Professional Socialization: Implications for Occupational Therapy Education

(occupational therapy, professional values, role models)

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Socialization is classically defined as the process by which individuals acquire and internalize the values, norms, roles, and skills that enable them to function as members of their cultural group (1).

Although we participate in many socializing experiences during childhood, these experiences cannot prepare us for all the roles we may fill in later years (2). Each time we join a new group, we must learn its unique values, norms, and roles; we do so through a socialization process.

Socializing influences to which students are exposed during their professional education may have greater impact on their future practice than the academic and clinical information they learn. The socialization process into professions has been studied widely. However, little of this research has examined, or been applied to, occupational therapy.

Occupational therapy educators continually strive to maintain high quality academic and clinical preparation for entry into the profession. Increased understanding of the socializing influences that are, and can be, transmitted will be valuable in improving these educational programs further.

Professional Socialization

The Goals

Like any socialization process, the goal of professional training is to prepare its participants to enter new roles. This preparation entails learning new skills, learning behavior patterns and norms, learning values and attitudes, internalizing these values and attitudes, and acquiring self-identification with the role (1-5).

The Stages

Professional preparation is generally divided into two segments: a) formal academic education, usually within a university setting, and b) a period of apprenticeship, or clinical training. Some authors feel that there is a third segment to the socialization process; that is, the situational demands of the individual’s early work setting (6, 7).

Wheeler (2) examined various structures of formally organized socialization settings. Table 1 illustrates differences in the social con-
Table 1
Typology of Interpersonal Settings

<table>
<thead>
<tr>
<th>Social composition of other members</th>
<th>Individual</th>
<th>Collective</th>
</tr>
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<tbody>
<tr>
<td>Disjunctive</td>
<td>First occupant of a newly created job</td>
<td>Summer training institute</td>
</tr>
<tr>
<td>Serial</td>
<td>New occupant of a job, where former occupant still works at the setting</td>
<td>Schools and universities</td>
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The text of entering members and in the social composition of previous members. This classification can be useful when examining the differences between socializing influences during the two stages of formal professional preparation.

New members can enter the setting either individually or as part of a larger, collective group. The social composition of other members may be either serial or disjunctive. In a serial pattern of socialization, the newcomers have the opportunity to interact with previous members who have experienced the same process and who can teach them about the setting. In a disjunctive pattern of socialization, predecessors are no longer at the institution when the neophytes arrive.

The academic phase of occupational therapy preparation is characterized by a serial pattern of socialization and a collective status of entering recruits. This structural factor has implications for the role of the peer group in the professional socialization process. The student is in frequent contact with other members of the collective group. In addition, students in advanced classes are available to share their experiences and teach entrants about the setting.

Clinical training usually takes place in a different social context. Here, the student often interacts with supervisors in an individual rather than a collective context. Furthermore, the entry cycle in a clinical training setting may be disjunctive rather than serial. The absence of peers at one's own or at more advanced levels in the system may contribute to the student's stronger identification with clinical supervisors than with university instructors as role models for professional behavior.

Sherlock and Morris (5) describe the processes of professional socialization. Their sequence is illustrated in Figure 1.

Careful selection of participants, through well-formulated admissions criteria, is the first component of the socialization process. Socialization during adulthood can only consist of "creating new combinations of old response elements" (2, p 22). A person's prior knowledge, biases, and attitudes will significantly influence the learning of a new adult role.

A major purpose of selective admission to professional programs is to limit entry to individuals with qualities that the profession considers to be desirable and congruent with its goals and definitions of practice. Occupational therapy, however, has not yet clarified which qualities it values for prospective students. A study of 40 occupational therapy curricula revealed inconsistencies in the selection criteria between schools (8).

Another effect of selective admission is that it increases motiva-
tion and commitment from students who feel honored to have been accepted into a given preparatory program (5).

Sequestration, or separation from external influences, eliminates competition from other, possibly conflicting, socializing forces. Professional programs are frequently housed in separate buildings on a university campus. Most programs allow students to take few elective courses outside of the professional curriculum. In addition, because of the quantity of work required by most professional training programs (5), students are relatively deprived of opportunities for external pursuits.

Sanctioning can be defined as the socializing institution's capacity to provide meaningful rewards and punishments as appropriate reinforcers of students' performances. Moore (9, p 879) emphasized the critical role that negative experiences may play in the socialization process.

