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Exploring the Professional Identity Development and Leadership Capacities of a Doctor of Occupational Therapy

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Abstract

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Keywords

Professional identity, doctorate, Doctor of Occupational Therapy, leadership, qualitative

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ABSTRACT

Occupational therapy literature contains little evidence of the added value of clinical doctorate education, the professional identity of a Doctor of Occupational Therapy, or distinctions between master's-prepared and doctorate-prepared occupational therapists. This study is intended to add to the literature base through the systematic and in-depth exploration of the experiences of graduates from a post-professional clinical doctorate program in occupational therapy. The goal of this study was to examine the professional identity transformation experienced by occupational therapists completing a doctorate degree, and to better understand the Doctor of Occupational Therapy identity. The study followed a qualitative descriptive design, including participant focus group interviews and document review. Participants included sixteen recent graduates, two male and fourteen female, of a post-professional doctorate program in occupational therapy. Data analysis revealed recent graduates' perceptions of the leadership characteristics and capacities they developed throughout their learning experiences in the program and contributing to their professional identities as Doctors of Occupational Therapy. Results may have implications for the capacity for leadership within the profession. Further study is warranted to examine the impact of occupational therapy doctoral education on professional identity and capacities.

For over a decade, the occupational therapy profession has engaged in rigorous debate regarding the ideal entry point for practice; nevertheless, the profession has not yet mandated a single point of entry. Literature reflects this debate, and the pros and cons of doctorate level education are thoroughly documented across various healthcare professions (Brown et al., 2016; Brown et al., 2015a; Brown et al., 2015b; Case-Smith et al., 2014; Fulton et al., 2012; Paplham & Austin-Ketch, 2015; Rodriguez, 2016; Smith,

2013; Smith, 2007; Valverde, 2016;). Fulton et al. (2012) emphasized the need for research on the positive outcomes and value that doctorate level graduates bring to a profession to better inform the decision regarding the ideal entry point of matriculation.

Occupational therapy literature contains little evidence of the added value of clinical doctorate education, the professional identity of a Doctor of Occupational Therapy, or distinctions between master's-prepared and doctorate-prepared occupational therapists. One study found by Kim et al. (2020), although not specific to occupational therapy, explored confidence levels among healthcare practitioners to determine whether confidence was directly impacted by years of education and training. This study found that neither knowledge nor years of education directly impacted providers' confidence levels. Rather, the greater the breadth and variety of tasks completed by the provider, the greater their confidence level. More recently, occupational therapy studies have begun to examine the outcomes of doctorate level education (Miller et al., 2021; Morrow et al., 2020; Recigno et al., 2020). Studies by Miller et al. (2021) and Morrow et al. (2020) examined professional characteristics and outcomes of doctorate occupational therapy students and graduates. Morrow et al. (2020) found that graduates of a post-professional doctorate program were transformed into confident and empowered practitioners with advanced skills across leadership, critical thinking, advocacy, and clinical practice. These advanced skills afforded the doctorate graduates greater career opportunities. Professional characteristics identified through the Miller et al. (2021) study included improved advocacy skills and the capacity for influencing change.

Although there is limited systematic evidence of the outcomes of clinical doctorate education, many occupational therapy academic programs have transitioned to an entry-level doctorate degree. Currently, there are 89 entry-level professional doctorate programs in operation across the United States, plus an additional 130 programs in the candidate or applicant phase of accreditation and 63 post-professional Doctor of Occupational Therapy programs (Accreditation Council for Occupational Therapy Education [ACOTE], n.d.). At present, 55.7 % of current occupational therapy students pursue a professional doctorate degree (American Occupational Therapy Association [AOTA], 2023).

