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# The Caring Occupational Therapist: Scope of Professional Roles and Boundaries

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Key Words: holistic health • qualitative method • role delineation

*Objective. This article links two dimensions of occupational therapy within the context of professionalism: the role of caring and the implications of occupational therapy being a predominantly female profession.*

*Method. Seven occupational therapists representing various levels of professional experience were interviewed to determine (a) how female occupational therapists perceive caring and (b) the implications of this perception for professional role definitions.*

*Results. Participants' daily professional work role was determined by three factors: the interpretation of holistic philosophy in their everyday activities as occupational therapists, the influence of their caring attitude in broadening their responsibilities beyond the occupational therapists' role definition, and the organizational settings in which their work took place.*

*Conclusion. The seven participants had a broad definition of the scope of their professional responsibilities and experienced difficulty defining the limits of their role. Caring is a central part of the occupational therapists' role; therefore, perceptions about caring are central to the role definition of occupational therapists.*

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*This article was accepted for publication May 18, 1994.*

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Professionalism and the continuing search for professional identity have been recurring themes in the occupational therapy literature since the early 1960s. Although being or becoming a profession is generally considered a goal for occupational therapy, the word *professionalism* has been used in many different ways in the occupational therapy literature, and the concepts included in the term are not always well defined. This emphasis on professional identity and uniqueness, although ostensibly driven by past and present reimbursement and legislative issues, appears also to be a reaction to difficulties encountered in defining the profession of occupational therapy, its scope of practice, and its intrinsic value.

These difficulties, and the concurrent search for a unifying identity, may occur in part because many definitions of occupational therapy are broad and link the profession's domain of concern to almost all areas of human life (Devereaux, 1984; Hubbard, 1991; Lycett, 1991). The all-inclusive and sometimes disparate definitions of the profession's role, and the possible connection between these definitions and the relatively low status of occupational therapy as perceived by some occupational therapists and by some other professionals, has disturbed many occupational therapists (Breines, 1986; Fidler, 1979; Gilfoyle, 1984; Parker & Chan, 1986; Vogel, 1991; Yerxa & Sharrott, 1986). This article examines how female occupational therapists perceive their role as professional caregivers and how they define this role in their own everyday practice.

Discussion of professional role issues in the occupational therapy literature can be divided into two categories. The first category comprises authors who accept the classic sociological definition of professions based on adherence to certain standards; according to this definition, medicine and law are the only true professions (Parsons, 1954). Asserting that there is a continuum of professionalism rather than the dichotomous categories of professions and nonprofessions, these authors have analyzed occupational therapy in terms of its autonomy, commitment, and educational requirements, as well as the other salient characteristics identified by sociologists as belonging to professionals (Fidler, 1979; Gillette, 1979; Jongbloed, 1984; Mathewson, 1975). On the basis of these analyses, they maintained that occupational therapy must change with regard to some of these characteristics to become more like a profession than like Etzioni's (1969) definition of *semi-professions*, which includes nursing, teaching, and social work.

The second category of discussion comprises authors who also accept the classic sociological definition and admit that occupational therapy is not yet a full-fledged profession. These authors, however, emphasize the critical role of occupational therapy research as the primary way to validate occupational therapy's achievements and enhance its future status, thus ensuring that it will eventually be designated a profession (Gilfoyle &

Christiansen, 1987; Grady, 1987; Johnson, 1981).

This search for models of professionalism to analyze issues related to validation of a profession's role, definition, and status is not unique to occupational therapy; all nonphysician medical professions engage in this quest. However, the relevance of applying this mainstream ideology of professionalism to professions such as occupational therapy has been questioned by Breines (1988), Cracknell (1989), and Sachs (1989). Furthermore, despite the value of these discussions in the occupational therapy literature, some occupational therapists are still dissatisfied with analysis of the profession based on sociological theories. The emphasis on models, theories, and research may neglect some of the work and humanistic values of practicing occupational therapists involved in direct care. Furthermore, such discussions may be perceived as dichotomizing theory and practice.

There appear to be two core professional identity issues particularly relevant to occupational therapy that underlie both of the foregoing categories of discussion but are usually ignored or misinterpreted in the occupational therapy literature: (a) the consequences of occupational therapy being a predominantly female profession (nearly 95% of occupational therapists are women [American Occupational Therapy Association (AOTA), 1993]) and (b) the relationship between the caring nature of the work of occupational therapy (Devereaux, 1984; Gilfoyle, 1980; King, 1980) and the meaning of caring in the social, economic, and political climate in which this caring work takes place. These two issues are intimately related to one another and to the present and future professional status of occupational therapy.

