Perceptions of Practitioners, Educators, and Students Concerning the Role of the Occupational Therapy Practitioner

Kimberly A. Vogel

Key Words: modalities, occupational therapy • occupations • philosophy, occupational therapy • purposeful activities

In this study, the attitudes of 348 occupational therapy educators, practitioners, and students were assessed concerning the perceived role of the practitioner. The three groups' perceptions of the practitioner's role offers a starting point from which changes in education and practice can be made to reflect the profession's pending decisions concerning physical modalities, unification of theory and practice, and status of the profession. A 4-point Likert scale was used to measure the subjects' responses to 19 statements on major professional issues concerning occupational therapy's unique philosophical base, the appropriateness of certain treatment modalities, and the profession's future focus. One-way analyses of variance, Student-Newman-Keuls (Winer, 1971) procedures, and t tests were performed to identify attitudinal differences by respondent type, specialty area, and length of clinical experience. The results indicated agreement among all respondents that occupational therapists should be skilled in analyzing activities and that occupational therapy services should be covered by third-party payment. Additionally, strong attitudinal differences were identified among educators, practitioners, and students regarding treatment modalities and therapists' role characteristics.

Kimberly A. Vogel, EdD, OTR, is Assistant Professor, Program in Occupational Therapy, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, Texas 78284-7770.

This article was accepted for publication July 3, 1990.

Three problems influence our professional identity as we move into the 21st century. The first is the continuing debate between the proponents of the profession's philosophical base (i.e., belief in occupation as the organizing premise of theory and practice) and those who believe that non-traditional, nonpurposeful treatment modalities are more effective than purposeful activity or occupation (West, 1984).

The second problem is the fragmentation of the profession into a group of loosely related technical specialties because of a lack of agreement about a generic basis of knowledge and practice. This results in the loss of recognition of occupational therapy as an autonomous profession (Gillette & Kielhofner, 1979).

Those who support occupation as the profession's philosophical base advocate the reexamination and reclamation of occupational therapy's heritage as the generic basis for the profession's future (Fidler, 1981; Gillette & Kielhofner, 1979; Kielhofner & Burke, 1977). Original beliefs in purposeful activity and the occupational nature of human beings have been proposed as the fundamental constructs on which the profession can unify current theory and practice.

Universal endorsement of the proposed generic base, however, has not occurred. Strong stands were taken against the perceived limitations of purposeful activity by many physical disabilities occupational therapists when the "Occupation as the Common Core of Occupational Therapy" (American Occupational Therapy Association [AOTA], 1979a) and "Philosophical Base of Occupational Therapy" (AOTA, 1979b) resolutions were passed in 1979 (Courtsunis et al., 1982; English, Kasch, Silverman, & Walker, 1982; Horan, 1982). The Eliason and Gohlgiese (1979) study indicated that occupational therapists frequently used physical modalities (nonpurposeful activities), such as massage, ultrasound, hot packs, paraffin, and joint manipulation. It was not stated whether these modalities were used as ends in themselves or as preparation for the patient to engage in purposeful activity.

The controversy over occupational therapists' use of physical agent modalities has been addressed in legal action in New York in the early 1980s and in Kentucky in 1987 (Fox, 1989). The Florida and Pennsylvania Occupational Therapy Associations and Physical Therapy Associations have established communication channels to clarify the appropriate use of modalities by each profession (Fox, 1989).

In 1983, AOTA passed the current policy on occupational therapists and modalities (AOTA, 1983). The policy states that "a registered occupational therapist
is qualified and competent in the use of a variety of modalities” and that the occupational therapist “shall comply with federal and state laws, comply with AOTA Principles of Ethics, the AOTA Philosophical Base and the AOTA Standards of Practice” (p. 816).

This policy was called into question at the 1989 Representative Assembly meeting. Resolution E 630-89, “Review of the AOTA Policy on ‘Occupational Therapy and Modalities’” (Fisher, 1989), was introduced, amended, and adopted. The resolution proposed that a task force review the 1983 policy and recommend any revisions or additions as well as “review the area of physical agent modalities and occupational therapy practice” (p. 10). Justifications for the resolution were the increasing specialization and certification of occupational therapists who specialize in hand therapy and therefore use physical agents, the New York and Kentucky litigation, physical therapy state associations’ requests for AOTA’s opinion on this issue, and the need for therapists’ use of modalities to comply with state laws (Fisher, 1989).