In spite of this proliferation of entry-level doctorate programs, the profession grapples with the challenge of discerning the distinct skill set between a graduate with a master's degree versus a doctorate degree. Attempts to operationalize differences between the two entry-level degrees are evident in the ACOTE® (2022) draft standards; however, professional identity has not been deeply examined in occupational therapy literature, which further exacerbates this dilemma. As Program Director and Associate Chair of an occupational therapy program with a large entry-master's program cohort each year, the majority of whom continue into a one-year post-professional doctorate program, authors anecdotally observed a transformative experience during this doctoral year of education, as graduates began to embody the new identity of Doctor of Occupational Therapy. The purpose of this study was to systematically explore these anecdotal observations through the distinct perceptions of recent Doctor of Occupational Therapy

graduates regarding their professional identity as Doctors of Occupational Therapy, and to examine more closely the transformative process of becoming a Doctor of Occupational Therapy. Primary research questions were “What does it mean to be a Doctor of Occupational Therapy?” and, “What factors contribute to students’ transformation during the Doctor of Occupational Therapy program?”

Methods

Researchers were particularly interested in understanding how recent graduates experienced their professional transformation during the post-professional Doctor of Occupational Therapy program, and more specifically, how graduates perceived their professional identities as Doctors of Occupational Therapy. Given the intent of the study was to more fully understand the graduates’ lived experiences, authors selected a qualitative descriptive approach (Sandelowski, 2010) to answer the research question. The study was approved by the Institutional Review Board (HS-18-00348) and participants were recruited from three cohorts of post-professional Doctor of Occupational Therapy graduates in 2019 and 2020 upon graduation from the program.

Participants

Participants consisted of a convenience sample and were recent graduates from the post-professional Doctor of Occupational Therapy program. An email was sent to all students upon graduation, inviting them to participate in the study. Sixteen (16) graduates responded to the outreach email, agreeing to participate, and completed the informed consent. Two (2) individuals identified as male and fourteen (14) as female. Fifteen of the sixteen participants enrolled in the post-professional Doctor of Occupational Therapy program directly following completion of the entry-master’s program, during their first year of clinical practice, and one of the participants returned to the Doctor of Occupational Therapy program after a little more than five years of practice experience. Consent included participation in a focus group with their peers, and/or submission of their final reflective paper “My Envisioned Future as a Doctor of Occupational Therapy,” an assignment for one of the required Doctor of Occupational Therapy courses. A subset of six graduates participated in the focus groups, based upon logistics pertaining to location, scheduling, and availability. One focus group was held in-person on campus, and another was held remotely via Zoom.

Consideration of Bias

The authors were faculty at the same institution as the study participants and familiar with the study participants. Both authors were privileged in holding leadership positions. The first author served as the Program Director of the post-professional Doctorate program, and the second author served in an academic leadership role overseeing all academic programs. As Program Director, the first author was highly connected to the phenomenon of study: professional identity development among post-professional doctorate students, having worked with approximately 500 graduate students from the

program across eight years prior to the implementation of the formal study. In qualitative research, this closeness to the phenomenon has been acknowledged as a benefit, leading to a richer, more comprehensive understanding of the phenomenon being studied; but also debated in terms of the complexities of this “dual role” of both “insider and outsider” (Raheim et al., 2016). Intentional efforts to reduce the influence of bias included the practice of self-reflexivity and the assessment of personal biases and motivations, as authors engaged in repeated dialogue to question assumptions and evolving interpretations of the data. These strategies were implemented to determine whether the authors were well-suited for data collection and analysis without compromising the sincerity of the findings (Tracy, 2010).

Trustworthiness

Authors strived to achieve trustworthiness and credibility of the research findings throughout the data collection and analysis processes. To enhance credibility, authors adopted the practices of triangulation and multivocality (Tracy, 2010). *Triangulation* (Tracy, 2010) was achieved, whereby authors met multiple times to discuss their interpretations of the data and to ensure both points of view converged on the main themes and concepts that emerged from the focus group transcripts and final reflective papers. The lead facilitator implemented *multivocality* during the focus groups, in an effort to ensure that all participants had opportunities to share their views, and frequently probed for alternative or opposing perspectives to the comments that were shared by other participants.

Data Generation

Data consisted of transcripts from the two focus groups, each with three participants, and ten students’ reflective papers. Each focus group was approximately one hour in length and was facilitated primarily by the second author, using a semi-structured interview guide (see Table 1). Each focus group was recorded and transcribed verbatim by an administrative staff member. The transcripts from the focus group interviews were read multiple times and coded by the authors.