In this article the term *caring* is defined as "that range of human experiences that have to do with feeling concern for, and taking care of, the well-being of others" (Graham, 1983, p. 14). Caring focuses on satisfying the emotional and physical needs of the care receiver. Caring is a complex concept, as it includes both labor (activity) and an emotion (feeling) directed toward the preservation and growth of the person in need. Thus, caring encompasses concern for the entire spectrum of human needs.

The concept of caring in the medical professions is generally juxtaposed with the concept of curing. It has been well documented (Bloom, 1965; Dreitzel, 1971; Duff & Hollingshead, 1968; Eisenberg, 1977; Hawkins & Higgins, 1985) in medical, nursing, and other health care literature that curing is the domain of physicians and caring is the domain of other health care professionals. These sources have also pointed out the positive value placed on curing and the relatively low value placed on caring.

This attitude toward caring follows the custom in most Western societies of undervaluing and underpaying for caring tasks, which are almost entirely assigned to and assumed by women (Cahn, 1979; Deitch, 1980; Parry,

1983; Statham, Miller, & Mauksch, 1988). This devaluation of caring, combined with the designation of such work as the natural work of women, historically enabled societies to ignore the labor involved in caring and to keep that labor socially and economically invisible. It also forced caregivers (who were primarily women) to take care of others without receiving either positive societal recognition for their actions or the necessary resources to carry out the caring work (Adams, 1971; Fisher & Tronto, 1990; Glazer, 1993; Ungerson, 1983). Many of the predominantly female professions actually originated as a natural extension of these caring activities, with part of the caring labor transferred from the home (unpaid) to the marketplace (paid) (Fisher & Tronto, 1990; Reverby, 1987).

Despite the complexity of caring and its centrality in women's personal and professional lives, only a few researchers have studied the experience of caregiving, and almost none of them have done so from the professional caregiver's perspective. Corley and Mauksch (1988), in their research on nurses' caring work, claimed that the professionalization of caring—in which caring was transformed from an activity carried out by women at home to an occupation such as nursing—transferred many of the societal attitudes about women's work from women's personal lives to their public lives. They suggested that behaviors needed for caring were devalued because they were considered a natural endowment of women (i.e., a natural by-product of female instinct). Corley and Mauksch claimed that "a set of characteristics which otherwise would earn applause and prestige can be neutralized, if not trivialized, when identified with the presumed natural consequences of low status attributes" (1988, p. 136). Diamond (1988), in his research on nursing assistants, concluded that caring labor is not only trivialized when carried over to the workforce, but also ignored. He suggested that health care organizations formalized the invisibility of caring work through bureaucratic procedures. For example, he found that many of the necessary and time-consuming tasks involved with caring were not listed in formal job descriptions or documented in activity records. Tasks such as comforting a crying patient who is in pain, persuading a patient to get dressed, or calming a frustrated elderly person who is upset over the deterioration of his or her abilities could not be listed in the time records of a caregiver's daily activities, because there were no categories in which to place them. Thus, these unreported tasks were not counted as part of caregivers' daily work.

The daily activities of most practicing occupational therapists, as documented in the literature, involve caring (Devereaux, 1984; Gilfoyle, 1980; Huss, 1977; King, 1980). These authors considered caring the basis for the profession's philosophy and practice, as it encompasses the attitudes and emotions required to excel as an occupational therapist. Because most occupational therapists

are women and caring is closely associated with both the personal and public dimensions of all women's lives (Adams, 1971; Fisher & Tronto, 1990; Gilligan, 1982; Graham, 1983), analyzing the caring character of occupational therapy work might reveal the sources and nature of the distress many occupational therapists face relative to their professional role. Therefore, to understand the scope, nature, and reality of occupational therapists' professional caregiving, we examined the perceptions of selected female occupational therapists regarding their role and the meaning they give to caring. The specific questions posed were how female occupational therapists perceive their role as professional caregivers, and how the coexistence of multiple and sometimes contradictory meanings of caring affects these occupational therapists' professional identity.

