Ways to Retain or Reactivate Occupational Therapists

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The previous paper (Bailey, 1990) reported on the reasons for leaving occupational therapy in a sample of 696 therapists. This follow-up paper discusses the reasons given and suggests ways to retain or reactivate therapists. The issues addressed include child rearing; geographic location; feeling professionally out of date; excessive paperwork; lack of pay and promotional opportunities; returning to school; stress; disillusionment; type of caseloads; illness; desire for more status, autonomy, and challenge; and lack of in-service training and continuing education.

Child Rearing

The largest group of respondents (315) left the field to remain home with their children either full-time or part-time. The respondents who remain in the workforce part-time do so in non-occupational therapy jobs. Contrary to the findings of earlier studies (Flint & Spensley, 1968; Madill, Brindnell, Stewin, Fitzsimmons, & Macnab, 1985), more than 50% of the sample had reasons other than child care that contributed to their leaving occupational therapy. Labor statistics indicate that fewer women are routinely leaving their jobs when they have children; increasingly, women are combining careers with child rearing. The therapists in the present study spoke of the stresses of juggling their jobs and the needs of child rearing. If we are to retain these working mothers, we must make working conditions more amenable. As pointed out in "A Child-Job Dilemma" (Brown, 1988), many mothers working full-time as occupational therapists experience frustration and guilt over leaving their children. Although their employers "try to accommodate them with job-sharing and flexible schedules, full-timers have major problems juggling work hours with daycare schedules and unexpected emergencies" (p. 1).

We in occupational therapy are not alone in our concern about retaining working mothers, and observing others' successes in dealing with the problems is helpful. Some companies have addressed the problem by giving working mothers a voice in how they are compensated for their work. The choices afforded these employees include sharing jobs, working unconventional hours, and choosing the makeup of a benefit package or taking no benefits at all in exchange for fewer working hours. One of the most common solutions is flextime, which allows employees to select their own hours. Companies that have experimented with flextime say that the option has served its main purpose, which is the reduction of absenteeism among working mothers (Cohn, 1988).
Companies that offer the option of job sharing, which allows two employees to split the hours of one full-time job, say that most job sharers eventually return to full-time work, thus eliminating the need to find and train new employees. Close communication between partners as well as a well-defined job structure are necessary to make job sharing work. The practicalities of patients' schedules and the frequency of needed treatment would probably dictate the best structure in a hospital setting. As an example of job sharing in occupational therapy, two therapists in Maine, each of whom work 2½ days per week, meet over lunch on Wednesdays to discuss the events of that week and to hand over the job smoothly. At the end of each week, the second therapist types a computer note for the first to review on Monday morning.

In 1985, a few companies began experimenting with flexible benefits, now known as “cafeteria-style” benefits. Employees are allotted “benefit dollars” and allowed to select from a menu of choices, which usually includes several medical and dental plans, long- and short-term disability, life insurance, optional retirement plans, and child care. Alternatively, the employees may choose no benefits at all and instead take home extra cash. Most companies find that they save money on benefits for their employees, and the employees prefer having some control over their compensation.

Sixty-one percent (422) of the survey respondents had children at home when they left occupational therapy. The ability to obtain part-time work and, in some cases, to obtain flexible hours was of great concern to these mothers. Another concern was the ability to find quality day care. Forty-five of the respondents who have left the profession said they were unable to find day care and so cannot work even though they would like to. The other respondents in this group preferred locating part-time jobs, and they are now employed in non–occupational therapy jobs.

Medical settings and health care institutions increasingly are following industry's example and providing on-site day care for their employees' children. This trend will help what has been an insurmountable problem for many therapists. Quality day care in the workplace may ease the guilt and worry of the mothers working as occupational therapists and certainly must contribute to the retention of therapists.

