and adapting their self-presentation to fit white, able-body-minded, Western, heterosexual, middle-class, cisgender norms of professional comportment took significant time and effort. One therapist described how: "I always felt like I look unprofessional, if my hair was not straight. I've spent quite a bit of time straightening my hair. I felt like I needed to dress up quite a bit." Others reported consciously switching between personal and professional life, noting what aspects of their self-expression they had to make an effort to erase to avoid conforming to stereotypes that threatened their professionalism: "I wear bright clothing in my personal life, but I don't think I'd do it very much in my work. I think I definitely dress conservatively at work." This conscious awareness that an unmonitored, authentic self would clash with professional norms and the continuous, conscious effort to recognize and avoid conforming to "unprofessional" (i.e., racialized, disabled, ethnocentric, non-heteronormative, and lower-class) stereotypes resulted in significant time, energy, and effort across professional spaces. In

addition, extra work was required to navigate a sense of "homelessness" in the profession. As one therapist described:

> In terms of what a professional looks like and acts like, well, I felt as though I had to, I went through a serious struggle where I felt like I couldn't be myself in all that I am. The way that we were structured to have conversations with clients was very homogenous. I really struggled . . . to see how I could use therapeutic use of self.

This constant effort can be exhausting: "You're constantly on, you're having to perform. It's a performance, all week long. It is a lot of work, the mental exhaustion of it."

Discussion

Despite therapists of different marginalized groups experiencing different forms of exclusion in different spaces, the processes of exclusion were resoundingly similar. Exclusion arose through isolation, abrasion, presumed incompetence, and coerced assimilation, each of which functioned to exclude therapists and also required extra work to shape themselves to fit the professional space delimited by occupational therapy's white, able-body-minded, Western, heterosexual, middle-class, cisgender norms (Grenier, 2020). A professional context haunted by the specter of a "normative" (dominant group) therapist casts all of these therapists as misfits, as not quite belonging.

The Costs and Benefits of Being Misfits

From disability studies, Garland-Thomson's (2011) notion of misfits reminds us that fitting and misfitting are about the person-environment juncture; they are relational. Fitting is produced when majority body-minds move through and in spaces created with them in mind, "a world conceptualized, designed, and built in anticipation of bodies considered in the dominant perspective as uniform, standard, majority bodies" (p. 595). Fitting allows a sense of being suitable "so as not to stand out, make a scene, or disrupt through countering expectations" (p. 596). Misfits are created when social and material spaces create disjunctures, contexts where unexpected bodies are left out, conspicuously set apart. Misfits are cast, by ideas, assumptions, expectations, attitudes, and the built and arranged material world, as unfit in particular spaces and contexts. This resonates with the experiences of occupational therapists across marginalized groups.

Some of our participants described a sense of "homelessness" in occupational therapy: not really belonging in a profession that asserts values of enabling, inclusion, and justice but does not extend these same values to its own members. Living this contradiction led to exhaustion, frustration, and disillusion with occupational therapy. Although occupational therapy as a profession asserts these inclusive values, professionalism is rife with exclusion; access to professions has always been restricted to those with particular kinds of academic backgrounds, incomes, characteristics, and qualities (Martimianakis et al., 2009). While particular kinds of people are no longer formally excluded from the professions in Canada, it is clear that some people fit better than others, and misfits are expected to assimilate as the price of admission (Beagan, 2001; Jain, 2020; Murphy, 2019). Kenji Yoshino (2006) argues that when overt discrimination became hampered by civil rights protections, it took more subtle forms, demanding conformity to enter the halls of power. The therapists in this study described how the halls of power where conformity is required in occupational therapy extend beyond purely professional spaces to include the academic and kairotic spaces that occupational therapists inhabit throughout their careers.

Professional power and authority reside partly in expertise and credentials but also in adherence to the expectations of professional "respectability" (Young, 1991). Authority hinges on the degree of

conformity with expected ways of being: "Norms of professional comportment entail repression of the body's physicality and expressiveness. Professional behavior, which in this society signifies rationality and authoritativeness, requires specific ways of sitting, standing, walking, and speaking – namely without undue expression" (Young, 1991, p. 139). The participants in this study indicated that this desired way of being permeates all aspects of professional space and serves to create feelings of exclusion or force conformity among those who do not easily fit this expected norm. In her study of everyday racism, Philomena Essed (1991) documented how racialized physicians were expected to tone down their laughter, voices, and very selves; they are deemed too emotional, too expressive, and too colourful. Those who named this racism were dismissed as "too sensitive." Our study suggests that this extends to racialized occupational therapists and also to other marginalized groups who are expected to tone down their religious convictions, flamboyancy, need for assistive equipment or support, class- and culture-infused language, accented English, and "deviant" mannerisms to fit within the boundaries of the occupational therapy profession.