## Method

This research was part of a larger qualitative study of the perceptions of caring held by female occupational therapists. The methods and results of the larger study have been reported in an unpublished doctoral dissertation (Sachs, 1989). This article reports on one of the four themes that emerged: the scope of professional roles and boundaries in occupational therapy.

### Participants

Using the purposeful sampling method (Bogdan & Knopp-Biklen, 1982), we selected for this study seven female occupational therapists from the New York City metropolitan area who had been working in occupational therapy for 5 to 25 years. These therapists represented a variety of ages, levels of professional education, types of work experience, work settings, patient populations served, and professional functions (see Table 1).

The sample size was determined by the principle of saturated sample (Glaser & Strauss, 1967), in which, after each interview, data are analyzed to develop categories of meaning. Saturation of the sample is defined as the point at which the addition of new data from participants does not provide new categories for the analysis or new information about each category. In this study, saturation of the sample was evaluated by five external judges who were qualitative researchers from other helping professions. After two in-depth interviews with each of the seven participants, the sample was found by the researchers and the judges to be saturated.

### Procedure

At the first stage, one of the researchers conducted preliminary observations in two of the six occupational therapy departments in which the interviews would later take place. This step allowed her to become familiar with the settings and with the professional culture and language, thereby increasing the credibility of data collection. Next, using an in-depth ethnographic interview, the researchers interviewed all participants twice, for 1 to 2 hr each time. The interviews were unstructured but were based on an interview guide listing common issues to be covered (Lofland & Lofland, 1984; Spradley, 1979). All interviews were conducted at the therapist's place of employment and were recorded and transcribed verbatim for later analysis. The first interview was guided by a list of topics and questions in the interview guide. The second interview was conducted after an initial analysis of the first interview. This second interview added to the credibility of the data by providing an opportunity for (a) persistent observation, in which relevant issues are clarified and pursued and additional details are gathered, and (b) member checks, in which the researcher's ideas and

**Table 1**  
**Description of Research Interviewees**

Age	Years of Experience	Professional Education	Patient Population Served	Professional Function	Work Setting
35	6	Bachelor's degree, <sup>a</sup> graduate student	Physical disability/rehabilitation	Supervision, management	City hospital
46	24	Bachelor's degree, <sup>a</sup> master's degree	Physical disability/rehabilitation	Management, supervision, consultation	City hospital
33	10	Bachelor's degree, <sup>a</sup> master's degree, doctoral candidate	Physical disability, developmental disability, cognitive disability	Direct patient service, management, consultation	Private practice
36	10	Bachelor's degree, <sup>a</sup> graduate student	Pediatric, physical disability, developmental disability	Direct patient service, supervision	Public children's hospital
42	10	Master's degree <sup>a</sup>	Adult developmental disability	Management, supervision	State developmental institution
60	5	Bachelor's degree <sup>a</sup>	Long-term psychiatric	Direct patient service, supervision	State psychiatric hospital
47	25	Bachelor's degree, <sup>a</sup> master's degree	Short- and long-term psychiatric	Management consultation, research, direct patient service	University medical center and private practice

<sup>a</sup>In occupational therapy.

working hypotheses are validated with the participants (Lincoln & Guba, 1985).

The list of topics guiding the interviews was initially drawn from issues identified in the occupational therapy literature concerning the profession's role, functions, and identity and from the literature about female caring. The guide was revised during and after the early interviews and was then evaluated by six experienced occupational therapists not involved in the research. Following are two examples from the interview guide:

- Please describe the activities you are involved in during one working day. (Probe for—Why are you involved in these activities? Are they part of the occupational therapist role definition? Are they involved with caring? What do you like about these activities? What are the difficulties you confront in everyday work?)
- What does caring mean to you? (Probe for—Is it important to you in your personal or professional life? Do you or others perceive you as a caring person? Is it important for you to be considered a caring person?)

#### *Data Analysis*

Emerging categories of meaning were identified and coded with data from the first interviews. Data from later interviews were coded according to these categories and were the basis for identifying new categories or eliminating old ones. This cyclic, interactive process determined the final selection of the most salient and important categories of meaning for this study (Bogdan & Knopp-Biklen, 1982). In addition, the investigator kept detailed field and reflective analytical notes and a log describing the process of developing the coding system. To strengthen the trustworthiness of the data analysis, the transcribed interviews and the reflective notes and log were used for peer debriefing, in which the five external judges analyzed and evaluated the emerging findings and their interpretations.