### Geographic Location

The number of respondents unable to find occupational therapy jobs in their geographic area, and who consequently have left the profession, was surprisingly high (285). Geographic location was the third largest contributing cause for leaving the field. It is difficult to suggest ways to retain or reactivate these therapists, except to mention that other respondents said that they have worked hard to create new and, in some cases, unusual positions for themselves. Some of these respondents have educated service providers as to the benefits of occupational therapy and consequently have found occupational therapy work in the local community in a variety of nontraditional set-

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### Table 1
Survey Respondents' Reasons for Leaving Occupational Therapy

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Respondents</th>
</tr>
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<tbody>
<tr>
<td>Wanted to stay home and care for children, either full-time or part-time</td>
<td>315 (45%)</td>
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<tr>
<td>Wanted more flexible hours to accommodate family's schedule and could not find that in occupational therapy</td>
<td>294 (42%)</td>
</tr>
<tr>
<td>Relocated and could not find job in area</td>
<td>285 (41%)</td>
</tr>
<tr>
<td>Felt professionally out of date</td>
<td>261 (38%)</td>
</tr>
<tr>
<td>Excessive paperwork</td>
<td>227 (33%)</td>
</tr>
<tr>
<td>Wanted more pay and promotional opportunities</td>
<td>217 (31%)</td>
</tr>
<tr>
<td>Returned to school in non–occupational therapy field</td>
<td>210 (30%)</td>
</tr>
<tr>
<td>High caseload, stress, burnout</td>
<td>204 (29%)</td>
</tr>
<tr>
<td>Disillusioned with occupational therapy, actual practice of occupational therapy not what was expected</td>
<td>175 (25%)</td>
</tr>
<tr>
<td>Bureaucracy and red tape</td>
<td>160 (23%)</td>
</tr>
<tr>
<td>Characteristics of client caseload</td>
<td>142 (20%)</td>
</tr>
<tr>
<td>Could not find part-time occupational therapy job</td>
<td>120 (17%)</td>
</tr>
<tr>
<td>People in power not using occupational therapist to fullest potential</td>
<td>114 (16%)</td>
</tr>
<tr>
<td>Could not compete with younger therapists for jobs</td>
<td>87 (13%)</td>
</tr>
<tr>
<td>No suitable job in geographic area for returning therapist</td>
<td>87 (13%)</td>
</tr>
<tr>
<td>Conflict with supervisors</td>
<td>82 (12%)</td>
</tr>
<tr>
<td>Illness of therapist or family member</td>
<td>75 (11%)</td>
</tr>
<tr>
<td>Wanted more challenge</td>
<td>73 (11%)</td>
</tr>
<tr>
<td>Could not find job in specialty area</td>
<td>67 (10%)</td>
</tr>
<tr>
<td>Wanted more status</td>
<td>66 (10%)</td>
</tr>
<tr>
<td>Had a negative experience on affiliation or first job</td>
<td>66 (10%)</td>
</tr>
<tr>
<td>Too much responsibility</td>
<td>61 (9%)</td>
</tr>
<tr>
<td>Wanted more autonomy</td>
<td>54 (8%)</td>
</tr>
<tr>
<td>No in-service or continuing education opportunities</td>
<td>53 (8%)</td>
</tr>
<tr>
<td>Could not find child care</td>
<td>45 (7%)</td>
</tr>
<tr>
<td>Could only work part-time and part-time occupational therapy was not economically viable</td>
<td>41 (6%)</td>
</tr>
<tr>
<td>Lack of respect for occupational therapy by other professionals</td>
<td>39 (6%)</td>
</tr>
<tr>
<td>Lack of understanding of occupational therapy by other professionals</td>
<td>36 (5%)</td>
</tr>
<tr>
<td>Need to constantly justify reimbursement for occupational therapy</td>
<td>9 (1%)</td>
</tr>
<tr>
<td>Role conflict with physical therapy</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Could not cope with family and job</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Disliked being the only occupational therapist in the setting</td>
<td>6 (1%)</td>
</tr>
</tbody>
</table>

Note: Therapists often gave more than one reason for leaving.
tings. Those therapists who are sufficiently motivated to remain in the field will probably continue to do so.

