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Personal Narrative

Beyond Superpowers: Naming and Dismantling Ableism in Occupational Therapy Through the Lens of Lived Experience

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INTRODUCTION

Occupational therapy is often described as a progressive, inclusive profession that values participation, diversity, and occupational justice (Townsend and Wilcock, 2004; Hammell, 2020). However, there is a gap between this ideal and the realities of practice. Many occupational therapists work in systems led by diagnostic categories, resource constraints, and performance targets (Rudman, 2021).

Ableism refers to the systemic discrimination and social attitudes that privilege non-disabled ways of being, doing, and thinking. It positions disability as something to be fixed, overcome, or pitied rather than accepted as a normal and valuable aspect of human diversity (Campbell, 2009).

In the United Kingdom (UK), the Equality Act of 2010 defines disability as a “physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal daily activities”. However, this article adopts a broader definition. Drawing from the social model of disability, it recognises that disability arises not only from health conditions but from inaccessible environments, policies, and attitudes (Shakespeare, 2014). This includes people with mental health needs, long-term health conditions, and neurodivergence.

In recent years, both disability and occupational therapy have been framed at times as “superpowers”, a narrative that, while well-intentioned, can obscure the systemic barriers that persist. Framing survival as strength may be inspiring, but it risks ignoring the work required to create genuinely inclusive environments.

Lived Experiences: Beyond Inclusion, Towards Belonging

I have lived with disabilities and neurodiversity all my life. This has given me the unique privilege of experiencing the profession as a receiver, learner, observer, and practitioner. These experiences have given me a critical viewpoint on how our profession is delivered, especially within medical-model systems that go unchallenged. Despite rhetoric around inclusion, ableism continues to shape expectations, definitions of success, and the way disabled people are perceived and treated within the profession.

As a child receiving occupational therapy, I experienced a strong focus on milestones based on non-disabled norms. Success was measured against what non-disabled children could do, rather than what was meaningful or relevant to my own life and development. Whilst I understand the clinical value of exploring typical patterns of functioning to support assessment, there is still a need to avoid imposing narrow or unachievable standards. Relying on dominant developmental frameworks can risk overlooking individual strengths, aspirations, and ways of engaging in occupation (Hammell, 2020).

When I trained as an occupational therapist, the ableism I faced was overt and constant. I always disclosed my cerebral palsy to every placement educator in advance. Each time, before even meeting me, I was met with questions about whether I would be able to do the job or whether the placement was “suitable” for someone like me. Never were adjustments or creative problem-solving approaches explored. Instead of being seen as a future colleague with potential, I was treated as a problem for the profession to manage.

Sadly, this experience remains common. In 2021, I co-founded AbleOTUK, a peer support and advocacy network for disabled and neurodivergent occupational therapists and students. We host a monthly support group, and every month, colleagues join to share strikingly similar stories of discrimination, poor understanding, and a lack of reasonable adjustments within our profession.

If we cannot practise inclusion among our colleagues, what chance do the people who access occupational therapy have? Unconscious bias about disability is often not deliberate, but it still influences how decisions are made and how people are treated. It can lead to lowered expectations, missed opportunities, and assumptions about a person’s occupational performance. These biases are rooted in systems that treat disability as something to manage, not understand. For those with lived experience, the impact of these biases can be deeply excluding. We must reflect on where these assumptions come from and take responsibility for challenging them, starting with how we treat each other (Brown & Leigh, 2018).

During two separate hospital admissions, as an adult. I found that occupational therapy was again not tailored to my baseline of occupational performance. After breaking my leg, standard assessments did not reflect my usual functioning as a disabled person. When I asked about home adaptations and a hospital bed for discharge, I was told I did not meet the criteria, not based on an individual assessment, but seemingly as a matter of policy: “We don’t normally do this for broken legs”.

Following a year-long hospital stay due to COVID-19 and related complications, my experience of occupational therapy was fragmented. What stood out most was the lack of continuity and joined-up thinking across services. Different occupational therapists completed their individual specialist tasks as I moved through the system, but there was little sign of a coordinated or holistic approach. There was minimal formal assessment or intervention to fully understand my needs or address my occupational performance. Care was shaped more by the label of the ward or service I happened to be in than by any real exploration of what mattered to me.

My disabled body did not recover or rehabilitate in the same way a non-disabled body might; that reality was overlooked. I kept asking for support that matched my needs, but it felt like I wasn’t being heard. Instead, everything came back to checklists and service criteria, not what would help me live the life I wanted.

Once discharged, I was unable to transfer safely without the use of a hoist. Yet again, my needs were not assessed through the lens of being a disabled person with complex, long-term requirements. I was left to figure things out for myself. Fortunately, I had the professional knowledge, family support, and financial resources to privately purchase equipment and rehabilitation, and to organise my care.

