APPLYING THE STANDARDS OF EDUCATION OF THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS TO SELECTED OCCUPATIONAL THERAPY EDUCATIONAL PROGRAMS IN THE UNITED STATES

A DISSERTATION

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BY

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Husny Amerih entitled "Applying the Standards of Education of the World Federation of Occupational Therapists to Selected Occupational Therapy Educational Programs in the United States." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Occupational Therapy.

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ABSTRACT

HUSNY AMERIH

APPLYING THE STANDARDS OF EDUCATION OF THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS TO SELECTED OCCUPATIONAL THERAPY EDUCATIONAL PROGRAMS IN THE UNITED STATES

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In higher education, accreditation has been used to maintain the quality of education at universities and their schools by setting standards of education. Both the World Federation of Occupational Therapists and the Accreditation Council of Occupational Therapy Education set standards of occupational therapy (OT) education so that educational programs can graduate practitioners with the needed "tools" for effective practice in OT. To explore the issue of differences and commonalities between the ACOTE and the WFOT standards of education, and how they may affect graduating therapists, three studies were conducted.

The first study consisted of a literature review related to: higher education in the United States, occupational therapy standards of education in the US, the World Federation of Occupational Therapists' standards of education, the cross-countries challenges and adaptation of foreign healthcare workers. The Second Study applied the WFOT Revised Standards of occupational therapy education to a selected sample of OT schools in the US, to investigate to what extent do OT schools in the US meet the WFOT

Standards? And to what extent do OT curricula in the US emphasize the substantial knowledge, skills and attitudes outlined in the WFOT Revised Standards? Five OT Schools in the US participated. On average, all the universities covered 87% of the WFOT competencies at the Knowledge, Skills, and Attitude levels, ranging from 77% to 90%. The universities combined coverage to Knowledge was 88%, Skills was 85%, and Attitudes was 80%. The third study explored the challenges and adaptation of occupational therapists who practice in foreign countries; the perceptions of occupational therapists to their readiness to practice OT in a different country. Seven occupational therapists were interviewed. Three main themes emerged from analyzing the interviews, they were: general challenges while working in a foreign country; OT-related challenges; and issues related to occupational therapy education, several subthemes emerged as well. This dissertation contributed to OT literature by comparing standards of education of the ACOTE and the WFOT. Also by bringing attention to the challenges that occupational therapists face when moving to foreign countries and how they adapt to these challenges.

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CHAPTER I

INTRODUCTION

Quality of higher education has always been a concern for all the stakeholders of the educational process. Maintaining quality of higher education is especially important for healthcare professions in an ever-changing health care environment. The goal remains to protect the public and to enhance patient care (Greiner & Knebel, 2003). Greiner & Knebel (2003) suggested that reform of education of healthcare professionals is critical; they also argued that education of health professions needs a major overhaul because it has not kept pace with, or been responsive to, shifting patients' demographics or the current trends in the healthcare field.

Currently the trend among the different stakeholders is that academia should focus on student mastery beyond individual courses. Advocates call for looking beyond grades and credits, to an examination of overall student achievement. Even some accrediting agencies have shifted their focus to the general competencies that students develop, as a way to measure the quality of an institution (Forest & Kinser, 2002). The goal is to extend students' learning beyond the confines of the classrooms, whereby educators have to anticipate present as well as future needs (McTernan & Hawkins, 1972).

Statement of the Problem

All occupational therapy (OT) students in the United Stated (US) who plan to actively practice as occupational therapists within the US must first be certified by the National Board of Certification for Occupational Therapy (NBCOT). To be eligible to sit for the NBCOT certification examination the students must have graduated from OT educational programs that are accredited by the Accreditation Council of Occupational Therapy education (ACOTE).

The main purpose of accreditation is to maintain the quality of higher education. Accreditation is voluntarily sought by institutions of higher education, and it is generally viewed as a form of peer evaluation (Yura et al., 1986). The United States Department of Education (USDE) recognizes the ACOTE of the American Occupational Therapy Association (AOTA) as the entity that is responsible for the specialized accreditation of OT educational programs in the US.

In addition to national accrediting agencies, numerous international agencies and organizations provide suggestions and guidelines pertinent to the content and sequence of the curricula in various fields of higher education. One of those organizations in the field of OT is the World Federation of Occupational Therapists (WFOT). The WFOT was founded in 1952 to serve as the key international representative for occupational therapists worldwide and to be the official international organization for the promotion of occupational therapy (WFOT, 2005). Even though the US was one of the founding countries of the WFOT, the OT educational programs in the US do not necessarily follow

the recommendations of the WFOT regarding the content of their OT curricula, they only have to follow the standards of the ACOTE.

To explore the issue of differences and commonalities between the ACOTE and the WFOT standards of education, and how they may affect graduating therapists, three studies were conducted.

1. The first was a literature review that described the following issues: first, the subject of higher education in the US, its development, the current challenges it faces, and the topic of quality of education; second, standards of OT education in the US, its history and present status; third, the WFOT standards of OT education, the history, and recent development of these standards and; fourth, the challenges that healthcare workers face when they practice outside their native countries.
2. The second study applied the WFOT Revised Standards of OT education to a selected sample of OT programs in the US. The aim of this study was to explore the extent to which OT programs in the US meet the WFOT standards of OT education. On average, all the universities combined covered 87% of the WFOT competencies ranging from 77% to 90%.
3. The third study explored the challenges that occupational therapists face when they practice OT in foreign countries, and how those therapists adapted to theses challenges. The researcher interviewed seven occupational therapists. Those interviews were transcribed and analyzed for themes and trends. Three main themes, with multiple subthemes, emerged: general challenges

occupational therapists face when working in a foreign country; occupational therapy/practice-related challenges, and: issues related to OT education.

Each of these studies was submitted for publication in peer reviewed professional journals. The combined studies as a whole is now being submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Graduate School of Texas Woman's University.

Statement of the Purpose

Both the WFOT and the ACOTE set standards to accredit OT education so that educational programs can graduate practitioners with the needed "tools" for effective practice in OT. The two organizations have two different sets of educational standards. The WFOT standards seem to be less structured and more flexible in order to be applied in countries with diverse cultures and to accommodate different educational systems. The ACOTE standards are meant to be applied in the US at institutions of somewhat comparable settings. Both sets of standards have the same objective, yet they appear different. This research was designed to explore the issue of differences and commonalities between the two sets of standards, and how they affected graduating therapists. The intent was to answer the following questions:

1. To what extent did the syllabi of the selected OT programs in the US, individually and collectively, correspond with the WFOT standards?
2. To what extent do OT educational programs syllabi in the US emphasize the substantial knowledge, skills and attitudes in the five areas outlined in the WFOT Revised Standards?

3. What areas, if any, of the OT US syllabi are underemphasized, from the WFOT's point of view?
4. After answering these questions, what conclusions and recommendations can be made regarding the OT education in the US based upon comparison with WFOT standards?
5. What is the perception of the occupational therapist to his/her readiness to practice OT in a different country?
6. What challenges do therapists face when they practice in different countries?
7. How do therapists adapt to such challenges?

Significance of the Study

This proposed study could potentially stimulate a debate about the WFOT standards of OT education. It is expected that this research will bring more attention to the WFOT Revised Standards. In addition, the research could potentially improve OT education in the US by integrating some of the WFOT standards in the OT curricula of the American OT Programs. It will ensure that OT programs in other countries are benefiting from the enormous research that is conducted by occupational therapists in the US.

To explore the issue of differences and commonalities between the educational standards of the ACOTE and the WFOT and to what extent they may affect graduating therapists, three studies were conducted.

CHAPTER II

BACKGROUND

Introduction

At first glance, the concept of accreditation and the concept of educational standards may appear to be the same. However, from a higher education perspective these two concepts are discrete but intertwined, this study will predominantly focus on standards of education. Accreditation is defined as certifying a school, college, or the like as meeting all formal official requirements of academic excellence, curriculum, facilities, etc. (The Random House Dictionary, 1987). The Accreditation and Institutional Eligibility Staff of the US Office of Education defines accreditation as "The process whereby an association or agency grants public recognition to a school, institute, college or specialized program of study that has met certain established qualifications of standards as determined thought initial and periodic evaluations" (McTernan & Hawkins, 1972). Educational programs that meet the same accreditation requirements do not necessarily have the same curricular content or sequence.

From the 1600s, efforts have been made to maintain the quality of education in the United States by way of accreditation, by private nongovernmental organizations. Accreditation in the US is thought of as a form of peer evaluation, and it is voluntarily sought by institutes of higher education. In other countries, accreditation is done by governmental organizations (Yura, et al, 1986)

There are two types of accreditation at institutions of higher education in the United States, institutional accreditation and specialized accreditation. The institutional accreditation is concerned with the quality of the higher education institute as a whole. It is done by one of the six regional accrediting associations. Together the six regional associations form the Federation of Regional Accrediting Commissions in Higher Education (Yura, et al, 1986).

Specialized accreditation is concerned with the quality of education of one particular discipline or field of study, such as medicine, engineering, or occupational therapy. Specialized accreditation is not handled by the regional accrediting agencies instead it is handled by accrediting bodies that are discipline-specific. These bodies are recognized by the United States Department of Education (USDE) as the accrediting agencies for that particular discipline or field of study (Yura, et al, 1986).

The specialized accreditation agencies phrase their accreditation requirement in a qualitative manner, which makes those standards open to different interpretations. The content of the curriculum of a particular educational program flows from the mission and philosophy of that particular school, and the institution where it is located. When designing a curriculum, and its sub-units, the staff of the educational program follow the mission and philosophy of that program. For example, occupational therapy programs have to meet the standards of the ACOTE, but they don't have to have the same curricular content or sequences. This phenomenon is even more apparent when the educational programs are located in different countries, yet they have to meet the same set of international standards. The two accrediting agencies that will be discussed in this

research are the WFOT and ACOTE. The focus will be on their standards of education rather than the process of accreditation itself.