Feeling Professionally Out of Date

Because a considerable number of respondents said they had planned to take time off from their jobs to have and raise children, it would be too good to deal with record keeping their record-keeping skills. Perhaps occupational paperwork, but they are difficult to find, according to reentry education to address both the personal and their professional needs of the reactivators (Labovitz, 1986; Labovitz & Howard, 1978) advocated that the profession take an active role in reactivating and assisting returning therapists. Experienced therapists can be valuable role models and mentors and can provide continuity within occupational therapy by carrying on the work of earlier pioneers as well as interpreting the field to newcomers (Labovitz, 1986). Labovitz suggested that "we provide a structured mechanism for encouraging professional activity on the part of therapists during periods of non-practice. . . . [and] organize a program of reentry education to address both the personal and professional needs of the reactivators" (p. 11).

Eighty-seven survey respondents indicated that they felt they could not compete for jobs with younger, recently trained therapists. This complication might be alleviated through tailored reentry programs such as that piloted by Labovitz in 1978. Her program included sessions on confidence building as well as on current occupational therapy knowledge. Such a program might assure returning therapists that they bring valuable assets to the clinical situation and give them the self-confidence to compete for jobs with and work alongside recently trained therapists.

Excessive Paperwork

Excessive paperwork was not only checked frequently on the list of factors contributing to attrition but was also frequently written in as the item the respondents disliked most about their jobs. The respondents' frequency of mention and vehemence expressed toward paperwork was impressive. Excessive documentation is a result of the trend toward accountability and economic belt tightening in health care today. Some settings may require less paperwork, but they are difficult to find, according to the respondents. Workshops might be organized by professional associations to assist therapists in honing their record-keeping skills. Perhaps occupational therapy students can be forewarned and better prepared to deal with record keeping by learning labor-saving methods and ways to determine what is crucial and what may be omitted. Unfortunately, each setting has its own format and requirements for record keeping, and materials that encompass all of these formats may be difficult to find.

Lack of Pay and Promotional Opportunities

Because salaries have increased in recent years, the issue of pay has tended to drop in priority on health professionals' dissatisfaction lists (Huey & Hartley, 1988). In fact, only 11% of the respondents listed dissatisfaction with salary as their main reason for leaving the profession, and 48% said that their leaving had nothing to do with pay. Poor promotional opportunities seemed to be a more important issue. One therapist said, "Limited advancement (financial and professional) made it easier to leave when I had a baby." Others said they were interested in a career ladder, in increasing their responsibilities, and in being in a position to influence the provision of services. They were able to achieve this status only by leaving jobs where their title was occupational therapist and taking generic positions with such titles as director of rehabilitation services and program director. The biggest complaint was that the occupational therapy profession is two-tiered; that is, it consists only of clinical positions and department director positions. Of course, this is by no means a problem unique to occupational therapy.

What can be done about this? Perhaps ways can be found to assist occupational therapists in maintaining their professional title and identity while moving up the health care career ladder. Both occupational therapists and administrators will need to be convinced that therapists are capable of taking on higher level positions and that these therapists can keep their occupational therapist job title while performing the new tasks.

Greater numbers of therapists are entering private practice, where they are enjoying challenges and opportunities not available in traditional clinical settings. Private practitioners are in a position to take on as much responsibility and leadership as they are able to handle, and they are not forced to leave behind their occupational therapist identity. Those who do move into positions with generic job titles must be encouraged to maintain their occupational therapist identity by keeping in close touch with other members of the profession, by maintaining membership and holding office in state and national occupational therapy associations, by speaking at conferences and workshops where other occupational therapists are present, and by writing for professional occupational therapy journals. In this way, not only
are these therapists' ideas and talents retained in the profession but they also provide role models for other ambitious therapists, who then see that one can climb a career ladder and still maintain a professional identity.

**Returning to School**

Thirty percent of the respondents left occupational therapy to return to school and pursue training in non-occupational therapy fields. Presumably, most of them did this because they were not satisfied with occupational therapy as a career and saw additional training as a way to move into another career.

A few respondents said they wished to return to school, but because there was no graduate program in occupational therapy in their geographic area, they turned to a related field of training. Most of these respondents obtained master's degrees in special education. Although several of these therapists intended to return to practice in occupational therapy, they switched fields when they found that in education they could work schedules that more easily accommodate child rearing. Hence, these therapists were lost to occupational therapy because of working hours, not because they were dissatisfied with the profession.