The final coding system included 52 codes organized into eight categories as follows:

1. Elements of caring (time, doing the caring work, emotional responsiveness, giving beyond expectations, results of caring, sources of satisfaction, types of caring, limits of caring)
2. Conflicts and limitations of caring and professional roles
3. Dealing with limitations
4. Self-perception (me) and caring
5. Occupational therapy (my profession) and caring
6. Gender role
7. Monetary compensation

#### 8. Interprofessional and intraprofessional relationships

Analysis of these eight categories led to the emergence of four main themes that incorporated the commonalities and differences in the perceptions of caring of the participants (Sachs 1989): (a) self-perception as a caring person, (b) definition of professional caring, (c) scope of professional roles and boundaries in occupational therapy, and (d) contradictions between caring and conditions of caring. The results for the third theme are presented in the text that follows.

#### Results

Two dimensions were identified from the scope and boundaries of the participants' professional activities. The first was internal and related to how the participants defined their roles as caring occupational therapists. The second dimension was external and related to variables affecting the participants' everyday responsibilities at work (e.g., the institutions at which they worked or the other professionals with whom they worked).

#### *Defining Professional Role and Boundaries: Internal Dimension*

All participants had difficulty defining their occupational therapy role. Their definitions of their role were very broad, but they used two primary criteria to guide their role activities: a holistic approach and a commitment to responding to patients' needs guided their definitions of professional role and boundaries, and a caring attitude affected their professional role behaviors.

The first criterion seemed to be based on occupational therapy philosophy and practice. The participants perceived holism, the philosophy on which occupational therapy is based, as a broad concern for patients' well-being; they considered responding to patients' needs as the goal of the profession's treatment.

Three of the participants talked about the effect of "being holistic" on their role and activities. They described being holistic as an attitude and a perception of patients that guided their actions in general. As one said, "We do everything. We want every piece of the pie because the person is a whole." Another participant clarified what she meant by being holistic, saying

I have always been comprehensive in my caring. I can't go to a private patient and say, okay, you are going to be treated in this hour and then I will see you next week. Who am I helping if I don't get back to their home environment and if I don't get back to the people who are involved? That's why I say that as far as I am concerned, when I take a case I take the whole.

Most of the participants defined the goal of occupational therapy as responding to patients' needs. One defined her treatment goal with the long-term psychiatric

population as “trying to meet their needs.” In contrast to other professionals who treated the illness, she treated patients’ survival needs, such as basic hygiene and interpersonal communication. Because patients’ needs evolve and change, she described the scope of her role as an occupational therapist as being very broad, constantly changing, and difficult to define. She treated any problems that arose relative to the needs presented to her by her patients. For example, when patients were to return to their community after discharge, she felt responsible for teaching them all the living skills needed to survive there, because learning basic living skills (e.g., handling a washing machine, preparing meals, entertaining friends, and communicating with resource people in the community) would enable patients to eventually take care of their needs themselves.

Another participant identified the scope of her role as one that evolved as patients’ needs evolved; she defined its boundaries in the same way. For example, in describing what she was doing with one patient, a woman with a long history of mental illness, she said that her role as an occupational therapist was to help the patient in all areas that the patient could not manage:

I do a variety of things with her. I mean, I’ve gone shopping with her to help her pick up clothing, help her buy furniture, help her handle her finances, stuff like that. I usually go to her apartment once a month in order to see how things are going there because there is a history of a lot of chaos, and I will meet with her and her mother when her mother is in town, and we will have dinner together, the three of us....But on the other hand there was a point at which she took great pride in not needing me to go with her....Her situation will define my limits within reason. I mean, I’m not available to see her every day, although I will see her as frequently as it is necessary, but there are certain limits in terms of what’s reasonable from a professional point of view.

Therefore, defining what was professionally reasonable was not easy for this participant. Her professional activities expanded because she did not want to limit patients when they had needs that she believed she could deal with. However, despite difficulties in delineating and delimiting their activities and role, both of these participants seemed to reach a point at which they relied on their status as professionals to help them set limits on the scope of their caregiving.

Being holistic and responding to patients’ needs seemed similar when translated into practice; when participants talked about treating a person as a whole, they usually referred to attending to patients’ comprehensive needs. Regardless of which concept was used, defining the boundaries of their occupational therapy role was difficult for the participants because of the broad range of activities that that role included.