The third problem influencing our professional identity is differences among groups of therapists in their perceptions of the status of the profession, the quality of occupational therapy education, and the methods by which the status of the profession and the quality of education can be changed. In Fleming and Piedmont’s (1989) study of therapists’ attitudes about the status of occupational therapy, a sample of 811 registered occupational therapists and certified occupational therapy assistants expressed common areas of concern about the profession’s low visibility and status and lack of recognition of the value of occupational therapy services by “third party payers,” “the general public,” and “other health professionals” (p. 105). Each of these groups, however, identified different professional areas as the most important to change. Therapists with master’s degrees and those in administrative roles cited reimbursement, whereas therapists with doctoral degrees and educators considered research for practice most important. Methods for changing the status of the profession included “more marketing,” “more visibility,” “more research,” and “more education” (p. 106).

Therapists’ attitudes toward their own education, the quality of current education, and the elements that they thought should be emphasized in future education were also examined in this study (Fleming & Piedmont, 1989). With subjects grouped according to years of practice, therapists with 16 or more years perceived their liberal arts background as more important than did therapists with 6 to 15 years and therapists with 0 to 5 years of experience. The former group believed their Level I and Level II fieldwork and occupational therapy technique courses were less important than did the groups with less experience. Therapists with 16 or more years of practice thought themselves to be the best prepared compared with the other two groups in the areas of occupational therapy technique and professionalization, whereas the therapists in the 6-to-15-year group thought themselves to be the least prepared in the areas of personal development and professionalization.

With subjects grouped according to academic degree held, therapists with bachelor’s degrees thought their education had least prepared them in the areas of professionalization, management, and critical thinking, compared with therapists with associate’s, master’s, and doctoral degrees. Therapists holding doctoral and master’s degrees valued their liberal arts background more highly, compared with those with associate’s and bachelor’s degrees. The associate’s and bachelor’s degree groups believed their occupational therapy technique and Level I and Level II experiences to be more important than did the master’s degree group.

In response to questions about the quality of current education, therapists with doctoral degrees and those with 16 or more years of experience believed that new graduates were well educated and demonstrated strengths in the areas of occupational therapy technique, self-confidence, and professionalization. Therapists with bachelor’s and master’s degrees found new graduates to have deficits in the areas of basic knowledge, self-confidence, interpersonal skills, understanding of the health care system, and knowledge of clinical conditions.

When asked what areas occupational therapy education should emphasize, therapists most frequently selected critical thinking, problem-solving skills, and clinical judgment. When grouped according to degree held, however, therapists with associate’s degrees selected practice skills, those with bachelor’s degrees specified administrative skills, and those with master’s and doctoral degrees proposed cognitive skills as the most important area of emphasis for future education.

Fleming and Piedmont (1989) summarized their results by stating that most therapists believe strongly that the status of occupational therapy and the education of occupational therapists should change, but there is little agreement regarding the most important areas to change and the methods for changing them. Differing attitudes appear to be associated with specific subgroups within the profession. The researchers pointed out that

It is difficult to promote change without broad agreement on what should change and how that change should take place. It may be that disagreements about specifics have prevented the profession from taking a broader view and mobilizing its re-
The subjects were randomly selected by computer surveys was 390 (54%), of which 348 (49%) were usable for research. The final sample comprised 253 practitioners, 46 educators, and 49 students enrolled about these issues, which could help resolve differences that now hinder professional growth.

The four research questions were as follows.

1. Do students, educators, and practitioners differ in their attitudes toward the perceived role of occupational therapists?
2. Do practitioners working in the specialty areas of mental health, physical disabilities, developmental disabilities, gerontology, or sensory integration differ in their attitudes toward the perceived role of occupational therapists?
3. Do practitioners who have worked in only one of the above specialty areas and practitioners who have worked in two or more of the above specialty areas differ in their attitudes toward the perceived role of occupational therapists?
4. Do recent graduates (i.e., those with up to 1 year of practice after graduation) and experienced practitioners (i.e., those who have been working for at least 5 years) differ in their attitudes toward the perceived role of occupational therapists?