Accreditation Council of Occupational Therapy Education

Specialized accreditation for occupational therapy educational programs is handled by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association (AOTA).

The idea of accrediting OT educational programs arose around the time of the conception of the National Society of the Promotion of Occupational Therapy (now AOTA) in 1917. Around 1920 the association decided to establish a set of minimum standards of training for occupational therapists. In 1923 accreditation of occupational therapy educational programs became one of the functions of AOTA (AOTA, 2004). A schedule of Minimum Standards of Training was adopted during the meeting of the Association's Standing Committee on Teaching Methods in 1923; those standards were further updated in 1927 and 1930 (Quiroga, 1995). The final version of those standards was adopted in October 1930; they were titled "New Minimum Standards for Training for Occupational Therapists Who Desire to Qualify for Registration". The "New Standards" consisted of four sections:

1. Pre-requisites for Admission, this section included conditions such as age, high school education, character, health, probationary period, and credit for previous training.
2. The Course of Training, this section set the minimum length of time for the whole course. It also set the length of the "practice-training".

3. Content of Course outlined the six areas that OT students need to have lectures on; the first five were theory lecture (165 [contact] hours) in different topics such as mental sciences, physical sciences, medical lectures, occupational therapy, and electives; the sixth area was training in different occupations such as textile, basketry, metal work, woodwork, etc (1000 [contact] hours).
4. Practice Training; this section decided the length of time for practice at 1300 contact hours; it also dictated the distribution of that time (AOTA, 1930). See Table 1.

In 1933, AOTA collaborated with the Council on Medical Education of the American Medical Association (AMA) to develop and improve occupational therapy educational programs. This collaboration yielded the "Essentials of an Acceptable School of Occupational Therapy"; those new standards were adopted by AMA in 1935. Since then a lot of changes and updates have taken place. One of the most significant shifts occurred in 1972, when the focus of accreditation started to shift from the content of the curriculum to the performance of graduates meeting identifiable and measurable goals and objectives (Johnson, 1974). Another significant shift occurred in 1994 when the AOTA Accreditation Committee changed its name to the Accreditation Council for Occupational Therapy Education (ACOTE), and it was recognized by the United States Department of Education (USDE) as the accrediting agency for occupational therapy education in the US.

The aim of ACOTE is to set standards for OT educational programs in the US so those programs would graduate occupational therapists who possess the skills as healthcare providers, consultants, managers, researchers, educators and advocates for the profession. The ACOTE 1998 Standards, accredits OT educational programs based on three sections. Sections A and C contain general standards and section B outlines standards that are specific to the OT curriculum. The extent to which an OT educational program complies with the standards determines its accreditation status. Those sections are:

1. Section A is titled "General Requirements for Accreditation". It contains information about the sponsoring institution(s), academic resources, students, operational polices, curriculum framework, and information about program evaluation.
2. Section B is titled "Specific Requirements for Accreditation" outlines standards that are specific to the content of the OT curriculum. It has information about the foundational content requirements, basic tenets of OT, OT theoretical perspectives, screening and evaluation, intervention plan formulation and implementation, context of service delivery, management of OT services, use of research, professional ethics, values and responsibilities, and information about fieldwork education.
3. Section C of the ACOTE requirements is titled "Maintaining and Administering Accreditation". It has information about the responsibilities of

the program and the sponsoring institutions, and about the ACOTE responsibilities.

For an OT educational program to receive initial accreditation or continue its accreditation by ACOTE, the OT program must submit a report of Self Study Document and all other required reports to AOTA following a letter of intent. ACOTE evaluators will evaluate the Self Study Document. Their evaluation is point-by-point comparison of how much that institution's standards agree with the ACOTE standards.

The other report that is usually done by ACOTE is the Evaluators' Report of On-Site Evaluation" (ROSE). This report aims to provide judgment on the effectiveness of the program in meeting the Standards. It also provides suggestions to enhance the program, outlines the major strengths of the program, and areas of noncompliance with the standards.

World Federation of Occupational Therapists

The World Federation of Occupational Therapists is the agency that maintains the international standards for the education of occupational therapists. Maintaining international standards of OT education is done to provide consistency and cohesiveness of OT practice worldwide and to regulate the recognition of OT qualifications internationally. The latest version of the WFOT standards was published in 2002; they are titled the "Revised Minimum Standards for the Education of Occupational Therapists". The WFOT standards describe the international and the local context that should influence the OT educational program; they also describe the "areas of essential

knowledge, skills and attitudes for competent occupational therapy practice" (Hocking & Ness, 2002, pg 10)

WFOT standards are designed to be broad enough to be applied by different educational systems in various countries and cultures. These standards try to reflect a global vision of OT and they tend to echo the international views about health, disability, and occupations. The WFOT Revised Standards do not list specific courses that must be taught by the educational programs. Instead, they describe an educational process that would produce practitioners with the sufficient knowledge, skills, and attitudes in the following five areas of competence:

1. The person-occupation-environment relationship and its relationship to health.
2. Therapeutic and professional relationships.
3. The occupational therapy process.
4. Professional reasoning and behavior and
5. The context of professional practice.

Significance

Some commonalities and differences exist between the educational standards of the ACOTE and the WFOT. They both aim to graduate competent occupational therapists with adequate knowledge and skills to become competent practitioners. ACOTE prepares therapists to practice in the United States, a somewhat cohesive environment while the WFOT sets standards to prepare occupational therapist to practice worldwide in vastly different environments. Occupational therapists who move to foreign countries to practice OT may face work-related challenges and/or personal challenges. Some of those

challenges, and the way the way the therapists adapt to them, may be related to the therapist's education. The proposed research aims to examine the OT standards of education from a WFOT perspective, and it also aims to explore the challenges and adaptation of foreign-trained occupational therapists.

CHAPTER III

A LITERATURE REVIEW OF ACOTE AND WFOT STANDARDS FOR OCCUPATIONAL THERAPY EDUCATION

Submitted for publication to Occupational Therapy International

Introduction

This study consisted of a literature review to identify and synthesize aspects related to: higher education in the United States (US); occupational therapy standards of education in the US its history and present status; the World Federation of Occupational Therapists (WFOT) standards of OT education, its history, and recent development; and, the cross-countries adaptation of foreign healthcare workers. This study is significant as it contributes to the concept of educational standards in OT. Occupational therapy educational standards are examined in the United States and internationally. The study is also significant as it demonstrates the lack of research that examines challenges and adaptation of occupational therapist who practice in foreign countries.

Methods

Most of this literature review focused on the content of the two educational standards from ACOTE and WFOT and on the forces that led to the evolution of these standards, rather than the process of accreditation. The literature review was done following the procedure outlined by Gall, Gall, and Borg in 2002.

Searching preliminary sources, those used for this study included: Educational Resource Information Center (ERIC), Current Index to Journals in Education (CIJE),

Resources in Education (RIE) and Cumulative Index for Nursing and Allied Health Literature (CINAHL) indexes to dissertation and theses. The keywords or descriptors that were used were "healthcare education", "curriculum design", "higher education accreditation", "globalization of higher education", "internationalization of qualifications", "Accreditation Council of OT Education", "World Federation of Occupational Therapists", "acculturation", "adaptation" and others.

A number of relevant secondary sources were obtained after reviewing the preliminary sources. They where obtained from local, national or international sources. Most of these were books, reports, encyclopedias and unpublished doctoral dissertations that covered topics relevant to curriculum design, higher education, adaptation of workers, accreditation, AOTA, and WFOT.

Results

Higher Education in the United States

In 1818, Thomas Jefferson met with other commissioners, to report on establishing the University of Virginia. He stressed the importance of the "higher branches of education". He was quoted to have said about its values:

> To form the statesmen, legislators... to develop the reasoning faculties of our youth, enlarge their minds; ... to enlighten them with mathematical and physical sciences, ... and administer the health ..." (The Commission for Education Quality, 1994).

In later years, higher education was defined as "education beyond high school, specifically that [is] provided by colleges, universities, graduate schools and professional schools" (The Random House Dictionary, 1987).

Universities are among some of the oldest institutions in society. They are among the rare organizations that survived from the Middle Ages. Universities are involved in vocational training of professionals such as physicians, nurses, clergy, accountants, etc. They are also involved in the affairs of the society; they are considered repositories of society's wisdom by ways of teaching, providing libraries and knowledge to the public, and in recent decades through their involvement in research projects to benefit society (Forest & Kinser, 2002).

The two decades between 1950 and 1970 have been called the Golden Age of American higher education. In those years, several factors led to an increased enrollment and variation of institutions of higher education. Three factors that contributed to this Golden Age were the Morrill Land-Grant Acts, the GI Bill, and the Baby Boom generation.

The Morrill Land Grant Act of 1862 gave every state a huge territory of federal land. Those states, then, could sell the land and use the proceeds to endow at least one college that would offer courses in agriculture, engineering, and economics, as well as regular academic programs. More than seventy "land-grant" colleges were established as a result of this Act. This led to expansion of higher education in the Middle and the Western parts of the U.S. The second Morrill Act in 1890 extended the land-grant provisions to more states in the south; it also allowed the southern states to divide federal funds between white and black schools. The significance of the Morrill Land-Grant Act is in the fact that it was the first time the federal government involved itself into funding

and directing higher education in the United States. This trend continues throughout the present time (Forest & Kinser, 2002).