The second criterion, a caring attitude, was related to a personal characteristic. All participants mentioned that because they were caring persons, the scope of their role inevitably broadened. Because they cared for their patients, the participants made themselves available to and were responsible for patients far beyond their per-

ceived professional role definition. As one participant said: “Probably the more you care, the more responsibility you will take for the [patient], outside of your strict role responsibilities.”

Thus, according to the participants’ perceptions, they had enormous responsibilities and tasks. One participant, who was in private practice, went to even greater extremes than did other participants. Her caring responsibilities went beyond both time and monetary limitations and beyond professional and institutional requirements. For her, caring involved doing “extra” things.

My understanding of caring is you have it in the therapy and outside the therapy. If anything happens in that person’s life they can call me and I sit down and help them work it out or talk to them about it. There’s not a caring point where it starts and ends after your 45-minute or 1-hour session is over. They know they can come to me any time they want...When my treatment session is over, despite the fact that it is over it is never really over.

Being caring and treating patients’ needs involved the participants in a large number of tasks, some of which went beyond the definition of their role. Being involved in all these tasks was acceptable to them, because the broad scope of professional responsibility and the personal quality of caring, although sometimes overwhelming, gave the participants many advantages in working with patients. They provided therapy that satisfied their own understanding of what is professionally right. Consequently, they gained patients’ trust and cooperation in the therapy process and felt competent.

### *Everyday Responsibilities at Work: External Dimension*

The work for which the participants felt responsible was affected not only by their perceptions of the professional role, but also by the organizational setting of their workplace and by the division of labor within the health care team.

Three participants believed that they had to take on additional responsibilities for patient care while working within the hierarchically organized medical model, because this model does not emphasize patients’ well-being. These responsibilities increased even more in state and city facilities that did not seem “very caring” in their treatment of persons of lower socioeconomic status.

One participant worked in a hospital with children from a lower socioeconomic group who had physical and developmental disabilities. She cited the lack of availability and caring on the part of many professionals and the inability of parents to cope with their children’s disabilities and with the medical system as reasons for taking on additional responsibilities outside her role. These responsibilities included scheduling ambulance transportation, dealing with social services, taking care of parents’ needs and anxieties, and representing parents to physicians. Because she would not allow anything to “slip be-

tween the cracks," she engaged in what she termed *compensatory responsibility* (i.e., taking on responsibilities outside her role).

At the same time, this participant claimed that physicians considered themselves the primary responsible figure in the treatment; legally they were the most accountable, and therefore the physicians thought that all other professionals were there to help them. This put her in a paradoxical situation in which she considered herself responsible for patients' comprehensive care, but physicians considered her to be their helper.

Two other participants who worked in state institutions with long-term populations also took on compensatory responsibilities to offset the lack of caring in the system (i.e., hospital management) and the unavailability of other professionals such as physicians and social workers. These participants assumed tasks such as listening to patients when patients felt the need to talk, talking to key people in the community to find out what the community had to offer a patient after discharge, and locating resources to develop a feeding program for patients.

Another participant described how, even within the same institution, the organizational setting within which the treatment program occurs influences the division of labor and the responsibilities of the occupational therapist. In her medical center, occupational therapists in the outpatient psychiatry program had an important role and major responsibility. Their status in the multidisciplinary health care team was equal to that of others; occupational therapists served as primary therapists and placed occupational therapy treatment goals on patients' protocols. In contrast, in the inpatient unit, the occupational therapists' role was considerably narrowed and very specific to conform to physicians' medical goal of curing patients' symptoms.

Most of the participants claimed that the medical model orientation was not limited to physicians. Other professionals, such as physical therapists, psychologists, nurses, and sometimes even social workers, focused mainly on patients' symptoms and neglected many other areas. These occupational therapists undertook the neglected responsibilities and found themselves involved with patients' families and with community services to a degree greatly beyond the occupational therapist's role. One participant, because no one else did it, took on, without any compensation, the responsibility of coordinating treatment goals among the different professionals involved with her private patients. Another participant working in a city rehabilitation hospital reported that when she took on certain responsibilities for patients' comprehensive needs because of her holistic orientation, other professionals assigned her even more responsibilities. She suggested that her behavior was convenient to the institution in which she worked and to her colleagues on the rehabilitation team and led to further institutional pressures to expand her role. She stated that although it

was satisfying to be needed, the result was an acute sense of role diffusion.