At the same time, Garland-Thomson (2011) is clear that misfits bring a valuable perspective and serve a beneficial role in making visible the inequities built into business-as-usual. As such, they can be catalysts for change, illuminating the limitations of contexts that are designed for some while excluding others. She calls this the "productive power of misfitting" (p. 604). The illumination, she notes, arises from the "experience of slamming against an unsustaining environment" (p. 597). While Garland-Thomson is focused on disability, Ahmed (2012) speaks similarly of how the experience of racialized people, when welcomed into institutions, "confirms the whiteness of what was already in place" (p. 33). She argues that only the continual "practical labor of 'coming up against' the institution" makes this intransigent whiteness visible (p. 174).

Yet, to be clear, this beneficial vantage point comes at a cost. This "slamming against" or coming up against the normative requires work, Ahmed's "practical labor" (2012, p. 174). She describes the everyday-ness of the "experience of hesitation, of not knowing what to do in [particular] situations," the "labor in having to respond to a situation that others are protected from, a situation that does not come up for those whose residence is assumed" (p. 176–177). The informal conversations, she notes, establish who is expected to be present in the space (p. 122). Our participants detailed the ways they are excluded from, and in, those informal kairotic (Price, 2011) social spaces. They described the constant work of having to decide whether to disclose, whether to speak up, whether to challenge, or whether to swallow yet another instance of marginalization, wounding heart and soul.

This idea of repeatedly coming up against or slamming into boundaries that are often invisible to those who easily fit within them was echoed in the experiences of the therapists in this study. They were acutely aware of the abrasions they experienced from coming up against and slamming into these boundaries, and the subsequent need to continually scrape off parts of their identity to better fit within dominant norms. As a profession, we need to interrogate how the continued wearing down of marginalized therapists affects not only their experience in the profession but also the lost value of what is worn away that could help sustain a profession that professes inclusion, diversity, and justice.

Change-Making

Multiple, interlocking systems of oppression seem daunting and overwhelming. Yet there is a possibility here for change and movement toward equity and justice. From queer theory, "queering," as a verb, urges examination of what is considered normal and taken for granted through a lens that troubles it in some way, renders it strange and no longer assumed, opening up gaps and spaces of possibility

(Richards et al., 2017). Moving far beyond gender and sexuality, queering is centrally about transgression, contestation, violating norms, and so making them visible as social constructs. As Black feminist scholar Patricia Hill Collins (1986) articulated decades ago, the outsider within can make strange the familiar, allowing all to see the patterns usually invisible and unquestioned. "Marginality," she says, "has been an excitement to creativity" (p. s15).

Professional standards ensure client safety and competent practice. Critical reflexivity is required to discern when expectations and requirements are genuinely about safety and when they are matters of conformity to "professional respectability" and ideas of "this is how it is done" grounded in the norms and expectations of dominant social groups. This demands critical interrogation of business-as-usual, asking how we reproduce oppression and exclusion through our (professional) expectations of ourselves and our colleagues while not compromising the quality work we bring to clients. We need to interrogate the presumed normal embedded in professional practices, processes, frameworks and standards, as well as in institutional policies and guidelines.

The marginalization and exclusion the study participants recounted occur among colleagues; we can all choose to do differently, enacting change at micro and macro levels. None of us are solely oppressed or privileged, we live out complex intersections of simultaneous privilege and oppression. Moreover, taken all together (racialized, ethnic minority, LGBTQ+, disabled, working class), the misfits likely constitute a statistical majority.

Change-making requires attending responsively to the things illuminated by misfits. Garland-Thomson (2011) argues that when the professional and institutional contexts constitute some people as misfits, "social justice and equal access should be achieved by changing the shape of the world, not changing the [misfitting individuals]" (p. 597). Like fish trying to see the water in which they swim, that means trying to see the normal, trying to see the assumptions built into everyday practice that inevitably include and exclude. It means encouraging students and therapists from marginalized groups to be all of who they are, rather than hiding behind vague notions of professionalism that demand conformity and assimilation. Therapists and students from oppressed groups do not come to the profession with cultural deficits, "lacking necessary knowledge, social skills, abilities and cultural capital" (Yosso, 2005, p. 70). Rather, they come with "community cultural wealth" and transgressive knowledges and skills that are not only helpful to working with a wide range of clients but also key to transforming institutions and social structures. Our human differences are indispensable to helping occupational therapy measure up to its values regarding inclusion, equity, and justice, not only as a profession but also in the profession.

Conclusion

In the profession, occupational therapists from oppressed groups may experience varying degrees of isolation, social exclusion, abrasion, and presumptions of incompetence. This positioning as misfits in the profession requires them to engage in identity navigation, including processes of selective disclosure, assimilation, or toning down to render themselves less "troublesome" in professional contexts. The extra work required of them simply to survive and thrive in their profession can be exhausting. While the position of misfit in any social context is an uncomfortable one, it also carries a potential productive tension, the inevitability of highlighting taken-for-granted assumptions that are foundational yet usually rendered invisible to those who fit easily. Misfits are catalysts for change toward the inclusion, equity, and justice that occupational therapy professes to value. What remains to be seen is whether we have the political will.

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