Following World War II, the Servicemen's Readjustment Act of 1944, commonly known as the GI Bill, provided access to higher education to millions of returning veterans, by providing them with financial support, such as tuition, living expenses, etc. This was a new era in higher education, characterized by an increase in enrollment rates. The GI Bill has been characterized as the most influential legislation involving access to higher education. Without this bill, veterans would have returned to the society without jobs, or opportunities (Forest & Kinser, 2002). Instead, they earned degrees to achieve a measure of the American dream of upward mobility, and to pass this ideal to their families. It can be argued that this was the greatest turning point in American higher education history, without which we could have risked another "Great Depression" instead of the economic boom of the 1950s (Breinig, Gebhardt, & Ostendorf, 2001).

Between the years 1946 and 1964 around 76.1 million Americans were born. Sociologists have defined this group of people as "baby boomers". States spending on colleges and universities increased during the 1960s and 1970s, as the educational system tried to serve the baby boomers. This increase in enrollment-age students boosted the expansion that the GI Bill started. The baby boomers placed a demand on the higher education system that necessitated the establishment of new universities, classrooms, research facilities, and new dormitories to accommodate the increased number of students. Many state institutions expanded and developed new campuses and new

academic programs to accommodate the needs of the new students (Forest & Kinser, 2002).

Following the Land-Grant Act, the GI Bill, and the enrollment and graduation of the Baby Boomers, the American higher education institutions grew rapidly. New institutions were built, old ones expanded. The competition for resources and grants grew, and so did the competition to attract new students. This competition necessitated specialization. The large institutions could no longer be "all things to all people"; each institution tried to develop its individualistic identity (Breinig, et al, 2001). This is where higher education stands now; thousands of institutions, with hundreds of programs and highly specialized disciplines. Institutions are competing for limited state and federal funding, grants, and endowments, to attract both high school and nontraditional students.

The Value of Higher Education. The value of higher education can be appreciated at an individual level, national level, and societal or global levels. At the individual level, one of the basic measures of the value of higher education is an economic and social one. The monthly income of a graduate of a community college is generally one and one-half times that of a high school graduate. A four-year university graduate earns twice as much as someone with high school diploma. The rate of return on an investment in higher education is estimated to be around 12 to 13 percent per year (The Commission for Education Quality, 1994). Another measure of the value of higher education, at the individual level, is the increased likelihood of employment for those with higher degrees in comparison to individuals with or without high school diplomas. Forest and Kinser (2002) argued that higher education plays an essential role in allocating employment

opportunities. The enrollment of minority groups is on the rise, with the goal of personal, familial and societal betterment (The National Center for Education Statistics, 2004).

At the national level, higher education institutions are known to keep the nation economically competitive. These institutions foster knowledge, discovery, skills development, and they engage in research that stimulates the economy. An example of this is the economic boom of the 1950s that was attributed to the increased numbers of higher education graduates following the passage of the GI Bill. The knowledgeable and skilled workforce that was produced by higher education institutions is accredited with turning the postwar era from potentially another "Great Depression" to an economic boom. Higher education institutions can also help in solving societal and global problems. They possess the intellectual resources and personnel that can highlight important societal and global issues and concerns. In addition, they can help in suggesting possible solutions to those problems (Breinig, et al, 2001). On a societal scale higher education institutions serve as transmitters of our civilization and cultural values.

Institutions of Higher Education in the US. In the United States, there is a broad scope and great diversity of learning institutions. In 1997, the National Center for Education Statistics reported that 6689 postsecondary education institutions existed in the US. Higher education institutions, in the 1994-95 school years, granted 2,141,900 degrees. Twenty five percent of those were associate degrees, 54% Bachelor degrees, 19% were Master's degrees and 2% were Doctoral degrees (The National Center for Education Statistics, 2004).

Higher education institutions in the United States can be classified based on their locus of control into three categories, public, private or proprietary. Public institutions are governed by boards that are appointed by elected officials. They also depend on taxes to fund their operations, which makes it hard to change directions to respond to changing professional issues. On the other hand private institutions are governed by boards with minimal public oversight, and are largely dependent upon income from trusts and students, which makes them more flexible in adopting new and innovative ideas. Both public and private institutions are nonprofit organizations that aim to educate and return no profit. A proprietary institution means that the institution is concerned with the sale of educational services, and it is governed by a board that is accountable to stock holders (Breinig, et al, 2001). Seventy six percent of the higher education students are enrolled in public institutions. Twenty percent of the students are enrolled in private institutions. The proprietary institutions only enroll four percent of the higher education students (The National Center for Education Statistics, 2004).

Another commonly used classification system is the Carnegie Classification of Institutions of Higher Education. It is a leading typology of American colleges and universities. The Carnegie Classification was originally published in 1973, and subsequently updated in 1976, 1987, 1994 and 2000. Carnegie Classification categorizes higher education institutions into six categories:

1. Doctoral/Research Universities Extensive and Doctoral/Research Universities Intensive.
2. Master's Colleges and Universities I and Master's Colleges and Universities II.

3. Baccalaureate Colleges-liberal arts, Baccalaureate Colleges-general, and Baccalaureate Colleges-associate colleges.
4. Associate's Colleges.
5. Specialized Institutions, and
6. Tribal Colleges and Universities.

Issues Facing Higher Education in the US. Higher education in the U.S. is currently facing some issues that scholars are trying to resolve. Examples of these issues are access, expense, quality, accreditation and other related issues. Some of these issues may be a by-product of the expansion that higher education went through during its development, as outlined above.

Access to higher education is taken for granted by high school graduates in the United States. Most of them view access to higher education as an entitlement. High school graduates overwhelmingly indicate that they intend to go to college, regardless of their academic achievement in high school, socioeconomic status, gender, race, or ethnicity. Prior to the Land Grant Act and the GI Bill, higher education was out of reach for most Americans except the elite and the enfranchised white. Other minorities, such as women and African-Americans were disenfranchised. A series of court rulings helped those disenfranchised minorities gain better access to higher education (Forest & Kinser, 2002). The National Center for Education Statistics reports that the enrollment of women, African-Americans and Hispanics is on the rise. The percentage of women enrolled in higher education has increased from 52% to 55% between 1985 and 1995. For African-American and Hispanics the trend is similar (Breinig, et al., 2001). Even with those

improvements, access to higher education is still highly correlated to family income, race, and student's age.

As the cost of living rises so does the cost for attending universities and colleges. In the United States between 1985-86 and 1995-96 school years, the total cost for attending a public university increased by 77% (24% adjusted for inflation), and the cost for attending a private university for the same period rose by 91% or 34% adjusted for inflation (The National Commission on the Cost of Higher Education, 1998).
With the increased cost of higher education, there is also an increase in the availability of financial assistance in the form of grants, loans, aid, etc. In the 1997-98 school year, more than half of the higher education students received financial aid, totaling approximately $60 billion (Breinig, et al., 2001).

Quality of higher education has always been a concern for all the stakeholders of the educational process such as the institutions, employers, students, their parents, and the local, state and federal governments. Quality means different things to different stakeholders. To tackle the issue of quality, institutions formed committees for "quality assurance" and for "quality monitoring". Currently the trend among the different stakeholders is that academia should focus on student mastery beyond individual courses. Advocates call for looking beyond grades and credits, to an examination of overall student achievement. Even some accrediting agencies have shifted their focus to the general competencies that students develop, as a way to measure the quality of an institution (Forest & Kinser, 2002). Some scholars envision a "Total Curriculum" that describes all of the experiences that are provided by the educational institution to

influence the behavior of its students as they are studying and in their future practice. The goal is to extend students' learning beyond the confines of the classrooms, whereby educators have to anticipate present as well as future needs (McTernan & Hawkins, 1972).

Quality of Health Care Education

Maintaining quality of higher education is especially important for healthcare professions in an ever-changing health care environment, with daily advances in medical research, increased move toward evidence-based practice and in an environment where future changes and challenges may be unknown, but are inevitable. The goal remains to protect the public and to enhance patient care (Greiner& Knebel, 2003). Greiner& Knebel (2003) argued that reform of education of healthcare professionals is critical; they also argued that education of health professions needs a major overhaul because it has not kept pace with, or been responsive to, shifting patients' demographics or the current trends in the healthcare field. To illustrate the lack of responsiveness to current trend in healthcare, they cited the disconnect between the academic environments of healthcare professions that is discipline-based and the practice settings that are interdisciplinary-based.

In a recent study, the Institute of Medicine recommended that an interdisciplinary summit be held to reform the education of health professions in order to enhance patient care, quality and safety. The report focused on integrating a set of five competencies into the education of health professions: patient-centered care; interdisciplinary teams; evidence-based practice; quality improvement; and informatics. This set of competencies

was recommended for all clinicians regardless of their discipline in order to meet the needs of the 21st century health system. The committee acknowledged that the core competencies will differ in application across the disciplines but that these competencies are relevant to all clinical disciplines (Greiner& Knebel, 2003). Beyond the five competencies that were recommended across disciplines, each profession has its own unique competencies that enable practitioners to adequately perform their roles.

To ensure that students are prepared to deliver quality healthcare the first step is to establish competencies that students should possess at the time of graduation. The second step is to articulate the knowledge, skills, and attitude underpinning each competency. This process is called competency-based education or outcome-based education.