Working in institutions organized according to the medical model resulted in differing descriptions of the scope of occupational therapy. For some participants the role was narrowed, whereas for others, responsibilities increased. At the same time, occupational therapists were involved in activities beyond their role definition because other professionals such as physicians, psychologists, and social workers were not available or were not functioning according to what the participants thought these other professionals should be doing.

## Discussion

In-depth interviews of seven occupational therapists provided an understanding of the scope of their professional activities and how they defined the role of a caring occupational therapist. It was clear that they all had difficulty delineating the boundaries of their role. These difficulties stemmed from three factors: (a) their interpretation of the holistic philosophy in their every activity as occupational therapists, (b) the nature of their caring work as broadening their activities beyond the strict occupational therapy role definition, and (c) the characteristics of the organizational settings in which their work took place. The first two factors can be perceived as intrinsic to the participants' professional understanding and personal attitudes. The third factor relates to the environment in which they worked.

Holism is the underlying philosophy of professional principles, theories, and practice in occupational therapy (Devereaux, 1984; Hubbard, 1991; Johnson, 1981; Mosey, 1981; Wish-Baratz, 1988). Wish-Baratz claimed that holism has been established as a norm in the profession through the use of the term *biopsychosocial* to define the model of health. The word *holism*, however, is often used generally to refer to an understanding of human beings and to define how to take care of them, without an analysis of its meaning when translated into actual human service practice (Hubbard, 1991). According to Hubbard, the difficulties in applying holism to occupational therapy practice arise "because therapists have tried to treat all the person all at once" (1991, p. 417). Congruent with the occupational therapy literature, most of the research participants used holism as a basis for defining their role. Nevertheless, as Hubbard suggested, they interpreted the idea of holism as requiring practitioners to take care of and be involved in all aspects of patients' lives. This interpretation led to role strain, especially with the populations with severe impairments with whom all the participants worked.

The occupational therapy domain of concern includes a wide range of human performance necessary for survival. A comparison of the participants' definition of their professional role with Mosey's (1981) definition of

the profession can help determine whether the participants functioned within the prevailing norms of the occupational therapy role. Mosey defined occupational therapy's focus of intervention as clients' life tasks, or "all of those activities one must be able to perform to meet his or her own needs and to be a contributing member of a community" (1981, p. 6). When Mosey's definition of professional intervention was compared with the participants' description of their everyday practice, it became clear that they understood the conceptual base of occupational therapy as applied in their everyday practice. The use of holism and patients' needs as the focus of intervention could be a source of both weakness and strength in occupational therapy practice. Although using a broad professional definition to guide the scope of occupational therapy's role raises difficulties in defining the profession's boundaries, such a broad definition enables occupational therapists to understand their patients as whole human beings in the context of their environment. The mandate to perceive patients holistically was seen by the participants as a major advantage in understanding patients and providing valid answers to their comprehensive needs, despite the broad scope of responsibilities this mandate engendered.

The nature of caring work also contributes to the broad scope of occupational therapists' professional role. As previously mentioned, caring for persons' needs historically had been considered a female role (Gilligan, 1982; Graham, 1983). Listing all the responsibilities and tasks in which the research participants were involved (e.g., listening to patients, teaching patients to get dressed and to care how they looked, teaching patients to communicate with and to trust people, and shopping with patients) showed that many of the tasks belonged to the traditional caring work of women within their private (home) and public (work) domains (Adams, 1971, Corley & Mauksch, 1988; Fisher & Tronto, 1990). The participants described how they were involved with caring tasks that went beyond formal definitions of the occupational therapist's role and institutional requirements, beyond time limitations, and sometimes beyond financial considerations. Apparently, when their employers did not provide them with enough resources to care, they did what women have been traditionally expected to do: they absorbed the costs (Fisher & Tronto, 1990).

This association between occupational therapy work and women's traditional labor seemed to influence the participants' perceptions of their professional role and image. This association merits further investigation and serious consideration by the profession, especially in light of the low self-image found among occupational therapists in some studies (Parker & Chan, 1986).

Six of the seven participants worked in health care institutions. In general, most professional caregiving takes place in institutions and is organized bureaucratically. The lack of care by others, the division of responsibility

in institutions on the basis of the medical model, and the focus on patients' medical needs emerged as the most critical external factors affecting the participants' professional work.