**Stress**

The next largest group of respondents who have left the profession identified items that concerned stress on the job, large caseloads, and feelings of being overwhelmed by responsibility, all of which they felt contributed to burnout. They commented that they are expected to carry extremely high caseloads, that they could not tolerate the constant pressure of seeing patients every half hour and then writing subsequent records, and that they felt overwhelmed by the responsibility of treating patients with conditions that they did not feel trained to treat when they did not have adequate time or resources to research appropriate treatment techniques. As one therapist put it,

> Occupational therapy, like other health professions, demands so much from the individual without providing adequate time to nurture and care for that health provider. Before long that therapist becomes tired, apathetic, conscious of other needs, and starts to fade and look elsewhere.

Apparently, many employers are pushing therapists to their limits, perhaps in response to a shortage of personnel and to pressure to meet the financial demands of the institution. Such employers would be better able to retain therapists if they could lessen the pressures on these therapists and take care of some of their personal needs.

**Disillusionment With Occupational Therapy**

The eighth largest category of respondents who have left the profession indicated that they felt disillusioned with occupational therapy and found that the practice was not what they expected. Some had been in practice for several years and had come to the conclusion that their treatment was not making a significant difference in the lives of their clients. They made such comments as, "I was not at all clear that the work I did with children had any significant effect," "I was disappointed with the temporary impact of treatment," and "I felt I was not really changing anything."

Most respondents were disappointed by these feelings after having devoted several years to a specific area of treatment, and they expressed regret at leaving the field. Other respondents experiencing similar disillusionment have switched to a more satisfying client group and have reported a more positive attitude toward the field as a result.

**Bureaucracy and Red Tape**

Dealing with bureaucracy and red tape is an important and frustrating issue for many of the respondents (160). They mentioned such issues as the facility's priorities being on paperwork and making money rather than on giving patients quality care. One therapist stated, "The most distressing thing was having to discharge patients before they were ready, for insurance reasons." Another therapist said,

> What burned me out was having to treat patients so physically ill that they were not ready for occupational therapy—regardless of my professional opinion. This was because of institution and insurance policies, etc. I eventually gratefully left for maternity leave. It was a very unsettling issue for me.

It seems that some respondents were better able to cope with bureaucracies than others. Some respondents mentioned leaving institutional environments for private practice or for small private settings, where they are happier not having to deal with an unwieldy hierarchy. Switching jobs could be one way for therapists to deal with this problem rather than leaving occupational therapy and thus increasing the field's personnel shortage.

**Characteristics of Client Caseloads**

**Chronic Psychiatric Caseload Stress**

There is clear agreement in this study with Burnett-Beaulieu's (1982) finding that occupational therapists working with chronic psychiatric clients suffer stress and burnout as a result of the severity and chronicity of their clients' illnesses. The respondents in the pres-
ent study who worked with chronic psychiatric patients indicated that they found their work to be considerably more depressing than did those working with other types of clients, and they stated that this contributed to their leaving their jobs. Perhaps more important, significantly more of these therapists (24%) claimed that a chronic psychiatric caseload had contributed to their leaving the profession altogether, as compared with between 5% and 9% of the respondents working with other types of clients.

The current low number of therapists working in psychiatric occupational therapy makes this finding a cause for great concern and is an issue for which members of the profession have been seeking solutions for some years (American Occupational Therapy Association [AOTA], 1982). Ideas proposed to address this problem have included (a) placing more emphasis in occupational therapy curricula on the psychosocial rehabilitation model and the biopsychosocial frame of reference, on management and leadership skills, and on obtaining reimbursement for occupational therapy in mental health (AOTA, 1982); (b) providing students with supportive and stimulating psychiatric affiliations; (c) encouraging new graduates to take jobs working alongside experienced psychiatric therapists; (d) exploring new evaluation and treatment methods for working with psychiatric patients who are hospitalized for short periods; (e) sharing information about such methods through professional publications; and (f) strengthening the peer support network available to psychiatric therapists.