The quality of higher education has been maintained through the accreditation process since the early 1900s (Johnson, 1974). Accreditation has also been the most potent lever for curricular reform (Greiner& Knebel, 2003). In the United States, accreditation is voluntarily sought by educational programs or the institution, and it is usually thought of as a form of peer-review. In addition, the process of accreditation has been incorporated into federal and state licensure laws, grant funding, legislation, etc. So much so that the term "voluntary" is actually a misnomer. Educators agree that the accreditation process is costly, and that it requires too much time, but educational programs are willing to go though such a rigorous process to reassure the stakeholders that they want to achieve excellence and are willing to prove it (Berry, 1995). This debate was summarizes as follows:

> "Some educators believe that accreditation is a bane others believe it's a blessing. But until a more perfect mean of ensuring quality is developed educators feel that work needs to be done towards improvement of the standards and of the process of accreditation"

The American Occupational Therapy Association

Similar to higher education, the issue of maintaining the quality of the graduating occupational therapist is essential to the survival of the profession of occupational therapy. Since the inception of the profession ensuring the quality of OT education has been one of the main goals of the American Occupational Therapy Association (AOTA). In occupational therapy, quality means something different to the different stakeholders. To the OT students it means something different from what it means to an OT scholar, or to an OT client. However, the various stakeholders agree on the importance of graduating occupational therapists who can optimally and effectively serve their diverse clients. Occupational therapy focuses primarily on developing adaptive skills and to improve clients' performance in order to fulfill their occupational roles, such as activities of leisure; daily living; and avocational activities. OT is concerned with environmental, biological and psychological factors that inhibit occupational performance. Occupational therapists work with individuals whose abilities to cope with tasks of living are threatened by physical injuries, the aging process, psychological or social disability, chronic conditions, poverty, cultural differences, deficits in motor, sensory, cognitive, emotional or social development (Johnson, 1974). Peoples' occupations change and evolve so does occupational therapy, nowadays occupational therapists are practicing in

new areas such as disability prevention, and health maintenance and improvement, and working with new conditions and new technologies. The expansion in the new practice areas necessitates updating OT curricula, and philosophies. Updating OT curricula is also needed because of the discontinuation of other practice areas that deals with non-prevalent diseases and conditions such as tuberculosis, and polio.

Historically, the quality of OT programs has been maintained through the accreditation process, which is done mostly by establishing educational standards. The first effort to establish an OT course was in 1906 by Susan Tracy, the superintendent of nurses at Adams Nervine Hospital in Boston. She established a course in OT and made it part of the training of nurses so they can engage their clients occupationally.

The National Society for the Promotion of Occupational Therapy (NSPOT) was established in 1917. The newly formed NSPOT (now AOTA) was comprised of nurses, social workers, medical personnel, and individuals interested in the arts. One of the major decisions that had to be made was to establish definite standards for the training of occupational therapists. Around 1920 the association decided to establish a set of minimum standards of training for occupational therapists. The purpose was to establish a national register/directory of occupational therapists in order to protect the new profession from unqualified individuals posing as occupational therapists. This was specially needed following the increased numbers of OT schools after the return of disabled soldiers from World War I. In order to train individuals to provide the needed rehabilitation services numerous hospitals, colleges, universities, and free-standing schools- started offering short courses in OT. Theses short courses, of three to four

months, were offered between the years 1918 and 1920, by 1921 most of them were extended to twelve months (Johnson, 1974). Before establishing the needed national directory, the Association had to set minimum standards of training for occupational therapists (AOTA, 1930).

In 1921, the name of the National Society of the Promotion of Occupational Therapy was changed to the American Occupational Therapy Association, and in 1923 accreditation of the occupational therapy educational programs became one of the functions of AOTA (AOTA, 2004). A schedule of Minimum Standards of Training was adopted during the meeting of the Association's Standing Committee on Teaching Methods in 1923. The early versions of the Essentials of an Accredited Educational Program in Occupational Therapy focused on the content of courses, the number of credit hours, and the physical facilities of the OT school (Johnson, 1974). These standards were further updated in 1927 and 1930 (Quiroga, 1995). The final version of those standards was adopted in October 1930; they were titled "New Minimum Standards for Training for Occupational Therapists Who Desire to Qualify for Registration". The "New Standards" consisted of four sections:

1. Pre-requisites for Admission: this section included conditions such as age, high school education, character, health, probationary period, and credit for previous training.
2. Course of Training: this section set the minimum length of time for the whole course. It also set the length of the "practice-training".

3. Content of Course outlined the six areas that OT students needed to have lectures on; the first five were theory lecture (165 [contact] hours) in different topics such as mental sciences, physical sciences, medical lectures, occupational therapy, and electives; the sixth area was training in different occupations
   such as textile, basketry, metal work, woodwork, etc (1000 [contact] hours).
4. Practice Training: this section decided the length of time for practice at 1300 contact hours; it also dictated the distribution of that time (AOTA, 1930), see Table 1.

In 1933, AOTA began collaborating with the Council on Medical Education of the American Medical Association (AMA) to develop and improve the education of occupational therapists. This collaboration yielded the "Essentials of an Acceptable School of Occupational Therapy"; these new standards were adopted by the AMA in 1935. Since then a lot of changes and updates have taken place. One of the most significant shifts occurred in 1972, when the focus of accreditation started to shift from the content of the curriculum to the performance of graduates meeting identifiable and measurable goals and objectives (Johnson, 1974). Another significant shift occurred in 1994 when the AOTA Accreditation Committee changed its name to the Accreditation Council for Occupational Therapy Education (ACOTE), and it was recognized by the United States Department of Education (USDE) as the accrediting agency for occupational therapy education in the US. Following that split specialized accreditation of OT educational programs was no longer coordinated with the AMA.

The aim of ACOTE is to set standards for OT educational programs in the US so these programs would graduate occupational therapists who possess the skills as healthcare providers, consultants, managers, researchers, educators and advocates for the profession. In the 1998 Standards, the ACOTE accredits OT educational programs based on three sections. Sections A and C contain general standards and section B outlines standards that are specific to the OT curriculum. The extent to which an OT educational program complies with the standards determines its accreditation status. Those sections are:

1. Section A is titled "General Requirements for Accreditation". It contains information about the sponsoring institution(s), academic resources, students, operational policies, curriculum framework, and information about program evaluation.
2. Section B is titled "Specific Requirements for Accreditation" outlines standards that are specific to the content of the OT curriculum. It has information about the foundational content requirements, basic tenets of OT, OT theoretical perspectives, screening and evaluation, intervention plan formulation and implementation, context of service delivery, management of OT services, use of research, professional ethics, values and responsibilities, and information about fieldwork education.
3. Section C of the ACOTE requirements is titled "Maintaining and Administering Accreditation". It has information about the responsibilities of

the program and the sponsoring institutions, and about the ACOTE responsibilities.

The World Federation of Occupational Therapists

Occupational therapists focus on improving their clients' occupational performance and adaptation regardless of the client's age, gender, or culture. Occupational therapists work with people in different parts of the world, ranging from the most technologically advanced to the least advanced ones, which makes OT a truly unique profession. Occupational therapists who graduate in developed countries can relocate to less developed countries to practice OT, and vice versa. This transition is facilitated by the fact that there are some commonalities in the standards of OT education across the world. These standards have been established by the World Federation of Occupational Therapists (WFOT).

The WFOT recent education standards tend to reflect a global vision of OT. They also tend to be more reflective of the recent trends in international thinking about the issues of health, wellness, and disease. The WFOT standards are of great utility when occupational therapists move among member countries, because these standards facilitate the recognition of qualifications among member countries. They also allow OT students to do their fieldwork (clinical practice) in other countries.

The World Federation of Occupational Therapists (WFOT) sets accreditation standards for OT educational programs in its member countries. The most recent version of those standards is known as the "Revised Minimum Standards for the Education of Occupational Therapists". This revised version was published in 2002. The Revised

Standards describe the international and the local context that should influence the OT educational program; they also describe the "areas of essential knowledge, skills and attitudes for competent occupational therapy practice" (Hocking & Ness, 2004).

The Revised Standards describe an educational process that intends to produce OT practitioners with sufficient knowledge, skills, and attitudes for competent practice. The Revised Standards do not list the number or the names of the courses that had to be taught by OT educational program. Instead, they focus on the three components of educational process, the local context; the educational program; and the feedback process.

The local context covers the five aspects that are relevant to the practice of OT. They include: students entering the program; local health and welfare needs; local view of health giving occupations; local health, welfare, disability and legal system; and local OT history.

The educational program has five components: curriculum content and sequence; educational methods utilized; fieldwork experience/s; educators; educational resources and facilities. These five components are guided and directed by the program's philosophical understanding of occupation.

The feedback process is when information is gained from the new therapists, who are just entering the field, to be used to inform the educational program to improve its effectiveness.

From the five components of the educational program, The Revised Standards emphasize that all occupational therapists should have substantial knowledge, skills and attitudes in the following five areas:

1. The person-occupation-environment relationship.
2. Therapeutic and professional relations.
3. An occupational therapy process.
4. Professional reasoning and behavior.
5. The context of professional practice.

The need to establish an international organization to represent occupational therapy started following World War II, with the intensive effort to provide rehabilitation services to the physically and mentally disabled veterans and civilians (Spackman, 1967). The rapid growth of allied medical services, especially in countries where these services did not exist before the war necessitated the expertise, advice and help of the countries with already established medical and rehabilitation services. The experts from countries such as Canada, Britain, and the United States set out to establish the rehabilitation and medical services. Those experts had only the educational standards that were used in their own countries, and in most cases these standards were not fully applicable in countries with different cultural, economical and healthcare backgrounds (Spackman, 1967).

In 1951 at the Congress of the International Society for the Rehabilitation of the Disabled (now Rehabilitation International), a special meeting of occupational therapists took place at Countess Estelle Bernadotte's house. In that meeting, it was moved that an international organization be formed, and that a preparatory commission be held in 1952.

Seven different national OT associations were represented in the April, 1952 meeting; another four national associations sent written messages of support.