Instrument

The questionnaire designed for this study used concepts derived from the literature of two periods—1806 to 1934 and 1977 to 1986. The writings of Pinel, Tuke, Bucknell, Rush, Meyer, Slagle, Tracy, Barton, and Dunton, as interpreted by Bing (1981), allow the reader to trace the shaping influences of the 18th-century Moral Treatment movement on the development of occupational therapy as a profession in the 20th century. Trends in the literature over the first period focused on the differences between aimless exercise and goal-directed activity; the moral use of firmness and gentleness; descriptions of essential personality characteristics of those who worked with persons with mental illness; the importance of evaluations, occupations, and activity analysis; the view of humans as being inherently active; and the role of rest, play, occupation, and exercise in occupational therapy treatment. Ideas were selected from Bing’s interpretation of the early literature based on their relevance to the philosophical base of occupation and representativeness of broad trends in the profession.

The occupational therapy literature from 1977 to 1986 contains therapists’ views about the future directions of the profession. Ideas were selected from the literature representing both viewpoints of the internal professional debate (West, 1984) (i.e., proponents’ views of occupation and purposeful activity as the generic base and proponents’ views of the expanded use of physical agents in occupational therapy treatment). Additional ideas were selected representing such current issues as professional autonomy, specialization, third-party reimbursement, licensure, and occupational therapy’s movement into a health promotion model. In general, the items chosen for the questionnaire presented a sampling of professional issues, viewed differently by various therapists, which are important to occupational therapy’s future.

The concepts were rewritten as 19 position statements (see the Appendix). The subjects were to indicate their feelings about each statement using a 4-point scale, as follows: strongly agree (5), mildly agree (4), mildly disagree (2), strongly disagree (1) (a neutral choice was not available).

A seven-item demographic data form provided information concerning the subjects’ respondent type (i.e., educator, practitioner, or student); sex; age; highest level of education; entry level of occupational therapy education; number of years of clinical practice, educational practice, or both; and specialty practice. The two instruments were pilot-tested with students from three occupational therapy undergraduate programs and faculty from one occupational therapy undergraduate program and were modified in response to their suggestions, thereby addressing face

Study Purpose

Differences among therapists’ views regarding the philosophical base, differences in theory and practice among specialties, and differences in perceptions about the status of the profession and necessary educational changes are complex problems that need to be resolved for the profession to continue to grow. The purpose of the present study was to gather information about therapists’ viewpoints on the central issues facing occupational therapy. Specifically, the attitudes of occupational therapy practitioners, educators, and students toward the unique nature of occupational therapy and the perceived role of the practitioner were investigated. The identification of therapists’ and students’ beliefs can provide an understanding of each particular group’s perceptions about these issues, which could help resolve differences that now hinder professional growth.

The four research questions were as follows.

1. Do students, educators, and practitioners differ in their attitudes toward the perceived role of occupational therapists?
2. Do practitioners working in the specialty areas of mental health, physical disabilities, developmental disabilities, gerontology, or sensory integration differ in their attitudes toward the perceived role of occupational therapists?
3. Do practitioners who have worked in only one of the above specialty areas and practitioners who have worked in two or more of the above specialty areas differ in their attitudes toward the perceived role of occupational therapists?
4. Do recent graduates (i.e., those with up to 1 year of practice after graduation) and experienced practitioners (i.e., those who have been working for at least 5 years) differ in their attitudes toward the perceived role of occupational therapists?

Method

Subjects and Procedure

The subjects were randomly selected by computer through AOTA’s direct-mail service. A self-administered questionnaire and demographic data form were mailed to 716 subjects. The total number of returned surveys was 390 (54%), of which 348 (49%) were usable for research. The final sample comprised 253 practitioners, 46 educators, and 49 students enrolled in professional undergraduate programs.
validity. Although pilot-tested and revised several times, the instruments have not been validated or proven reliable through systematic validity and reliability studies.

**Data Analysis**

The raw data were entered into the computer according to ratings on the 4-point scale. Due to the wording of Items 2, 5, 7, 9, 14, and 17, the direction of scores was reversed to preserve the internal consistency of meaning in the scoring of the items (i.e., strongly agree responses were scored 1; strongly disagree, 5).