Among other things, the AOTA Mental Health Special Interest Section Task Force (1982) recommended that (a) AOTA work with related mental health associations; (b) an outline be made of the practice areas, educational preparation, and number of members in other activity disciplines; (c) AOTA distribute information on reimbursement for occupational therapy mental health services; and (d) master's degree programs in mental health that stress leadership and management skills be developed.

**Elderly Caseload Stress**

The age of clients affected the respondents who have left the profession, and considerably more respondents (36%) working with the elderly (61 years and older) than with other age groups reported that they found their work to be depressing. This finding is troublesome, because the general aging of the population is resulting in a greater need for health workers, including occupational therapists, to work with the elderly. In recruitment efforts, we must make potential students aware of these practice opportunities.

**Pediatric Caseload Stress**

Interestingly, several respondents chose to indicate that they were working with children with learning disabilities, developmental delays, or mental retardation, although such information was not requested on the survey. Thirty percent of the respondents working with clients aged birth to 3 years and 18% working with clients aged 4 to 21 years found their work to be depressing. Twenty-two respondents have left specific jobs because of the stress of working with children aged birth to 21 years, and 19 respondents have left the field altogether. Unlike other respondents who indicated that their caseloads were depressing and thus caused them to leave their jobs, the pediatric therapists felt compelled to add comments about their feelings, such as, "I didn't want to spend the rest of my life thinking of sad situations," "Working in sensory integration [with children], it seemed to take so long to see change. There also seemed to be many deficits that couldn't be changed," and "Many of the children I worked with did not make dramatic gains and would be carried from year to year."

Many therapists are entering the field of pediatrics now, usually through the school system. A large number of respondents reported being unhappy in this specialty. Apparently, seeing children with disabilities and a slow rate of progress is often depressing and a cause for burnout. Alternatively, perhaps these respondents' medical orientation is out of step with the school orientation. The profession is currently concerned with the large numbers of therapists experiencing difficulty working in school systems and is investigating ways to alleviate the problem (AOTA, 1989).

**Not Being Used to Fullest Potential**

The 114 respondents who have left the profession and who indicated that the people in power did not use them to their full potential tended to be working in physician-controlled environments such as hospitals and acute-care medical centers. The problem does not appear to be as great in rehabilitation centers, nursing homes, schools, or psychiatric settings.

Perhaps the physicians are not aware of the therapists' range of skills and techniques for treating clients. Alternatively, the services offered by those therapists may be available from other professionals, may not be needed by the clients, or may not be reimbursable by insurance. The therapists must prevent boredom and frustration by educating those in power as to the range of services they can provide, so that they may be used to their fullest extent.
Conflicts with Supervisors

Involvement in a conflict with supervisors was surprisingly high on the list of factors contributing to therapists leaving the field. About 40 respondents experienced a conflict with their occupational therapy supervisors and the same number with non-occupational therapy supervisors. The respondents who checked this item also tended to check items concerned with red tape and bureaucracy, the facility’s priority being on paperwork, excessive amounts of paperwork, and being disillusioned with occupational therapy. Apparently, these respondents were unable to reconcile or compromise their differences over such issues with their supervisors, and when coupled with other factors, this caused them to leave.

It seems likely that many issues affected the decision to leave the profession, and conflict with a supervisor may have been the last straw. Although it would be understandable to leave a job because of a conflict with a supervisor, it does not seem to be an important enough issue on its own to cause one to leave a profession.

Illness of Therapist or Family Member

Seventy-five respondents mentioned illness as their main reason for leaving the field. Some respondents had strained their backs and have subsequently entered occupations where there is no physical exertion, and some have emotional problems and could no longer take the stress of being a therapist. A larger group are caring for sick children or parents and could not handle the similar demands of a job working with sick patients. Some of the latter group have stopped working outside the home completely, whereas others have turned to less demanding or more "fun" occupations (e.g., travel agent).

Occupational therapy is a stressful and demanding occupation, and few persons have the inner resources to cope with sickness and disability 24 hours a day. Thus, it is understandable that people in this position, whether they are sick themselves or are caring for others, leave occupational therapy and find more relaxing and self-nurturing daily activities.