Fisher and Tronto (1990) claimed that caregiving is problematic in bureaucracies. Similarly, most of the participants thought that patients were not the actual focus of interest in health care institutions and that no one took the responsibility for looking after patients' comprehensive needs. Participants discussed the noncaring attitude that characterizes many health care institutions. Most stated that other professionals were interested only in limited aspects of patients' conditions and that some members of the health care team were not always available when patients needed them. Some of the participants believed, therefore, that they had to bridge the gap between the patients' needs and the institutionalized organization of caring.

Working in institutions that incorporated the medical model added a complex and sometimes demanding dimension to the bureaucratic organization of the participants' professional work. An increase in informal responsibility along with a decrease in professional role represented a paradox that medical model-based institutions imposed on the participants. Participants believed that the medical model narrowed the attention not only of physicians, but sometimes also of psychologists and social workers, toward a focus on the patient's disease. This medical orientation widened the gap between patients' comprehensive needs, which went beyond treating symptoms and curing disease, and institutionalized caring. As a result, most participants believed that as occupational therapists, they should take on additional caring responsibilities. At the same time, some participants believed that working in institutions that incorporated the medical model decreased their professional power and authority.

The sole participant who was in private practice experienced a different kind of role elaboration. Her ability to be available to her patients whenever they needed her, even when this involved an extreme effort on her part, may have been possible because of the lack of bureaucratic constraints (i.e., external barriers) imposed by an organizational structure, which may limit a therapist's involvement with patients.

Because qualitative methodology is sometimes used to uncover the meanings of complex, contradictory, or newly researched phenomena without a commitment to cover the entire area studied, sample size is often small (Glaser & Strauss, 1967; Lofland & Lofland, 1984). The seven participants, although they represented a variety of professional experiences and realities, were a purposeful sample and did not represent the entire range of the profession's reality. Thus, the sample size, which was appropriate for the methodology but small in actual numbers, must be considered when generalizing the results of this research.

The participants were not the passive recipients of responsibilities and tasks that were neglected by others. Instead, they actively took on these responsibilities and felt empowered by being caring persons. They believed that they were needed and appreciated by patients and that they made changes for the better in patients' lives. They were satisfied with their work and felt empowered by the control they had in directing their work on the basis of their professional skills and knowledge and their emotional involvement with patients. Their skills were sometimes appreciated by other professionals. Despite the knowledge of their power, however, the participants did not express feelings of professional strength. This apparent inconsistency may be related to society's low appreciation of both caring work and women's work, and to women's internalization of this view.

## Conclusion

The seven participants had difficulty delineating the boundaries of their professional role because the scope of their professional work was determined by their definition of occupational therapy work, by their understanding of caring, and by the professional organization of the institutions in which they worked. For this group of occupational therapists, the criteria defining the role of occupational therapy did not provide clear guidance regarding how to delineate its boundaries. Although they enjoyed the freedom inherent in having flexible boundaries, most of them expressed feelings of discomfort that this very openness led to role diffusion, which caused them stress. The process of professional caring includes taking responsibility for fulfilling patients' comprehensive needs in institutions employing the bureaucratic structures and ideology of the medical model. The broad definitions of their professional role thus caused the occupational therapists both satisfaction and distress.

This research has linked two dimensions of the profession that have an effect on the role of occupational therapy: the fact that occupational therapy is a predominantly female profession and the centrality of caring in occupational therapy work. During the course of the research it became clear that caring has been a central part of the occupational therapy role, and because of this, the perceptions about caring held by occupational therapists are central to the definition of the role of occupational therapy.

The search for professional identity has engaged occupational therapists for decades. Some consider uniqueness to be a critical component of professional status. Linking the role of caring and the meaning for occupational therapy of being a predominantly female profession adds new dimensions to this task and suggests a different way of valuing the unique contribution occupational therapists make to health care provision. When these dimensions are recognized as central to the profes-

sion's practice, occupational therapists can view and value the professional role of occupational therapy in a way that incorporates the process of caring and the experiences of occupational therapists in their everyday practice. ▲

## Acknowledgment

The research on which this article is based constitutes a partial fulfillment of the requirements for Dalia Sachs's doctoral degree at the Department of Occupational Therapy, New York University, New York, New York.

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