Ten participants submitted their final reflective paper from the required Doctor of Occupational Therapy course. All papers were de-identified by an administrative assistant prior to analysis. These final reflective papers were read multiple times by the authors and subsequently coded.

Table 1

Semi-Structured Interview Guide

Introduction: Thank you for participating in this focus group of recent Doctor of Occupational Therapy graduates. The purpose of this study (and focus group) is to better understand the identity of a Doctor of Occupational Therapy, from your perspectives, and the transformation you experienced through completing the Doctor of Occupational Therapy program.

1. Can you all please introduce yourselves and say a little bit about your current position?
2. Let's start by talking about what it means to you, today, to be a Doctor of Occupational Therapy…How would you define a Doctor of Occupational Therapy?
3. What characteristics are essential for a Doctor of Occupational Therapy?
4. Think back to when you completed your master's program in occupational therapy. What would you say are the major differences between how you felt then and how you feel now, as an occupational therapist?
    a. What are the differences in how you see yourself? How others see you?
    b. What are the differences in your role(s)?
    c. What are the differences in your job or job expectations?
5. How would you describe your "Doctor of Occupational Therapy experience" to someone else?
6. Can you share a story that provides an example of what you mean?
7. What is your perspective on the significance of this change – from master's preparation to Doctor of Occupational Therapy preparation – for the profession of occupational therapy?
8. Is there anything else you would like to share on the topic that authors have not discussed?
9. Do you have any questions for us?

Data Analysis

Authors first agreed on an approach to initial coding with the goal of systematic content analysis of all data that served to answer the primary research questions. Both authors independently completed several readings and reviews of the focus group transcripts and final reflective papers and coded each data source (focus group transcripts and final reflective papers). Following this initial open coding process, authors met to discuss interpretations and coding, and then agreed upon an evolving list of categories and sub-categories. Authors then read each focus group transcript and final paper again and coded them based upon the consolidated list of codes. Authors met a third time to compare and discuss interpretations of the data and to reach consensus upon the final themes and sub-themes. Authors completed multiple readings and met on multiple occasions throughout the writing of the manuscript to further discuss and clarify, achieving consensus on the theme and sub-themes that are presented in this paper.

Findings

Through the data analysis process, authors identified a key theme pertaining to the professional identity development of a Doctor of Occupational Therapy: *Leadership Characteristics of a Doctor of Occupational Therapy*. Within this key theme, four sub-themes emerged: 1) Communication, 2) Confidence, 3) Innovation and Change Implementation: OT Unconstrained, and 4) Advocacy. Table 2 outlines the key theme and sub-themes from this study. These leadership characteristics of a Doctor of Occupational Therapy are described in detail in this paper.

Table 2

Research Findings: Key Theme and Sub-themes

1. Leadership Characteristics of a Doctor of Occupational Therapy
    a. Communication
    b. Confidence
    c. Innovation and Change Implementation: Occupational Therapy Unconstrained
    d. Advocacy

Leadership Characteristics of a Doctor of Occupational Therapy

Many Doctor of Occupational Therapy programs identify leadership as an intended academic program outcome, and the experiences of these graduates aligned with that aim. The participants spoke of perceived shifts in their professional identities from that of a master's prepared clinician to a Doctor of Occupational Therapy. They reflected on their perceptions as master's-level graduates when they viewed leadership and innovation as "reserved for the select few". In contrast, following the doctorate degree, participants viewed themselves as leaders. Furthermore, they revealed a depth and breadth of specific skills and attitudes essential to leadership that emerged from their experiences and reflections. A participant's identity as a leader was embodied in their enhanced and enacted skills of communication, confidence, innovation, and advocacy.