The initiate is put through a series of tasks and duties that are difficult, and some are unpleasant. Success is accorded to most of the entrants, but not all; failure is a realistic possibility. These challenging and painful experiences are shared with others, who thus have a sort of relationship of suffering.

Many professional training programs arbitrarily maintain ritualized, difficult tasks even after their educational values may no longer be significant. Moore maintains that the punitive process of socialization accounts for resistance by members of the profession to major changes in occupational training.

The processes of didactic and apprenticeship instruction (see Figure 1) represent the stages of academic and clinical training. With these processes of instruction, sequestration, sanctioning, and sponsorship may all occur simultaneously.

Certification of all students who successfully complete the required process for induction into the profession serves a similar function to selective admission. From a sociological perspective, the major goal of certification is to increase commitment to the goals and cohesiveness of the group the student has been socialized to enter.

The socialization process continues well after students receive their professional degrees and certification. Sponsorship is a relationship in which an established practitioner takes responsibility for the professional enhancement of a colleague. It is the major socializing force after new recruits enter the working phase of their professional socialization. Rogers (10) stressed the importance of establishing sponsorship networks among occupational therapists. Studies are needed to determine if entry-level therapists tend to establish sponsorship relationships. These studies also need to ask if so, do these relationships tend to be with occupational therapists or with members of other professions?

The Participants

Any socializing process includes a similar general core of participants: the student (also referred to as the recruit, the neophyte, or the initiate, or "socializee"); the socializing agent (or role model), peers; and patients. Sociologists differ in the relative importance they ascribe to each of these participants.

Students are not simply passive recipients of socializing influences. Incoming members to any group need to actively create their own new identities by developing their own personal definitions of the situation and the role (3). Individual personality characteristics, skills, and attitudes will significantly affect this process. For this reason, recruitment and selection policies play an important role in professional socialization. Studies have shown that occupational therapy applicants and students tend to show a high degree of interpersonal skill, have a strong desire to "help others," and demonstrate greater interest in the humanities than do students entering other health fields (11-13).

Occupational therapy students encounter several different socializing agents during their formal training. Role models include full-time occupational therapy faculty members, practicing clinicians, who serve as part-time instructors, physicians, who teach background medical courses, and occupational therapy clinicians, who serve as supervisors during their fieldwork experiences.

Becker et al. (4) coined the now classic term "student culture" to signify the close and influential bond that forms between peers in medical school. Several factors facilitate the formation of student cultures in the occupational therapy profession. The heavy workload, combined with infrequent opportunities to attend classes with students in other programs, creates a sequestration of occupational therapy students. In addition, many courses encourage students to openly express their feelings to their peers. Other courses require that students complete assignments with partners or within small groups. Posthuma and Posthuma (14) found that fellow students play a greater role than faculty members in influencing personality development of occupational therapy students.
Labovitz (15) applied the concepts of peer influence and the serial social composition of the university setting to design a fieldwork experience that allowed senior occupational therapy students to play mentor-type roles to freshmen.

Client's expectations of a developing professional will affect the socializee's image of his or her professional role. Schoolteachers develop behavioral strategies in response to challenges presented by students (16). Third-year medical students, no matter how humble they felt beforehand, learn to model their behavior to match their patients' expectations that they be certain and decisive (17).

Patients may play a greater role in the socialization of occupational therapists than in other service professionals. Both faculty and clinical supervisors explicitly stress that students be open to learning from their patients. This has both positive and negative implications. It is valuable that occupational therapists view patients as active, responsible participants in the rehabilitation process. However, practitioners must also feel secure that they have unique knowledge and expertise to offer.

Consistency of Socializing Influences: A Major Determinant of Effectiveness

Three criteria enable a socialization process to function optimally: a) the goals of the organization must be clearly defined, b) these goals must be known to all socializing agents and neophytes, and c) the various participants must accept these goals as being valid and mutually compatible (18).

In reality, organizations seldom achieve complete consensus regarding goals. Environments with relatively consistent attitude and role model cues for students lead to more pronounced socialization in a particular direction than environments with low consistency in cues (19).

Several experimental curricula and clinical programs have been designed to transmit humanistic values to medical students (20). Such programs include a de-emphasis on grades and competition, earlier contact with patients and clinical activities, and a stronger emphasis on a team approach and giving attention to the psychosocial aspects of patient care. Longitudinal studies have shown that any changes in student attitudes are extremely short-lived (20). A probable reason is that these attitudes are not reinforced by subsequent experience. If the remainder of the peer group and other professional role models continues to maintain conventional attitudes about medical education and patient care, a single socializing experience is unlikely to have any lasting effect.