Student-Newman-Keuls procedures (Winer, 1971), one-way analyses of variance (ANOVA), and t tests were performed on the data. The data were analyzed by (a) type of respondent, (b) pure specialties, (c) pure versus mixed specialties, and (d) clinical experience. In all testing of hypotheses, the .01 level of probability was used.

**Results**

On the basis of the descriptive statistics computed on the raw data, 306 subjects' responses were not included because of missing values on one or more items) endorsed two ideas. They strongly agreed with the statements that occupational therapists should be skilled in analyzing activities to adapt their use for evaluation and treatment purposes (M = 4.87) and that occupational therapy services should be covered in third-party payment in medical insurance policies (M = 4.90).

Regarding the first research question, significant differences were found among practitioners, educators, and students for Items 2, 6, 7, and 9. The practitioners and educators both disagreed strongly on Item 2, that is, that occupational therapists should be all things to all people, but the students were neutral or mildly disagreed. The one-way ANOVA for Item 2 indicated significant differences among the means of the three groups. The calculated \( F \) value was 28.78 was higher than the critical value of \( F(4.61; df = 2, 345; p < .01) \) needed for significance at the .01 level with these degrees of freedom. The Student-Newman-Keuls procedure indicated that the mean of the student group formed a separate subset when compared with the means of the educator and practitioner groups. According to the Student-Newman-Keuls procedure, the practitioners (M = 3.87) were neutral or in slight agreement and differed significantly from the students (M = 4.59) and the educators (M = 4.48), both of whom agreed strongly with Item 6.

The students mildly disagreed with Item 7, that is, that in the future, occupational therapy should continue to focus only on remedial treatment in hospitals as it has in the past. The educators and practitioners disagreed quite strongly with this idea. The one-way ANOVA for Item 7 indicated that the means of the three groups differed significantly from each other. The calculated \( F \) value was 13.58 (\( F = 4.61; df = 2, 338; p < .01 \)). The Student-Newman-Keuls procedure indicated that the mean of the student group formed a separate subset when compared with the means of the educator and practitioner groups. According to the Student-Newman-Keuls procedure, the students (M = 4.00) mildly disagreed and differed significantly from the students (M = 4.71) and the practitioners (M = 4.65), both of whom disagreed strongly with Item 7.

The students strongly disagreed with Item 9, that occupational therapists should use modalities such as massage, ultrasound, paraffin, and hot packs in the treatment of physical dysfunction. The students and practitioners were neutral about this idea. The one-way ANOVA for Item 9 indicated that the means of the three groups differed significantly. The calculated \( F \) value was 20.06 (\( F = 4.61; df = 2, 343; p < .01 \)). The Student-Newman-Keuls procedure indicated that the mean of the educator group formed a separate subset when compared with the means of the student and practitioner groups. According to the Student-Newman-Keuls procedure, the educators (M = 4.63) strongly disagreed and differed significantly from the practitioners (M = 3.32) and the students (M = 2.96), both of whom were neutral on Item 9.

The results indicated no significant differences by respondent type on the remaining items. The results of the ANOVAs and Student-Newman-Keuls procedures indicated no significant differences among practitioners working in the specialty areas of mental health, physical disabilities, developmental disabilities, gerontology, or sensory integration in their attitudes toward the perceived role of occupational therapists. The results of the \( t \) tests indicated no significant
differences between practitioners who have worked in only one of the above specialty areas and practitioners who have worked in two or more of the above specialty areas, nor between recent graduates and experienced practitioners in their attitudes toward the perceived role of occupational therapists.

Discussion

I have drawn several implications from the results of this study. The first relates to the finding of homogeneous attitudes among practitioners of various specialty areas and practitioners with varying lengths of clinical experience. This study's finding that all therapists agreed that occupational therapy services should be covered by third-party payers is similar to Fleming and Piedmont's (1989) finding that all therapists were concerned about the lack of recognition of the value of occupational therapy services by third-party payers. Whereas Fleming and Piedmont found differences among therapists grouped according to length of clinical experience, however, these differences were in attitudes toward their own and new graduates' education, which were not explored in the present study. The findings from the present study indicate that although occupational therapy has become highly specialized, it does not appear that the profession is in imminent danger of fragmenting into groups of loosely related technical specialties.