Communication

Participants described communication skills as essential to their professional identity as a Doctor of Occupational Therapy and their capacity to be a leader within the profession. When speaking with physicians or other providers during team conferences, engaging in self-advocacy efforts to articulate the value of occupational therapy, or speaking with patients, communication skills were reported as essential to functioning as an effective leader. One summarized, "I have become a stronger communicator, navigating crucial conversations on a daily basis" (RP5, p. 6, lines 7-9). Another described how enhanced communication skills supported their ability to influence change:

> Throughout this semester, I observed the remarkable impact communication skills have on the success of mobilizing others to be involved in the change

> process. To mobilize change in others, I must develop skills in eliciting emotion in others via stories, connecting these stories to an area of need, and presenting a clear plan for change. (RP11, p. 7, lines 1-9)

Similarly, another participant described,

> I have walked away from conversations feeling defeated because I knew my point was valid, but I was not able to articulate this to colleagues. Each of these conversations drive me to become a better leader, to learn to stand my ground when appropriate, and to feel confident as a clinician that my point is valid. I have enhanced my ability to articulate certain aspects of our profession that may be more difficult for someone to see if they are not familiar with our role in a clinical setting. (IN3 p. 3 lines 4-12)

Confidence

"Confidence in Myself". Participants reported confidence as a characteristic of a Doctor of Occupational Therapy and a distinguishable outcome of the program. As one stated, "confidence was probably the biggest change" (FG2, p. 10, line 14). Participants described gaining confidence in their clinical judgment and in communicating recommendations to physicians and other healthcare providers:

> My clinical judgments and my confidence talking to other people, whether it's if I need to talk to a doctor - I can page a doctor and I don't feel like, 'Oh, I don't know if I can talk to this person'…Or having conversations with nurses and PT's [physical therapists] if I think that something should be happening that isn't happening, and things like that. (FG1, p. 13, lines 3-9)

Their increased confidence was linked to opportunities to specialize. As one described:

> So, you can really kind of dive in a little deeper and feel like you are starting to gain more expertise…in a specific area of occupational therapy, which I think helps you be more confident in that area that you're working in. (FG2 p. 10-11, lines 1-50)

As levels of confidence in their specialization increased, participants then described greater comfort with question and uncertainty. One stated, "My ability to trust that I am an expert in my field, balanced with the ability to admit when I do not know something, has been sharpened and honed" (RP7, p. 4, lines 10-14). Another summarized, "Not only did the Doctor of Occupational Therapy open doors for me, but it taught me how to open doors on my own" (RP2, p. 5, lines 6-7). Once the individual started to embody the identity as a Doctor of Occupational Therapy, they gained confidence in their own credibility:

> Because I feel like I'll have more credibility when I'm partnering with other organizations. I also think that I can cold email specialists and professionals from other countries and universities and have more clout; makes that introduction a little bit easier. (FG1, p. 37, lines 9-15)

"Others' Confidence in Me": Increased confidence was tied to changes in how they were perceived by others, and the added credibility afforded to them as a Doctor of Occupational Therapy. As one stated, "They listen to me a little bit more" (FG1, p. 9, line 21), and a second added, "...it does build capacity, your professional capacity, and I think, in a way, almost credibility" (FG1, p. 6, lines 12-13). Participants felt more heard and respected from colleagues; were consulted for 'expert advice'; and supervisors assigned them more responsibility: "I think my program manager's more willing to give me something to oversee, more responsibility....He lets me take OT and do what I think would fit the setting and meet the clients' needs, first and foremost" (FG1, p. 15, lines 1-5).

Other healthcare providers recognized the credibility of the Doctor of Occupational Therapy degree as equivalent to other professional doctorates:

> There was a discussion in a meeting about if occupational therapy could provide the core services required by the state, because I'm in a state-mandated treatment program, and it was like, 'Of course, an OT should be able to represent the services. She's an OTD. That's on par with a PsyD'…So, that felt like a validating moment. (FG1, p. 21, lines 17-23)

Patients regarded the Doctor of Occupational Therapy differently, due to the significance of the credential. One remarked,

> The times that patients do ask me a little bit of background of my education, and then I tell them I have my doctorate, I can see... something changes a little bit and they're a little bit more receptive to listening. I don't know if it's because I look so young, but they're like, "Oh, wait, this person's a Doctor. Maybe he knows what he's talking about now". So, I feel like I get a little bit of that. And then, not with just clients, but I think just people in the community. So when people find out I have my doctorate, I think it becomes a little bit more interesting to them and they listen a little bit more to what I'm going to say. (FG1, p. 23, lines 1-15)