The educational preparation of occupational therapists has been a central concern to WFOT since its establishment. The founding group faced many challenges in establishing the new international body, but setting the educational standards was one of their priorities in order to have international consistency in the quality of OT education (Hocking & Ness, 2004). After the 1952 Minimum Standards were established, they were quickly distributed to member countries and became the benchmark for developing OT programs (Hocking & Ness, 2004). Substantial revisions occurred between 1968 and 1971 to keep pace with the international developments in OT education and practice. Little change was done to the 1971 standards, expect for some amendments in 1985. The Minimum Standards dictated the content and sequence of subjects to be taught. According to these standards, the content of the OT curriculum should include (WFOT 2002, pg 37).

1. Pre-clinical conditions such as, anatomy; physiology; kinesiology and; ergonomics.
2. Clinical sciences such as, psychological, medical, surgical and psychiatric conditions.
3. Theory of OT, which should include introduction to the profession of OT; professional procedures; using activity as treatment and; principles of management and administration.

4. Sufficient variety of therapeutic activities that would potentially involve patients of all ages, backgrounds, etc. (WFOT 2002, pg 49)
5. Clinical practice or field work experience. Students should receive a minimum of 1000 hours of supervised experience. WFOT required that these hours be approximately divided into working with patients with psychiatric conditions, and with patients with physical conditions (WFOT 2002, pg 57).

As stated above, little change was done to the Minimum Standards between 1971 and 2000. The Minimum Standards of 1971 were amended in 1985, 1990, and 1993. The 1993 Standards were reprinted in 1998, and in 2000 with no changes. The stability of these educational standards provided consistency for the OT profession allover the world. They provided a clear description of what OT education entailed (Hocking & Ness, 2004). However, change was inevitable, especially with changes within the profession and within the entire healthcare arena. The Minimum Standards were radically revised to produce the "Revised Minimum Standards for the Education of Occupational Therapists, 2002". Some of the factors that necessitated such a major update were: first, the renaissance of occupation in describing the basis and purposes of the profession; second, the fact that the Minimum Standards allowed little flexibility for local variations, which made OT like a standard product across the world; third, that many member countries found the 1000 hours of field work too demanding, and; fourth, that educational philosophies and practices, in general, have changed from mandating the content of an educational process to describing its intended outcomes and by outlining the methods to achieve these outcomes (Hocking & Ness, 2004). The current Revised Minimum

Standards reflect an international thinking about health, wellness, impairment and disability; this is mostly influenced by the changing perspectives of the World Health Organization (WHO). The Revised Minimum Standards clearly reflect the influence of the WHO- International Classification of Functioning Disability and Handicap (ICF). The ICF addresses the personal components of health such as body structure and function, activities and participation in major life areas. It also addresses the environmental aspects of health that support or impede participation in occupations (Hocking & Ness, 2002). The Revised WFOT Standards exemplify the idea that a curriculum is not simply the addition of the different subjects that are learned over time, but that the curriculum should provide students with the knowledge skills and attitudes that are required to practice occupational therapy.

Adaptation of Foreign Occupational Therapists

As it is the case with other healthcare personnel, the demand for occupational therapists is on the rise. Numerous countries are having shortages in healthcare workers, and are looking overseas to fulfill their staffing needs (Daniel, Chamberlain, & Gordon, 2001; Mangnursdottir, 2005; Wither & Snowball, 2003; Xu, 2005). Because of these staffing shortages developed countries, such as the US and Britain, look to other areas of the world like Asia and Africa to recruit healthcare workers. Moreover, healthcare workers in the developing countries look forward to working in the developed countries, because they desire to realize their dreams and meet their unmet expectations in their own countries (Wither & Snowball, 2003).

When healthcare workers study in one country and move to another one to work, they are bound to experience some difficulty in adjusting to working and living in a foreign country. The gap between the expectations before moving, and the actual experience after the move may vary greatly (Wither, & Snowball, 2003). Some researchers have explored this phenomenon in nurses, physicians, and other healthcare workers. Lopez (1990) conducted a study to describe the process of acculturation that nurses from the Philippine go through while practicing in the USA. She found that the most common problems that the nurses faced were: deficiency in technical skills needed to function in an advanced healthcare system; difficulties in communication specially slang; supervising nursing aides; passing the licensure exam; and, experiencing conflict between being submissive and being assertive.

Xu (2005) outlined five challenges that Asian nurses face when working in a foreign health care environment. They were: communication, especially with accents and phone orders; interpersonal relationships and management of personnel; difference in role and scope of practice especially with paperwork; marginalization and alienation by staff and patients; and lengthy cultural adjustment.

Mangnursdottir (2005) used unstructured interviews to explore the lived experiences of foreign nurses. Five main themes emerged form the interviews: the multiple initial challenges and feeling overwhelmed; the challenge of being an outsider and needing to be let in; the language barriers and fear of the telephone; the different work culture; and finally, the sense of belonging and confidence after these challenges were overcome.

Other scholars have studied the adjustment process of healthcare workers who work in foreign countries. Yi and Jezewski (2000) concluded that adjustment to working in a foreign country is a social and psychological process that is composed of five categories or aspects,

1. Reliving psychological stress, confusion, anger, fear, frustration, rejection, alienation, and depression.
2. Overcoming the language barrier, the written, verbal, and nonverbal communication.
3. Accepting the foreign country's practices, roles and focus.
4. Adopting the foreign country's style of problem-solving.
5. Adopting the foreign country's style of interpersonal relationships.

Wither and Snowball (2003) cited Pilette (1989) who outlined four phases of adjustment that take place when an individual tries to adjust to anew culture They are:

1. Acquaintance phase, 0-3 months, when there is a feeling of euphoria and fascination for everything new.
2. Indignation phase, 3-6 months, with an awareness of the cultural, professional and psychological differences.
3. Conflict resolution, phase 6-9 months, when the individual has a tendency to speak out about the conflicts.
4. Integration phase, 9-12 months, less stress and more enthusiasm.

Most of the research that has been done on the challenges and adaptation of healthcare workers has done so with nurses and physicians. Research on the challenges and adaptation of occupational therapists who practice in a foreign country is virtually nonexistent. Even though the occupational therapy literature addresses the issues of cultural practices and beliefs of clients, and the need for therapists to be culturally sensitive, and appropriate, when treating clients, there is scant literature about the adaptation of therapists, themselves, adjusting to new and 'foreign' work settings.

Discussion

This study focused on higher education in the United States, how it developed from its early years to its current state, and on the factors that influenced its development. It also focused on the value of higher education and on the challenges facing higher education in the US currently. In light of higher education development, the history of accreditation of occupational therapy education was reviewed. Emphasis was placed on reviewing the content of the standards of OT education, how they developed since the early 1900s to their current status.

The history of the WFOT was summarized including how the WFOT started and why it was established following WW II, the development and evolution of the Minimum Standards and the factors that led to the development of the Revised Minimum Standards in 2002. The last topic the literature review highlighted the adaptation process experienced by healthcare practitioners who work in foreign countries. The literature in this area was virtually nonexistent for occupational therapists. The studies that were presented were

conducted with other healthcare workers; these studies highlighted the challenges and adaptation of the healthcare professionals.

Conclusions

Based upon this study, both the ACOTE and the WFOT aim to graduate competent occupational therapists with adequate knowledge and skills to serve their clients and their profession. ACOTE prepares therapists to practice in the United States, a somewhat cohesive environment. On the other hand, the WFOT sets standards to prepare occupational therapist to practice worldwide in vastly different environments. Occupational therapists who move to foreign countries to practice OT may face challenges while serving their clients in the new environments as well as face personal challenges trying to adjust to living in a foreign country.

The challenges and adaptation of these occupational therapists have not been investigated adequately. As a result, the literature on this topic is virtually nonexistent. The challenges that other healthcare professionals face while practicing in other countries have been investigated to some extent, and this literature may be relevant to occupational therapy. A need exists to explore the extent and ways in which occupational therapists adapt to these challenges.

Table 1, *Minimum Standards of Training for Occupational Therapists**

A- Content of the Course (200 hours)

A-1: Mental Science (minimum 35 hours):
- Neurology
- Psychology
- Abnormal Psychology
- Psychiatry
- Mental Hygiene
- Epilepsy
- Feeble-mindedness

A-2: Physical Science (minimum 50 hours):
- Personal and social hygiene
- Physiology and anatomy
- Kinesiology and joint motion
- Physical therapy
- American Red Cross First Aid

A-3: Medical Lecture (minimum 25 hours):
- Blindness and Deafness
- Tuberculosis
- Cardiac disease
- Orthopedics
- General medical conditions
- Contagious disease

A-4: Occupational therapy (minimum 45 hours):
- History of occupational therapy.
- Theory of occupational therapy.
- Occupational therapy in various types of institutions.
- Occupational therapy as applied in various diseases.
- Occupational therapy and its relation to Vocational and Industrial Rehabilitation.
- Occupational therapy and its relation to other social agencies.
- Organization of departments and records.
- Hospital etiquette and ethics.
- Miscellaneous general lectures.
- Observation including directed visits to institutions and clinics.

A-5: Electives (minimum 35 hours).

Table 1, *Minimum Standards of Training for Occupational Therapists, continued*

B- Training in Occupations (1000 hours)

B-1: Design:
- Theory and appreciation.
- Applied design
- Mechanical drawing.

B-2: Textile:
- Weaving, rake knitting
- Needle crafts, dyeing
- Block printing, stenciling.
- Knotting and netting.
- Miscellaneous.
- O T analysis and adaptation.

B-3: Basketry:
- Raffia, willow, fiber.
- Chair-seating (reed, cane, and rush)
- O T analysis and adaptation.

B-4: Woodwork:
- Bench work, carving, toy making
- O T analysis and adaptation.

B-5: Metal Work:
- Jewelry, miscellaneous.
- O T analysis and adaptation.