Several authors have examined inconsistencies in the socializing influences for nursing students between their academic education and their clinical training and early work experience. Faculty members' efforts to produce nurses who can function effectively as innovators are often counteracted by conflicting role messages from the students' clinical role models (21, 22). A study of nurse practitioners (23) yielded similar findings. When the effects of the educational program's and the work setting's socialization were similar, these former registered nurses did show steady shifts in both attitudes and activities related to their new professional role. However, when the effects of the program's socialization were not reinforced, or were counteracted in the work setting, the effects of the school as a socializing agent were lost.

The study did find a small group of nurse practitioners who more forcefully chose the educational program as their socialization model. These nurse practitioners either found ways to use the attitudes and skills of patient counseling within the constraints imposed by the work setting or they sought employment in settings where those skills would be compatible. This finding illustrates that individual personality differences among students contribute significantly to the success or failure of attempted socialization efforts.

Role stress will occur if the educationally defined role is incongruent with the role defined by one's employing organization (24). Two types of role stress have been differentiated: role conflict and role ambiguity. Individuals in role conflict are required to play roles that conflict with their value systems or to play two or more roles that conflict with one another. Role ambiguity implies that the person confronts single or multiple roles, which are not clearly articulated in terms of behaviors or performance levels expected.

Do occupational therapy students receive conflicting messages from the various socializing agents they encounter? Jantzen's (25) demographic study revealed significant differences in median age, marital status, type of basic professional education, and level of education between faculty and clinical practitioners. Eliason and Gohl-Giese (26) found poor continuity in the modalities that students are taught by their teachers during the academic phase and those used by clinical supervisors during fieldwork experiences. Further comparative research about attitudes and role definitions held by occupational therapy educators and practitioners would be helpful in...
identifying other discrepancies in professional values that are transmitted during these two phases of the socialization process.

Studies are needed to determine the existence and possible effect of the inconsistencies between occupational therapy faculty and physicians who teach the medically oriented courses. It is also important to assess if students experience incongruities between teachers who teach courses related to treatment of psychiatric patients and those teachers who specialize in services for the physically disabled.

The work setting may offer further differences in the socializing messages given to the newly graduated occupational therapist. As in other professions, influences on a person's first job serve as powerful socializing forces. Experienced occupational therapists' skills and general orientations may differ more on the basis of where they held their first jobs rather than on which university they attended for occupational therapy course work. Brolier's (27) study of occupational therapists, physical therapists, and social workers supports this theory. On tests of autonomy, deference, order, and dominance, occupational therapists working in physical disabilities settings performed more similarly to physical therapists than to their colleagues working in psychiatric settings. Scores for occupational therapists working in psychiatric settings were most similar to those of the social workers tested.

Values and Attitudes Transmitted

Socialization theory emphasizes that the goals of a training program should be clearly defined to all participants. It may be a fairly straightforward task for professional associations and curriculum developers to specify which skills and knowledge they seek to transmit to students. However, professional values and attitudes are another matter altogether. Most of the research that attempts to uncover which values are transmitted through professional socialization into health professions has examined only the nursing and medical professions.

Two central values serve as a core for the professional ideology of nursing (23). The major value is an emphasis on "care" as opposed to "cure." Care refers to providing psychological support, health counseling, and education in addition to performing the procedures necessary to maintain or improve a patient's health. A second value that nurses are trained to exercise is to make decisions autonomously within their areas of expertise. Unfortunately, it is felt that several aspects of current nursing programs tend to reinforce candidates' tendencies to be submissive and place themselves in subordinate roles (21).

Attitude surveys of medical students show that as they progress in medical school, they score lower on "idealism" and higher on "cynicism" scales (20). In addition, many health consumers feel that medical students' initial tendencies toward humanitarian and psychological concerns are systematically decreased during their professional socialization toward becoming physicians. Becker et al. (4) feel that this is not a fair judgment. In their view, the real development is an increasing emphasis on the technical ways in which medical students may help their present and future patients. Students graduate medical school with a "pragmatic idealism"—a desire to provide the most thorough care possible.

Another value transmitted in medical school is the attitude of detached concern (17). Students are taught that they will be most effective as physicians if they can learn to maintain a level of emotional detachment from the often disturbing problems encountered in their patients (17, 28).