Once participants perceived this increased credibility afforded to them by others, they were further empowered to speak up during team meetings, express their clinical opinions to physicians, and participate more actively in the care of their patients. This process reinforced within themselves that, as Doctors of Occupational Therapy, their contributions were equally important as other providers. Their growing confidence, and the confidence in them expressed by others, were interrelated. One participant summarized it as:

> Realizing…I was equal. Because in the hospital setting…we're around a lot of physicians and other professions that have those doctorate degrees, and I think having that too kind of gives you that power to feel more empowered yourself to…give your opinion and…participate in the care of a patient, and I think…having that…doctoral degree really helps with that. (FG2 p. 11, lines 7-13)

Participants shared that the Doctor of Occupational Therapy credential boosted their professional reputation, made advocacy efforts easier through increased respect from others, and afforded them opportunities that would otherwise be inaccessible. The

outcome of this embodied professional identity was summarized by one participant in the following way: “As a Doctor of Occupational Therapy…[I am] someone with the reputation and with the education to back up what I say and do” (FG2, p. 8, lines 29-30).

Participants expressed that during the master’s program they were “scrambling to become a generalist” (FG1, p.9, line 28) and to learn about various contexts of practice. While in the doctorate program, they focused on a specialized area of practice, and gaining this expertise boosted their confidence as a clinician. Participants shared that following their master’s program, they were able to *think about* ideas, whereas after the doctorate they possessed the capacity to *implement* their ideas.

Innovation and Change Implementation: Occupational Therapist Unconstrained

Participants described a newfound capacity to innovate as a Doctor of Occupational Therapy, which the authors conceptualize as the *Occupational Therapist Unconstrained*:

> I think there are benefits to being a new practitioner in making changes…I am the fresh set of eyes. I am the new face who can open up buried topics for discussion to the administrators and in the interdisciplinary team and respectfully challenge the current system to pave ways for innovation. As an OT, I have the ability to impact and make changes in both the system and patient level and am thankful to have realized the contributions that new practitioners can make. (RP10, p. 6, lines 5-16)

Participants provided examples of how they pushed the boundaries of traditional practice to develop new roles for occupational therapy in contexts that had not utilized occupational therapists as part of their service delivery model. A few examples of these new contexts included an outpatient pediatric concussion clinic previously staffed solely by physicians, and college campuses. Within the pediatric concussion clinic, the study participant developed new programs for children who experienced concussion through sports. Other study participants developed lifestyle management programs, mental health services, and accessibility and advocacy services for college students on college campuses that had not previously utilized occupational therapists in this way. Participants noted that individuals pursuing a doctorate degree likely want ‘to do something different’ and expand the scope of occupational therapy. One stated: “To me, an occupational therapy leader identifies challenges and takes steps to mobilize change by engaging stakeholders and developing innovative solutions. I strive to be an occupational therapist who takes these actions” (RP11, p. 4, lines 6-12). One participant elaborated,

> I have seen first-hand the impact of ‘the rule of seven touches’ as Gawande (2013) stated. I am able to model this theory by making a presence in clinic, being friendly and networking, and catering to the needs of the physicians. I realized that if I am able to help the physicians throughout their day and make work easier for them, they will see the value of my services on the team and increase utilization [of occupational therapy services]. Also, if I make an impact on their clients, I make an impact on the provider. I am able to show this value by participation in interprofessional team meetings and providing updates about my

> patient's progress. In this way, I am able to innovate and implement change by showing my value and being respectful and mindful of cultural norms in the clinic in order to create more sustainable change. (RP, p. 3, lines 1-3)

Overall, participants noted that the master's degree provided their theoretical lens as an occupational therapist, and the doctorate degree solidified their critical thinking lens. The doctoral graduates gained research skills needed to systematically analyze a complex situation before being compelled into action and elevated their policy and advocacy expertise.