B-6: Bookbinding and leather work:
- O T analysis and adaptation.

B-7: Plastic Arts:
- Clay modeling, pottery.
- O T analysis and adaptation.

B-8: Minor Craft and use of Waste Material:
- Beadwork, tin toys, brush-making, marionettes, etc.
- O T analysis and adaptation.

B-9: Miscellaneous:
- Recreation and remedial games and plays; including music, story telling, library work.
- Crafts for children, calisthenics, remedial gymnastics, and horticulture.
- O T analysis and adaptation.

Table 1, *Minimum Standards of Training for Occupational Therapists, continued*

C- Practice Training (1300 hours): Minimum of nine months (36 weeks) of hospital practice training under competent supervision, distributed as follows: C-1: Mental Hospital, minimum of two months. C-2: Tuberculosis Hospitals or Sanatoriums. C-3: General Hospital (Medical and surgical). C-4: Children Hospitals. C-5: Orthopedic Hospitals or Services.

* Adopted by AOTA in October 1930

CHAPTER IV

APPLYING THE STANDARDS OF EDUCATION OF THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS TO SELECTED OCCUPATIONAL THERAPY EDUCATIONAL PROGRAMS IN THE UNITED STATES: A SURVEY

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Introduction

Over many years, the quality of higher education has been maintained through the process of accreditation (Johnson, 1974); accreditation has also been the most potent lever for curricular reform (Greiner& Knebel, 2003). This reform is needed to ensure that students are prepared to deliver quality healthcare in an ever-changing healthcare environment. Curricular reform starts by establishing competencies that students should possess at the time of graduation, and then articulating the knowledge, skills, and attitudes that lead to each competency.

Although differences exist between the educational standards of Accreditation Council of OT Education (ACOTE) and World Federation of Occupational Therapists (WFOT), both entities aim to graduate competent occupational therapists with adequate knowledge and skills in order to serve their clients and their profession. ACOTE standards of education prepare therapists to practice in the United States (US), a somewhat cohesive environment. On the other hand, the WFOT standards prepare occupational therapist to practice worldwide in vastly different environments.

This study applied the WFOT Revised Standards of occupational therapy education to a selected sample of OT programs in the US, in order to answer the following questions: to what extent did the syllabi for the OT programs in the US, that participated in the research, meet the WFOT standards? To what extent do OT syllabi for the selected OT programs emphasize the substantial knowledge, skills and attitudes in the five areas of competence outlined in the WFOT Revised Standards? What, if any, areas of the OT syllabi, in the US are underemphasized, from the WFOT Revised Standards' point of view? Moreover, what conclusions and recommendations can be made regarding the OT education in the US based upon comparison with WFOT standards?

Literature Review

The quality of higher education has been maintained through the accreditation process since the early 1900s (Johnson, 1974). Maintaining the quality of occupational therapy education is essential to the survival of the profession. Historically, quality of education has been maintained through the accreditation process. The process involves establishing educational standards and ensuring that these standards are met. In 1920, the AOTA decided to establish a set of minimum standards of training for occupational therapists. The Association's Standing Committee on Teaching Methods adopted a set of Minimum Standards in 1923 ("Report of the Committee on Teaching Methods," 1923). The Minimum Standards of Training focused on the content of courses, the number of credit hours, and the physical facilities of the OT school (Johnson, 1974). These Minimum Standards were updated in 1927 and 1930 (Quiroga, 1995). The final version of those standards was adopted in October 1930; they were titled "New Minimum

Standards for Training for Occupational Therapists Who Desire to Qualify for Registration". They consisted of four sections: prerequisites for admission; course of training; content of courses, and practice training (AOTA, 1930). See Table 1.

The AOTA collaborated with the Council on Medical Education of the American Medical Association (AMA) to develop and improve occupational therapy education. The American Medical Association passed a resolution in June 1933, following the request by AOTA president in 1931, that AMA undertakes the inspection of Schools of OT. This collaboration yielded the "Essentials of an Acceptable School of Occupational Therapy" (AMA, 1933). Since then many changes and updates occurred. In 1994 when the AOTA Accreditation Committee changed its name to the Accreditation Council for Occupational Therapy Education (ACOTE), it was recognized by the United States Department of Education (USDE) as the accrediting agency for occupational therapy education in the US. Following the name change, specialized accreditation of OT and OTA educational programs was no longer handled jointly between AOTA and AMA. Nowadays, the ACOTE accredits OT educational programs based on three sections. Sections A and C contain general standards and section B outlines standards that are specific to the OT curriculum. The extent to which an OT educational program complies with the standards determines its accreditation status.

The WFOT sets OT education standards that tend to reflect a global vision of OT. They also tend to be more reflective of the recent trends in international thinking about the issues of health, wellness, and disease. The WFOT standards are of great utility when occupational therapists move among member countries.

Setting the educational standards has been one of the priorities of the WFOT since its inception in 1952. The aim was to have international consistency in the quality of OT education (Hocking & Ness, 2004). The WFOT Minimum Standards were first established in 1952; substantial revisions occurred between 1968 and 1971 to keep pace with the international developments in OT education and practice. The WFOT Minimum Standards dictated the content and sequence of subjects to be taught. According to these standards, OT curriculum should include pre-clinical conditions; clinical sciences; theory of OT; sufficient variety of therapeutic activities; and clinical practice or fieldwork experience (WFOT, 2000, pgs 37- 57). The Minimum Standards were substantially revised in 2002 to produce the "Revised Minimum Standards for the Education of Occupational Therapists, 2002" (Hocking & Ness, 2002). The revised standards describe the international and local context that should influence the OT educational program. The Standards also describe an educational process and purpose designed to produce OT practitioners with sufficient knowledge, skills, and attitudes for competent practice. However the WFOT Standards do not list the number or the names of the courses that have to be taught by an OT educational program. Instead, the focus is on the three components of the educational process: the local context, the educational program, and the feedback process. The Revised Standards emphasize that all occupational therapists should have substantial knowledge, skills and attitudes in the following five components of the educational program: the person-occupation-environment relationship; therapeutic and professional relations; occupational therapy process; professional reasoning and behavior; and the context of professional practice.

Method

Design

A quantitative survey was chosen to guide this study. Surveys are often used to guide research in which the purpose is to generalize the responses of a sample to a larger population. In addition, surveys are often concerned with describing attitudes and values, practices or characteristics of a specific group (Portney & Watkins, 1993). The Principal Investigator decided to use the survey method because he wanted to explore the content and attributes of the syllabi of the different OT programs and to match syllabi of OT programs in the US with the WFOT competencies.

Participants

The participants for this research were purposefully selected from OT educational programs in the United States that had been recently accredited by the ACOTE. The ACOTE evaluates the accreditation status of approximately 20-30 OT programs each year. After obtaining IRB approval, an email was sent to 28 OT programs that had been accredited by ACOTE between March 2005 and December 2005. The decision was made to send the emails to OT programs before the AOTA 86th Annual Conference and Expo that was scheduled for April 27-30 of 2006 in Charlotte, NC. This was done so that the directors would be able to view the survey before departing for conference, as they may be too busy upon their return. The subject of the email was "Dissertation Request", the "From" line contained the credentials of the principle investigator "MSc, OTR" and each email was sent twice as another attention getter to encourage the director of the OT programs more likely to read the email and respond to it. In the email a request was made

to obtain a copy of the program's Self Study Document that was submitted to ACOTE for accreditation in order to analyze the syllabi that were used at that program at the time of its accreditation. The emails were sent to the email addresses that were listed on the AOTA website for each OT program. Two emails were returned because of failure of delivery; alternative email addresses were looked up from the two OT programs' websites, and the emails were resent. A few days after the emails, letters were mailed (regular mail) to the same programs. The intent was for the directors to receive the letters after they had returned from the AOTA Annual Conference. During the following 12 days, no positive responses were received, and after consulting the chair of the PhD committee, six additional OT programs that had been accredited in the Fall/Winter 2004 accreditation meeting were contacted in the same manner to increase the pool of potential participants. Letters were sent to these programs the following day. Over the course of four days, 5/2/2006 to 5/5/2006, each and every program director was called to be reminded to send their Self Study Document, or at least a copy of the OT syllabi. In almost all the cases, the director's secretary took the message, or a voice message was left; whenever a voice message was left, a follow up call was placed. After all this effort, only three program directors agreed to send their Self Study Document, or the OT syllabi. These were analyzed in the fashion that will be described in the Data Collection section below. Some other OT programs were identified through personal contact from the Chair of the PhD committee around 11/29/2007; they were contacted and additional sets of syllabi were obtained. All together the researcher was able to obtain the syllabi for five OT programs. As stated above, the five OT programs that participated in this research

were accredited by ACOTE on or before December of 2005. The syllabi used for this study were those from OT programs accredited on the 1998 ACOTE standards (AOTA, 1998). ACOTE has recently adopted a revised set of standards (ACOTE, 2006).

Data Collection

The WFOT Revised Standards of 2002 do not list the number or the names of the courses that have to be taught by an OT educational program. Instead, the Revised Standards emphasize that the graduating occupational therapists should have substantial knowledge, skills and attitudes in five categories: the person-occupation-environment relationship; therapeutic and professional relations; the occupational therapy process; professional reasoning and behavior and; the context of professional practice. Two of these categories are divided into subcategories, and each category or subcategory lists a number of competencies, as Knowledge, Skills, and/or Attitudes. In all, the WFOT Revised Standards lists a total of 98 competencies under each category or subcategory (WFOT, 2002. pgs 13-20). These competencies were organized into a table to facilitate viewing and working with them. See Appendix D.