The second implication relates to the attitudinal differences among educators, practitioners, and students regarding the idea that occupational therapists should be all things to all people. Whereas both the educators and the practitioners strongly disagreed about whether occupational therapists should be all things to all people, the students' neutral to mildly disagreeing stance does not seem unusual. Although most occupational therapy students have engaged in volunteer or observational experience before entering an academic program, they have less accurate initial perceptions and less understanding of their discipline when compared with other allied health students (Nordholm & Westbrook, 1981).

Madigan (1985) found the reasons most frequently given by students choosing occupational therapy as a career were "to work with people and to be helpful to others" (p. 45). These students rated altruism as their most important work value, and most expressed their 5-year career goal as "becoming an expert in a special area of practice" (p. 44). In another study, the selection of a given specialty area for employment after graduation was determined by students' fieldwork experiences, feelings of effectiveness, and consistency with personal values of the chosen specialty (Ezersky, Havazelet, Scott, & Zettler, 1989). The findings from these two studies indicate an important growth process occurring over several years, in which students mature from positive open feelings of wanting to help generalized others to a more sharply defined, selective sense of knowing the specific client population with which they would like to work.

The third implication drawn from the present study concerns the students' mildly disagreeing with the idea that in the future, occupational therapy should continue to focus only on remedial treatment in hospitals as it has in the past, whereas the educators and the practitioners both strongly disagreed with this idea. Currently, undergraduate students spend many course hours learning specific techniques for remediation, restoration, and treatment of disease. Jaffe (1986) emphasized that occupational therapy students need to be aware of models of preventive health, which focus on health instead of disease, and the interrelationship of sociocultural, economic, political, and environmental forces that affect health. West (1984) highlighted Naisbitt's (1982) characterization of the information age as that in which humans intensively use mental energy, thus necessitating a balance of recreational and leisure activities. She predicted that "stress and mental disorders will displace physical disabilities as the main threat to health, and the human need for non-work-related activity will be compelling" (West, 1984, p. 21). Jaffe (1986) pointed out that occupational therapy students need to "have a clear understanding of the principles of health" in order to reach occupational therapy's basic goal of promoting "an individual's total well-being" (p. 751).

The fourth implication drawn from the present study concerns the appropriateness of various treatment modalities as perceived by respondent type. The educators strongly agreed that therapeutic crafts are very important as treatment modalities and strongly disagreed that occupational therapists should use modalities such as massage, ultrasound, paraffin, and hot packs in the treatment of physical dysfunction. The students strongly agreed with the first idea and were neutral about the second idea. The practitioners were neutral to slightly agreeing with the importance of crafts and were neutral about the use of physical agents in the treatment of patients with physical dysfunction.

A possible explanation for the students' strong endorsement of crafts paired with neutral feelings toward physical agents is their open-mindedness, previously held ideas about occupational therapy, and lack of exposure to clinical treatment. In many curricula, occupational therapy and physical therapy students are enrolled in interdisciplinary courses together, while at the same time taking media or physical agents courses separately. Exchanges of
information among students learning about their respective professions could support their consideration or acceptance of the use of all modalities as appropriate for rehabilitation by either profession. Additionally, Eliason and Gohl-Giese (1979) found discontinuity between the modalities taught during the academic phase of the occupational therapy program and those used during the clinical education phase of the program.

One of the unique characteristics of occupational therapy throughout its history has been that engagement in purposeful activity promotes mastery and competence. This fundamental principle, which may seem simple and commonplace, is, in reality, profound. It can serve well as a base or rationale with which students can begin to solve problems that they will encounter in the clinic. With this knowledge, they will be better prepared to deal with discrepancies in theory and practice during fieldwork experiences.

Summary

Differences among practitioners, educators, and students in their attitudes toward the unique nature of occupational therapy and the perceived role of occupational therapists were examined. Findings were discussed as they relate to the philosophy of purposeful activity and education of students. The study results showed that (a) strong areas of agreement exist among occupational therapists about many professional issues (i.e., occupational therapists should be skilled in analyzing activities and occupational therapy services should be covered by third-party payment); (b) the students mildly disagreed that occupational therapists should be all things to all people; (c) the students mildly disagreed with the idea that in the future, occupational therapy should continue to focus on remedial treatment only, as it has in the past; and (d) both the students and the educators strongly endorsed the use of therapeutic crafts as treatment modalities, and the practitioners and the students were neutral on the use of physical agents in the treatment of patients with physical dysfunction. The three groups’ perceptions of the practitioner’s role offers a starting point from which changes in education and practice can be made to reflect the profession’s pending decisions concerning physical modalities, the unification of theory and practice, and the status of the profession.