Advocacy

Participants perceived that a Doctor of Occupational Therapy is someone who demonstrates advanced skills in advocacy and would remain committed to advocacy efforts throughout their career. Engaging in advocacy was viewed as a responsibility and a necessary trait of an effective leader. "I find it my responsibility to be a leader for our profession and advocate for the future of occupational therapy" (RP2, p. 1, lines 8-10). Perceptions of challenging situations or "unattainable" goals evolved into an acknowledgment of their newfound skill to develop effective solutions when faced with barriers. One participant shared:

> I see the value in how much [the OTD degree] shapes your thinking as a therapist and how much it really pushes towards more evidence in the field and more advocacy for the field, and how it enables more occupational therapists to…be involved in…research or advocate. And so I think there's a lot of benefit there. (FG2 p. 20, lines 18-23)

Participants advocated for themselves as occupational therapy practitioners, for their clients and families, for the development of needed programs, and for occupational therapy as a profession. Advocacy efforts were present in presentations at interdisciplinary conferences, during team meetings, in the midst of brief encounters in the workplace, and at formal events such as Capitol Hill Day. One participant summarized, "I have worked to convince a team of neurologists, neuropsychologists, PhD.'s and basic science researchers that our profession of occupational therapy can make an impact and improve patient outcomes within a pediatric population with a history of concussion" (RP3, p. 1, lines 16-20).

Similar to confidence, advocacy skills went hand-in-hand with effective communication. A participant shared, "I learned when to be visible in meetings, the importance of being comfortable speaking to various professions, and how to effectively communicate…I feel that I can go into any arena and advocate effectively for our profession" (RP2, p.2, 11-19). Such advocacy required understanding and embodying the complex nuances pertaining to interprofessional dynamics. The ability to balance the fine line between advocacy efforts that support one's cause, and the desire to preserve professional relationships, was noted as an advanced skill set grounded in effective communication that one had to learn, practice, and embody as a Doctor of Occupational Therapy:

> There is an important balance between fighting for what you believe is true, and what others perceive as being sufficient, without a need for change. I feel this

> past year has helped me learn to recognize these situations more frequently and direct conversation so that the argument of both sides is heard and taken into account respectfully. (RP3, p. 2, lines 17-23)

Discussion

In her analysis of confidence levels in powerful versus powerless professions, Clark (2010) emphasized that occupational therapy must foster confident practitioners in order to reach the profession's fullest potential. Bearing Clark's (2010) influence, one of the tenets of the AOTA Vision 2025 (2017) is the development of effective leaders. This study supports this call by providing insights into the specific characteristics of confident occupational therapy leaders and the value-added of doctorate level training.

Confidence was a key leadership characteristic that emerged from the findings of this study that is consistent with existing literature focused on the outcomes of doctorate education in occupational therapy (Kim et al., 2020; Miller et al., 2021; Morrow et al., 2020; Recigno et al., 2020). In a study examining the determinants of confidence among healthcare providers, Kim et al. (2020) posited that the more confident the provider, the higher the quality of care that is delivered. This same study also found that neither knowledge levels nor years of training directly impacted providers' confidence levels; but rather, the greater the breadth and variety of tasks completed by the provider, the greater their confidence level. In considering Kim et al.'s (2020) findings, a doctoral degree in and of itself will not guarantee confidence among graduates. It is the nature of the learning activities embedded within the structure of the doctorate program that holds the capacity to shape confidence levels.

Results of the current study align with Morrow et al, (2020), who found that graduates of a post-professional doctorate program were transformed into confident and empowered practitioners with newfound career advancement opportunities. Advanced leadership skills, higher level critical thinking skills, improved advocacy skills, and advanced clinical practice skills were findings consistent across both studies. The development of communication skills necessary for effective advocacy and influencing change are consistent with the outcomes identified by Miller et al. (2021) and Morrow et al. (2020) in their studies examining professional characteristics and outcomes of doctorate occupational therapy students and graduates. While Morrow et al. (2020) depicted the opportunities available to Doctors of Occupational Therapy, such as promotions into leadership positions, higher pay, faculty roles, and additional responsibility; the results of this current study take a deeper dive into the actual "doing" of the Doctor of Occupational Therapy as a leader.

Standard A.2.1 in the 2022 ACOTE® Standards and Interpretive Guide (effective July 31, 2025) indicates that a program director of a doctoral degree program must have eight years of experience in the field of occupational therapy and a minimum of three years experience as teaching faculty. The results of this study suggest that post-professional Doctors of Occupational Therapy may be well-equipped to serve effectively in academic leadership roles without eight years of experience. The current faculty shortage coupled with the growth of occupational therapy programs compounds the

need for qualified faculty and academic administrators. As such, the A.2.1 standard should be systematically investigated, as the eight-year requirement may serve as a barrier to the profession's capacity to meet the need in academia.