The description and objectives for the course syllabi for each program were carefully compared with WFOT standards/competencies. The focus was on identifying the knowledge, skills, and/or the attitudes that the particular course intended to teach. As an inductive process, the research was guided by the following overarching question: "what knowledge, skills and/or attitude would the student gain by successfully achieving the objective contained within the respective syllabus?" To answer this question, the principal investigator reviewed the course description and examined the respective

course's objectives/components. This researcher used the WFOT Standards definitions (Hocking & Ness, 2006) for the words "knowledge", "skills" and "attitudes". The WFOT Standards defined knowledge as the "things that a person knows"; skills as "having the ability to do something" (which includes both physical and mental aspects); and attitudes as "a way of thinking about something".

The researcher also examined the words that were embedded within the objectives to infer the intended learning outcomes of the respective course. The presence of these words guided the researcher to classify an objective as a knowledge, skills, or attitude objective. The phrases associated with knowledge were: explore, relate, examine, identify, describe, understand, analyze, compare and contrast, know, recognize, discuss, develop, interpret, synthesize, design, evaluate, and articulate. The words associated with skills were: apply, demonstrate, explore, administer, engage in, and participate in. Those associated with attitude were: appreciate, value, assume responsibility for, and others.

Other components of the syllabi also influenced the researchers decision on the intended outcome of the class. For example, if an assignment required the student to demonstrate certain tasks, the assignment would be classified as a skill. If the student was asked to present "raw facts" that was classified as knowledge.

The answers to the overarching question provided a list of competencies. The course number that yielded those competencies was entered in the appropriate place in WFOT Standards of Education table at the appropriate cell/s, see Table 2, a separate and detailed table was done for each university. For example, the first cell of the table is the intersection between "Knowledge" and "What occupation is". The numbers of all the

courses in the OT curriculum that covered that topic were entered in that cell. The number of a particular course could be entered in more than one cell. A question mark (?) was used whenever a definite judgment was not established to whether if or not that particular course would cover that particular competency.

In matching syllabi of OT courses to WFOT standards, the principal investigator made an assumption that the syllabus for each course represent the content of that class. In addition, the principal investigator assumed that the syllabus for the class serves as a representation of what the student will learn and experience in that class. Educators prepare syllabi to outlines topics that will be covered, tests and assignments that will be completed at the class. In reality, analyzing the syllabi for an OT program may not totally reflect the knowledge, skills, or attitudes students would gain upon completing the required coursework. The principal investigator understood this limitation, nevertheless analyzing the syllabi was embraced as the most practical way to gain insight into what OT program teach.

Table 2. *WFOT Competencies Applied to OT Schools in the US*

	Knowledge	Skills	Attitudes	Is competence covered at K, S or A level? 1=Yes, 0=No
A list of the WFOT 98 Competences listed under 5 main categories, and several subcategories:				
↓↓↓↓↓↓↓↓↓	Course #,			1 or 0
↓↓↓↓↓↓↓↓↓		Course #,		1 or 0
↓↓↓↓↓↓↓↓↓			Course #,	1 or 0
Percentage of covered competencies as Knowledge, Skills, or Attitudes?				--- %

Data Analysis

After many consultations and discussions with a statistician and explaining the purpose of the research to him, he suggested using descriptive statistics, to display the data in an organized and summarized manner. Gall, Gall & Borg (2002) reported that categorical data (including dichotomies) are summarized by creating frequency distributions. The Principal Investigator decided to use frequency distribution as it serve the best way to handle these set of data consisting of dichotomous variables, i.e. meeting or not meeting the WFOT competencies.

The data for all universities were presented in one Table that was titled "WFOT Standards, All Universities". The Table included the number of WFOT Competencies in each of the five major categories and their subcategories. As a whole the table included 50 competencies under the Knowledge heading, 35 competencies under the Skills heading and 13 competencies under the Attitude heading. The Table also presented the

numbers & percentages of WFOT competencies that were met by each university individually, and for all universities combined. These numbers and percentages were presented for each of the five major categories and their subcategories, and for the Knowledge, Skills, and Attitudes. See Table 3.

Findings

Participants

After an extensive effort was made to recruit the needed number of universities, only five universities agreed to participate in this research by submitting their Self Study Documents or copies of their syllabi. To protect the identity of these universities, as required by the IRB, only brief and non-identifying information can be reported here. Four of the universities were public institutions; the fifth one was a private not-for-profit, as classified by the Carnegie Classification of Institutions of Higher Education. Two of the universities were classified as Doctoral/research universities, two were classified as Master College and Universities, and the fifth one was classified as a Specific Focus Institution. Geographically, the universities were located in different parts of the US; including eastern, midwestern, northern, northeastern, and the southern areas of the USA.

Results From the Quantitative Data

The results are presented in six Tables, one for each university individually, and one for the mean of all universities combined. The table for each university exhibits the percentages of how much that university covered in its OT curriculum in comparison to the standards set by the WFOT. The sixth table exhibits the percentages of how much the universities on average, when combined, met the WFOT standards.

On average, all the universities combined covered 87% of the WFOT competencies at the Knowledge, Skills, and Attitude levels. The universities individually ranged from 77% at University #5 to 90% at University #1. See Tables 4.

At the levels of Knowledge, Skills and Attitudes, the percentages of coverage varied too. The universities combined covered the Knowledge at 88% ranging form 96% at University # 3 to 80% at University #5. Skills were covered by all universities on average at 85%, ranging from 91% at University # 2 to 74% at University #5. Attitudes were the least covered by the Universities at an average of 80% ranging from 92% at University #1 to 69% at University #5. See Table 3.

Table 4 exhibits the mean for the Knowledge, Skills, and Attitudes at the WFOT categories and subcategories. Examining Table 4, reveals that the first category (The Person-Occupation- Environment Relationship) was covered at 88% by all the universities combined, ranging from 77% at University #5 to 94% at University #2. The four subcategories that are listed within this first category are Occupation, Person, Environment and the Relationship between Occupation and Health. They were covered on average by the universities at 81%, 91%, 93% and 85% respectively. The second category (Therapeutic and Professional Relationships) was covered at 93% by all the universities combined, ranging from 83% at Universities #2, and 3 to 100% at the other three universities. The third category of the WFOT standards address the Occupational Therapy Process and it was covered 100% by all the universities. The fourth category of the WFOT standards was the Professional Reasoning and Behaviors, it was covered by all the universities combined at 80%, ranging from 70% at University #5 to 90% at

University #1. This category lists five subcategories they are: Research/Information Search Process; Ethical Practice; Professional Competencies; Reflective Practice and Managing Self; Others and Services. These subcategories were covered by the universities at 97%, 67%, 72%, 58% and 100% respectively. The last category of the WFOT standards is the Context of Professional Practice, and it was covered on average by the universities at 85%, ranging from 64% at University #5 to 100% at University # 2.

Individually University #1 met 88 of the 98 WFOT competencies, a 90% coverage rate. For the first WFOT category, the university met 32 out of the 39 WFOT competencies, a 82% coverage rate. For the second category, the University met six out of the six WFOT competencies. At the third category, the University met nine out of the nine competencies. The fourth category was covered at 90% as University #1 met 30 out of the 33 WFOT competencies. The University #1 covered the last category of the WFOT standards at 100%. See Table 5 for more details.

University #2 met 87 of the 98 WFOT competencies, an 89% coverage rate. For the first WFOT category, the University met 37 out of the 39 WFOT competencies, a 94% coverage rate. For The second category, the Therapeutic and Professional Relations the University met five out of the six WFOT competencies, an 83% coverage rate. At the third category, the University met nine out of the nine competencies. The fourth category of the standards was covered at 79% as University #2 met 26 out of the 33 WFOT competencies. University #2 covered the last category at 91%. See Table 6.

University #3 met 86 of the 98 WFOT competencies, an 88% coverage rate. For the first category University #3 met 35 out of the 39 WFOT competencies, a 90%

coverage rate. University #3 met five out of the six WFOT competencies at the second category, an 83% coverage rate. At the third category, University #3 met nine out of the nine competencies. The fourth category of the standards was covered at 82% at University #3 as it met 27 out of the 33 WFOT competencies. University #3 covered the last category of the WFOT standards, Context of Professional Practice, at 91%. See Table 7 for details.

University #4 met 83 of the 98 WFOT competencies, an 85% coverage rate. For the first WFOT category as the University met 33 out of the 39 WFOT competencies, a 85% coverage rate. At the second category, University #4 met six out of the six WFOT competencies, a 100% coverage rate. At the third category, the University met nine out of the nine competencies. The fourth category of the standards was covered at 79% as University #4 met 26 out of the 33 WFOT competencies. University #4 covered the last category of the WFOT standards at 82%. See Table 8 for more details.

University #5 met 75 of the 98 WFOT competencies, a 77% coverage rate. The first WFOT category was covered at 77%, as the University met 30 out of the 39 WFOT competencies. For The second category, the University met six out of the six WFOT competencies, an 100% coverage rate. At the third category, University #5 met nine out of the nine competencies. The fourth category of the standards, the Professional Reasoning and Behaviors, was covered at 70% as University #5 met 23 out of the 33 WFOT competencies. University #5 covered the last category of the WFOT standards, Context of Professional Practice, at 64%. See Table 9 for more details.

Discussion

This study applied the 2002 WFOT Revised Standards of occupational therapy education to the OT syllabi of five OT programs in the US. The aim was to answer three questions: first, to what extent do OT programs in the US, individually and collectively, meet the WFOT standards. Second, to what extent did OT syllabi emphasize the substantial Knowledge, Skills and Attitudes in the WFOT Revised Standards? And finally, what areas of the OT syllabi, if any, are underemphasized from the WFOT Revised Standards' point of view?