Fox (17) describes medical education as "training for uncertainty." Several aspects of the curriculum and clinical training are purposely designed to prepare future physicians for the limitations in current medical knowledge and their own incomplete or imperfect mastery of available knowledge.

Yerxa (29) encouraged occupational therapy educators to examine which values are transmitted in the profession's socialization process. She suggested the possibility that our educational process may reward attributes such as conformity and passivity, which contradict the goals of the profession as a whole.

Occupational therapy literature includes discussions of two general categories of values in our profession: patient-related values and those values related to the collective professional status of the occupational therapy field (29).

Studies of patient-related values have focused on the importance for occupational therapy students of interpersonal skill development. There is general agreement in the literature that the occupational therapy profession respects practitioners who demonstrate interpersonal sensitivity (13), empathy (30, 31), noncontrolling and nonauthoritarian behavior (15, 32), and open-mindedness (33). Many occupational therapy curricula follow Posthuma's (32) recommendation to include small-group sessions as a means of increasing self-awareness and interpersonal sensitivity.
Occupational therapy leaders continually seek to elevate the professional status of the field. However, Mathewson (34, p 601) complained that "the socialization of women who enter the traditionally female and helping professions is a process whereby women acquire skills, attitudes and values and that include dependence, subservience and rewards mostly in the form of verbal praise for the job done." Yerxa (35) suggested that we examine the content and teaching methods used in our educational programs to promote the socialization of autonomous and assertive behavior, a capacity for self-directed learning, and a capacity to engage in necessary confrontation.

Rogers (10) stressed the need for occupational therapists to develop socialization networks that encourage leadership in practicing therapists through hierarchical and peer-level sponsorship.

In regards to the value of autonomy, studies have revealed wide discrepancies between groups of occupational therapists (27, 36). How much do educational programs in occupational therapy socialize students to view themselves as subordinate to physicians? Although it may be valuable for physicians to teach medical background courses in occupational therapy curricula, it may not be valuable for these courses to impose greater academic demands on students than the course work that provides direct preparation for future clinical practice.

Research concerning socialization in other health fields (37) suggests that schools may introduce or delete material from curricula to transmit a desired professional image to students. It would be interesting to study the history of course and prerequisite requirements in a sample of occupational therapy training programs and then to analyze if these curriculum changes reflect changing professional self-images held by leaders in the field.

The length of training is a commonly used criterion that determines the professional status of an occupational group. Therefore, we need to examine the effects of our current dual-entry route for registered occupational therapists.

Occupational therapists generally agree that adaptability is a fundamental patient-related value in the profession. The skillful occupational therapist appreciates the unique qualities of each patient and situation and thus modifies the available treatment approaches to meet the varying challenges. Fox (17) has proposed that medical students undergo "training for uncertainty." Are there specific mechanisms by which occupational therapy students participate in a "training for adaptability?"

Socializing students to maintain the value of adaptability has many positive effects on patient service. However, this value may also have some negative implications for the general identity of occupational therapy. Occupational therapists tend to define their roles situationally. They adapt to the demands of various health care settings by assuming those tasks that aren't already being addressed by other members of the team. This has led to a difficulty in defining the boundaries of responsibility between occupational therapists and practitioners of other rehabilitative services.

Summary and Recommendations

Educators and clinical supervisors need to become more aware of the socializing implications of various aspects of occupational therapy education. To form strong and healthy role identities, incoming members to any group must perceive an underlying consistency among socializing influences. Occupational therapy has a long way to go toward developing consistent admissions criteria between schools and consistent cues from role models in varying specialty areas and stages of the socialization process.

Educators in all professions face a similar dilemma. How should the domain of the profession be defined to determine how students will be trained? If the curricula and role models are based on a looking glass reflection of the current state of practice, students will be prepared to most comfortably enter the existing market. However, if we follow a philosophy that students can be prepared to serve as change agents after graduation, education can contribute to the dynamic growth of the occupational therapy profession. The answer lies midway between these two philosophies. Educational programs that present an unrealistically idealized version of professional practice run the risk of having students discard those values which are not reinforced in clinical settings. Occupational therapy education must continually present a balance between what is and what can be.

Finally, it would be valuable to examine the concept of adaptability, both as a professional value and as a personality variable. Are occupational therapists more adaptable than other health practitioners? If so, what socializing influences may account for this? Where, along a continuum, does role adaptability become role ambiguity? Occupational therapy educators need to...
find effective ways to develop stronger professional role identities for those students entering the profession without sacrificing the critical occupational therapy value of adaptability.

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