The ACOTE® (2022) draft standards propose the term "professional identity" be integrated into the standards revisions (Glossary, A.3.7, B. 3.0, Glossary). The current study offers insights pertaining to professional identity, which may help operationalize a definition of professional identity.

Implications for Occupational Therapy Education

Results from the current study contribute to the body of knowledge developing within the profession of occupational therapy focused on the outcomes of doctorate education, in particular professional identity and leadership capacity. Further study is warranted to examine how pedagogy can foster professional identity and leadership development among graduates at all levels of occupational therapy education, in order to strengthen the profession.

This study provided details regarding the types of skills or competencies associated with leadership in occupational therapy, and graduates reported several characteristics of their doctoral experiences that led to their embodiment and skills as leaders in the profession. For instance, students perceived that the identity of leader or innovator was seemingly "normalized" as a quality needed across the profession at large and an expectation for all occupational therapy practitioners, rather than "reserved for a select few". This may suggest that taking a deeper dive into examining the pedagogical approaches that foster leadership and innovation may be beneficial. The graduates also spoke about circumstances that led to their development of confidence, which is often identified as a challenge for new, and sometimes even experienced, practitioners. Students experienced increasing confidence from their ability to specialize in a practice area, as well as from breaking ground to develop occupational therapy services in contexts in which they do not exist. Feeling confident, in turn, led to greater comfort when they were confronted with and successfully navigated ambiguity in a variety of situations. Graduates also spoke of the never-ending opportunities for them to advocate for the profession and for themselves. Further examination of pedagogy that supports the continued growth in confidence among occupational therapy students and practitioners is warranted. Likewise, exploring the use of ambiguity as an intentional pedagogy may provide greater insights to inform the future of occupational therapy curricula.

This study offers insight into various pedagogical tools that can be further tested and integrated into occupational therapy curricula. Overall, in terms of these critical leadership skills – communication, advocacy, confidence – graduates reported the impact of learning by doing, which suggests the deliberate integration of experiential learning opportunities in curricula aimed at developing the knowledge and, especially, the skills required for leadership. Additionally, results of this study may have implications related to leadership capacity for the profession, including the qualifications

required to fulfill academic leadership roles; such as the consideration of demonstrated leadership competencies rather than years of service as qualifications to fulfill academic leadership roles.

Limitations

This study included a small convenience sample of graduates from the same institution as the authors. As such, the intent of the study was not to ensure generalizability, but rather to foster a deeper understanding of the phenomenon of professional transformation experience among graduates of a post-professional doctorate program. This university is well-resourced, affording students opportunities that may not be applicable to students attending smaller academic institutions. There are multiple faculty mentors at this institution, which may enhance the capacity to develop customized learning plans and individually tailored learning experiences for the enrolled students. The availability of funding to support a breadth of experiences across clinical practice, research, pedagogical, and administrative contexts allowed students to select from a range of opportunities that could fuel their passions. Given that a final paper attached to an academic course was utilized as a data source, results of the study could be biased toward the positive, as students may have written their paper to please the course instructor, rather than share authentically. Results from the focus groups may be overly positive, due to carryover excitement following the participants' graduation from the program. Likewise, the particular phrase "…the transformation you experienced" included in the introductory statement of the Interview Guide may have been leading for the participants to feel obligated to respond to the inquiries in a particular manner. Given their closeness to the phenomenon of study, author bias may have affected the interpretation of the findings, despite the intentional efforts to monitor and check potential bias throughout the study process.

Conclusion

The aim of this study was to better understand the Doctor of Occupational Therapy identity. Although further research needs to continue to examine occupational therapy's pedagogical approaches and doses to determine those that are the most effective in producing confident leaders for the profession, the results of this study are promising and support previous findings published in the occupational therapy literature. The authors anticipate that increasing numbers of Doctors of Occupational Therapy matriculating into the profession over the next decade and beyond will bode well for the profession.

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