Desire for Greater Status, Autonomy, and Challenge

Another group of respondents who have left the profession said they wanted more status, autonomy, and challenge in their profession, and some have switched to fields such as medicine and speech pathology in which they expect to find such challenges. Most of the respondents have remained in the health care services, although some have turned to business, the arts, the clergy, or law.

Those who complained of a lack of autonomy tended to be practicing in medical settings where physicians’ referrals and physicians regularly checking on the therapists’ practice was standard (e.g., several of these therapists were working with hand patients for an orthopedic surgeon) rather than working in more autonomous areas of practice, such as psychiatry or school system practice. Perhaps those therapists who dislike the constraints of such a practice could try one of the more autonomous areas available in occupational therapy, where they might find opportunities for independence sufficient to convince them to remain in the profession.

Another group of respondents felt the need for more challenge, and one or two complained of boredom, although the vast majority found it inconceivable that an occupational therapist would not feel challenged by clients’ daily demands and needs. The few respondents who felt a need for more challenge tended to work with a specialized clientele, such as with elderly people who had had cerebrovascular accidents or with children with cerebral palsy. Again, switching to a more fulfilling and varied client population might have prevented these respondents from leaving the field.

Too Much Responsibility

Sixty-one respondents said they have left the profession because too much was expected of them in their jobs. They felt the weight of excessive responsibility that they were not prepared to handle. Some said they had not been prepared sufficiently in school to do what was expected of them, and others wished to be paid a much higher salary to take on that much responsibility. Most of these respondents have held more than one job in occupational therapy and have found the burden of responsibility a repeated expectation.

Because these therapists were not novices experiencing an isolated case of an employer’s exploitation, I assumed that the amount of responsibility placed on them was typical in occupational therapy. Perhaps more responsibility is being placed on therapists with the advent of increasing accountability and cost cutting in the health care field. If this is so, supervisors, unions, and professional associations must protect therapists from overload so they do not feel that their only recourse is to leave the profession.

Lack of In-Service Training and Continuing Education Opportunities

Some respondents said that their salaries did not permit them to pay several hundred dollars to attend continuing education events. Others complained that
their employers would not give them time off and that few educational events are held on weekends. Still others pointed out that in their institutions (usually small ones) there are no in-service training events, and they felt that the staff members, themselves included, were stagnant and no longer challenged in their jobs. These often-bored therapists took the first opportunity to leave the field for more exciting jobs.

The failure to provide therapists with in-service training or with opportunities to attend continuing education events demonstrates the shortsightedness of employers. Professionals are known to value the chance to update their skills and to validate their treatment methods. An institution that gives its employees the opportunity to do so not only enhances a program but also encourages employees to stay. Also important is the fact that the provision of the best and latest services to clients can only be provided by therapists who are current in the field. It is discouraging to find that 53 of the respondents in this survey left the field because they did not have opportunities to update their skills and to meet with other therapists for professional exchange.

Peak Years for Leaving the Profession
The largest group of survey respondents who have left the profession (35%) did so after 5 to 10 years in practice. Perhaps burnout reaches a peak at this stage of one’s career; perhaps this brings women to an age where they wish to have children; or perhaps they become aware of the reality of a limited career ladder. Whatever the reasons, employers and supervisors should be aware that this is the peak time for therapists to leave. Therefore, employers may wish to take steps to ensure the satisfaction and happiness of employees at this phase of their careers. For those leaving to have children, perhaps arrangements could be made for them to return under specially designed circumstances (e.g., part-time or with flexible hours, with child care services or a pay allowance for child care).

Summary
 Attrition from occupational therapy is a serious problem. If some of the ideas presented here could be put into practice, it might be possible to retain more therapists in the profession and to reactivate others. Currently, many occupational therapy positions remain unfilled for long periods of time, and some are lost when employers cannot fill them. This results in the unavailability of occupational therapy services for some patients who need them and in a decreasing awareness of the services that an occupational therapist can offer. Increasing the number of practicing therapists to fill positions is of critical importance if occupational therapy is to maintain viability in the health care arena. ▲

Acknowledgment
I gratefully acknowledge Karen Locasio, upon whose work this study was based.

References