I was effectively written off by statutory services. The care package offered amounted to three 15-minute visits per day, often being put to bed by 7 pm as a 39-year-old woman. These visits were delivered by carers with limited training, and my needs were reduced to basic tasks: feeding, washing, and toileting. There was no coordinated rehabilitation plan, no meaningful support for longer-term recovery, and no recognition of my expertise in managing my care. When someone is discharged with a package like this, do we stop to think about what that means for their day-to-day life? There was no consideration of how I might leave the house, transfer into a car, or have a life.

Over the following year, with privately sourced rehabilitation, interrupted by further surgeries, I began to rebuild my physical abilities. I focused on what I wanted to achieve. There were moments of guilt about not being at work. I found myself worrying that I was being seen as a burden, a benefit-seeker, a drain on society, perhaps a reflection of my own internalised ableism. These feelings ran deep, shaped by years of messaging about productivity, independence, and worth. I knew I needed time to rebuild my life before I could return to it. Recovery wasn’t a straight line. It meant working around limits, trying things out, and figuring out how to live with new and ongoing challenges.

Returning to work was never in question for me, but it was for everyone else. I knew I had it in me. Being an occupational therapist is part of who I am. I returned with a more visible disability than ever before: a wheelchair, crutches, and assistive technology. Some things had changed about how I worked, but not about the value I bring.

Although I was met with kindness, the structures were not in place to support me. Assistive technology was not compatible with systems. Meeting spaces were inaccessible. Requests for reasonable adjustments were slow, requiring repeated advocacy. Still, I was called “inspirational” just for doing my job. This kind of praise feels hollow. It focuses on personal resilience rather than addressing the barriers that create the struggle.

Georgia Vine (2024) describes how disabled occupational therapists are often celebrated for surviving the system, not supported in changing it. The dominant narrative of disabled people as heroes overcoming adversity shifts attention away from the need to dismantle the structures that create the adversity in the first place.

What Needs to Change

Occupational therapy must move from symbolic inclusion to genuine anti-ableist practice. This means involving disabled people as equal partners across the profession, from policy and service design to inclusive placements and leadership.

AbleOTUK, a peer-led network of disabled and neurodivergent occupational therapists and students, has been instrumental in challenging ableism. As a founding member, I have seen the power of collective action. We have advocated for changes in education, better visibility of disabled professionals, clearer guidance on adjustments, and for co-production to be standard, not an afterthought.

Universal design should underpin all our work, not just accessible buildings and equipment, but flexible communication, documentation, and job design. Adjustments should be built in, not added on. We must stop seeing disability as exceptional and start designing for it as a normal part of life.

We also need to examine our assumptions. What kinds of success do we recognise? Whose needs are prioritised? As Hammell (2020) argues, occupational choices are shaped by culture, privilege, and policy, and cannot be considered neutral or free from context. Without conscious effort, occupational therapy can reinforce exclusion rather than challenge it.

We should also reflect on how we use stories of disabled people “overcoming” adversity. While meaningful to some, these narratives often comfort professionals rather than provoke change. True inclusion is not about those who survive the system, but about how well the system includes everyone.

As individuals, we must take responsibility for exploring our own unconscious biases and understanding how they may influence our professional behaviours and decisions. Understanding unconscious bias is essential if we are to create a truly inclusive profession. Occupational therapy has historically been shaped through a predominantly white, female, middle-class, and non-disabled lens (Pollard & Sakellariou, 2017). This framing influences what is considered 'normal', 'functional', or 'successful' within our models and practices. Professionals need to reflect on how these inherited biases may continue to shape our assumptions, assessments, and interventions. By questioning the foundations of our professional identity and remaining open to diverse perspectives, we can begin to dismantle the barriers that limit equitable care.

CONCLUSION

Ableism is embedded in occupational therapy through unquestioned norms. Our models, tools, and frameworks are often shaped by Western, non-disabled ideals of linear progress, independence, and productivity (Goodley, 2014; Hammell, 2020). These standards marginalise people whose lives do not follow standardised paths, such as those with lifelong impairments or neurodivergence (Campbell, 2009).

Disability is not rare. It is part of the human condition. As we age or experience health changes, any of us may become disabled. A profession that fails to prepare for this is not future-proof. To be truly needs-led, occupational therapy must question what it values and measures. If services only fund what is measurable, not what is meaningful, they risk reinforcing exclusion. Hammell (2020) cautions that occupational opportunities are shaped by what is valued and resourced in policy and practice, meaning those whose lives fall outside narrow definitions risk exclusion.

Occupational therapy is built on values of participation, meaning, and justice (Royal College of Occupational Therapists, 2022). It can lead by example, but only if it confronts the ableism in its models, measures, and expectations. We must move beyond celebrating the disabled person who adapts. Instead, we must adapt our systems and our profession to support everyone. That is the real work of occupational justice.

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