Appendix

Perceptions of the Practitioners’ Role Questionnaire

Therapists’ Role Characteristics

1. Occupational therapists should be patient, kind, gentle, but firm.
2. Occupational therapists should be all things to all people.
3. Occupational therapists should specialize within a certain population.
4. Occupational therapists should be skilled in analyzing activities to adapt their use for evaluation and treatment purposes.

Occupational Therapy Treatment

5. Pure exercise is as effective as goal-directed activity in the treatment of persons with physical dysfunction.
6. Therapeutic crafts are very important as treatment modalities.
7. In the future, occupational therapy should continue to focus only on remedial treatment in hospitals as it has in the past.
8. Occupational therapy should not limit its focus on injury and illness and restoration of function in hospital settings, but should involve itself in maintaining health and preventing illness in the community.
9. Occupational therapy should use modalities such as massage, ultrasound, paraffin, and hot packs in the treatment of physical dysfunction.
10. Purposeful activity is more effective (appropriate for occupational therapy) than massage, ultrasound, paraffin, and hot packs in the treatment of physical dysfunction.
11. Social adaptation and use of occupation are philosophical ideas that characterize the uniqueness of occupational therapy.
12. The unique base of occupational therapy is directed purposeful activity that is meaningful to the patient.
13. Occupational therapy is a consciously planned progressive program of rest, play, occupation, and exercise.

Profession

14. Occupational therapy should maintain its current relationship with the medical profession as a subordinate, helping profession.
15. Occupational therapy should aim toward becoming an autonomous profession.
16. Occupational therapy services should be covered in third-party payment in medical insurance policies.
17. Occupational therapy is becoming a specialty-based profession with no common generic philosophy to unite it.
18. The specialties of occupational therapy have a common generic philosophy that unites them.
19. Occupational therapy should seek licensure as a profession.

Note. Items were rated on a 4-point Likert scale, as follows: strongly agree (5), mildly agree (4), mildly disagree (2), and strongly disagree (1) (a neutral choice was not available).

Direction of scores reversed to preserve the internal consistency of meaning in the scoring of items.

References


The American Journal of Occupational Therapy


---

**Professional Resources from AOTA**

Must reading for educators and students!

**Reviews of Selected Literature on Occupation and Health**

*Reviews of Selected Literature on Occupation and Health* presents writings on specific areas related to your profession. Topics covered include: • free play of preschoolers • cognitive functioning in the elderly and its implications for productivity • productive occupation in small task groups of adults • psychosocial functions of leisure among adolescents. 1990

*Order now with MasterCard or VISA!*

<table>
<thead>
<tr>
<th>Program</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews of Selected Literature on Occupation and Health</td>
<td>$50.00 AOTA member, $55.00 non-member</td>
</tr>
</tbody>
</table>

**Environment: Implications for Occupational Therapy Practice**

This insightful book examines the role of the environment in occupational therapy practice from a unique perspective that incorporates sensory integration theory.

Order now with MasterCard or VISA!

Call 1-800-THE-AOTA (AOTA members), 1-800-654-5584 (Md. members), or (301) 948-9626 (non-members).

---

**Kitchen Training Program as an Occupational Therapy Activity: An Overview**

Featuring updated photographs, this practical guide describes a kitchen training program that is realistic for use in all occupational therapy clinics. It details adaptive kitchen appliances, different types of patient programs, ideal kitchen arrangements, and appropriate clean-up equipment. Reprint 1990

<table>
<thead>
<tr>
<th>Program</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Kitchen Training Program as an Occupational Therapy Activity: An Overview</td>
<td>$12.00 AOTA member, $16.00 non-member</td>
</tr>
</tbody>
</table>

---

**Order now with MasterCard or VISA!**

Call 1-800-THE-AOTA (AOTA members), 1-800-654-5584 (Md. members), or (301) 948-9626 (non-members).