The findings of this research concluded that the sample of the OT programs that were studied collectively met about 87% of WFOT Revised Standards; that on average knowledge was covered the most and attitudes the least. Another trend that was noticed was that the "Occupational Therapy Process" was covered the highest among all the WFOT categories at a 100% rate by all the universities. The least coverage was at the "Professional Reasoning and Behavior". It is worth mentioning here that the sample size was small, and that generalizing these findings to the approximately 150 OT programs in the US would be ill-advised. Furthermore, the small sample size may not accurately represent the diverse OT programs in the US; for example, none of the five programs was from the western parts of the US. In addition, only one out of the five OT programs was private, the other four were public universities, and that may have had some impact on how quickly these institutions adapt, and adopt newer OT standards such as the WFOT Revised standards. The ACOTE accredits about 20-30 OT programs annually, and the researcher contacted all OT programs that have been accredited in the year or so prior to the start of

the data collection to maximize the sample size. To the knowledge of the primary investigator, no research has been conducted to apply the WFOT standards at any university/ies. Therefore it will be interesting to see what results may be generated from conducting similar studies with larger sample sizes, and more diverse universities.

Individually, the universities differed in their percentage of coverage to the WFOT standards. University #1 scored the highest at 90% combined Knowledge, Skills and Attitudes coverage. University #5 scored the lowest coverage at 75%. Even though these numbers are based on objective data of the extent of coverage, this objective data is solely based on the subjective understanding of the researcher to the objectives of the courses. To account for this weakness the author recommends that the same courses be analyzed by more than one investigator.

Another important point that is worthy of mentioning is that this research evaluated the curricula of OT programs based on the WFOT standards. However, the research did not examine whether educational standards were covered by the universities beyond the WFOT standards. Some of the universities may have had covered OT standards beyond the emphasis of the WFOT Revised standards. Exploring these areas was beyond the scope of this research.

Conclusions, Implications and Limitations

The researcher was unable to find similar studies that were done to investigate the extent to which OT programs in the US meet the WFOT standards of education. Thus, further studies need to be conducted to confirm or negate findings of this research. If

future studies are to be conducted, the researcher feels that a larger and more representative sample may yield data that are more generalizable.

Even though accreditation in the US is voluntarily sought by institutions of higher education, the process has been known to be the most potent lever for curricular reform (Greiner& Knebel, 2003). Consequently the ACOTE may need to incorporate some of the WFOT standards into its own standards, especially the standards that were least covered by the participants of this research, or future ones. This incorporation is especially important since the WFOT standards tend to reflect a global, rather than national, vision of OT. Also the WFOT Standards tend to be more reflective of the recent trends in international thinking about the issues of health, wellness, and disease. In addition, incorporating some of the WFOT standards into the American standards of OT education may facilitate the mobility of occupational therapists to other countries.

Table 3, *WFOT Standards, All Universities*

	Knowledge:							**Skills:**							**Attitudes:**						
	The number & percentage of WFOT competencies met by the universities.							The number & percentage of WFOT competencies met the universities.							The number & percentage of WFOT competencies met the universities.						
Number of WFOT Competencies in each category/ subcategory.	+	U1	U2	U3	U4	U5	Av	+	U1	U2	U3	U4	U5	Av	+	U1	U2	U3	U4	U5	Av
A- The Person-Occupation-Environment Relationship:	**22**	**19**	**21**	**21**	**17**	**16**	**18.8**	**13**	**10**	**13**	**11**	**12**	**12**	**11.6**	**4**	**3**	**3**	**3**	**4**	**2**	**3**
		86 %	**95 %**	**95 %**	**77 %**	**73 %**	**85 %**		**77 %**	**100 %**	**85 %**	**92 %**	**92 %**	**89 %**		**75 %**	**75 %**	**75 %**	**100 %**	**50 %**	**75 %**
1. Occupation.	9	8*	8*	9*	4*	4*	6.6	8	7*	8*	7	7*	7*	7.2	1	1	1	1	1	0	0.8
		89 %	89 %	100 %	44 %	44 %	73 %		88 %	100 %	88 %	88 %	88 %	90 %		100 %	100 %	100 %	100 %	0 %	80 %
2. Person.	8	6*	8*	7*	8*	8*	7.4	2	2	2	1	2	2	1.8	1	0	1*	1	1*	1*	0.8
		75 %	100 %	86 %	100 %	100 %	92 %		100 %	100 %	50 %	100 %	100 %	90 %		0 %	100 %	100 %	100 %	100 %	80 %
3. Environment.	3	3	3*	3	3*	2	2.8	2	2	2	2	2	2*	2	1	1	1	1	1	0	0.8
		100 %	100 %	100 %	100 %	75 %	95 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	0 %	80 %

4. The Relationship Between Occupation and Health.	2	2	2	2	2	2*	2	1	1	1	1*	1*	1*	1	1	1	0	0	1	0	0.4
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	0 %	0 %	100 %	0 %	40 %
B- Therapeutic and Professional Relationships:	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	2	2	1.6
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	50 %	50 %	100 %	100 %	80 %
C- Occupational Therapy Process:	7	7	7	7	7	7*	7	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %
D- Professional Reasoning and Behaviors:	13	11	9	12	11	10	10. 6	15	14	12	11	12	9	11. 6	5	5	5	4	3	4	4.2
		85 %	69 %	92 %	85 %	77 %	82 %		93 %	80 %	73 %	80 %	60 %	77 %		100 %	100 %	80 %	60 %	80 %	84 %
1. Research/ Information Search Process.	4	4	4	4	4*	4*	4	1	1	1	1	1	1*	1	1	1	1	0	1	1*	0.8
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	0 %	100 %	100 %	80 %
2. Ethical Practice.	6	4*	2	6*	4*	3*	3.8	4	3*	4*	4*	3*	0	2.8	1	1	1	1	1	0	0.8
		67 %	33 %	100 %	67 %	50 %	63 %		75 %	100 %	100 %	75 %	0 %	70 %		100 %	100 %	10 0%	100 %	0 %	80 %

3. Professional Competence.	1	1	1*	0	1*	1*	0.8	3	3*	2*	1	1	3*	2	1	1	1*	1	0	1	0.8
		100 %	100 %	0 %	100 %	100 %	80 %		100 %	75 %	33 %	33 %	100 %	75 %		100 %	100 %	10 0%	0 %	100 %	80 %
4. Reflective Practice.	1	1	1	1	1	1	1	6	6*	4*	4*	6*	4	2.8	1	1	1	1*	0	1*	0.8
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	67 %	67 %	100 %	67 %	80 %		100 %	100 %	100 %	0 %	100 %	80 %
5. Managing self, others and services.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %	100 %	100 %	100 %
E- Context of Professional Practice:	**6**	**6***	**5**	**6**	**5**	**5***	**5.4**	**4**	**4**	**4**	**3***	**4***	**2**	**3.4**	**1**	**1**	**1**	**1**	**0**	**0**	**0.6**
		100 %	**83 %**	**100 %**	**83 %**	**83 %**	**90 %**		**100 %**	**100 %**	**75 %**	**100 %**	**50 %**	**85 %**		**100 %**	**100 %**	**100 %**	**0 %**	**0 %**	**60 %**
Total:	50	45	44	48	42	40	43. 8	3 5	31	32	28	31	26	29. 6	13	12	11	10	10	9	10. 4
	X	90 %	88 %	96 %	84 %	80 %	88 %	X	89 %	91 %	80 %	89 %	74 %	85 %	X	92 %	85 %	77 %	77 %	69 %	80 %

* Indicates competencies that were covered only by one course or class.

+ Indicates the Total number of competencies that are listed at the WFOT Standards under that heading.

U1: University #1; U2: University #2, etc. Av: Average of the 5 Universities for that category or subcategory.

Tables 4, *Number & Percentage of WFOT Competencies met by the Universities, Knowledge, Skills & Attitudes Combined.*

Number of WFOT Competencies in each category/ subcategory.	Knowledge, Skills and Attitudes Combined						
	**	University # 1	University # 2	University # 3	University # 4	University # 5	Average of all Universities
A- The Person-Occupation-Environment Relationship:	**39**	**32**	**37**	**35**	**33**	**30**	**34.4**
		82%	**94%**	**90%**	**85%**	**77%**	**88%**
1. Occupation	18	16	17	17	12	11	14.6
		88%	94%	94%	67%	61%	81%
2. Person	11	8	11	9	11	11	10
		72%	100%	82%	100%	100%	91%
3. Environment	6	6	6	6	6	4	5.6
		100%	100%	100%	100%	67%	93%
4. The Relationship Between Occupation and Health	4	4	3	3	4	3	3.4
		100%	75%	75%	100%	75%	85%
B- Therapeutic and Professional Relationships:	**6**	**6**	**5**	**5**	**6**	**6**	**5.6**
		100%	**83%**	**83%**	**100%**	**100%**	**93%**
C- Occupational Therapy Process:	**9**	**9**	**9**	**9**	**9**	**9**	**9**
		100%	**100%**	**100%**	**100%**	**100%**	**100%**
D- Professional Reasoning and Behaviors:	**33**	**30**	**26**	**27**	**26**	**23**	**26.4**
		90%	**79%**	**82%**	**79%**	**70%**	**80%**
1. Research/ Information Search Process	6	6	6	5	6	6	5.8
		100%	100%	83%	100%	100%	97%
2. Ethical Practice	11	8	7	11	8	3	7.4
		72%	64%	100%	73%	27%	67%
3. Professional Competence	5	5	4	2	2	5	3.6
		100%	80%	40%	40%	100%	72%
4. Reflective Practice	8	8	6	6	7	6	4.6
		100%	75%	75%	87%	75%	58%
5. Managing self, others and services.	3	3	3	3	3	3	3
		100%	100%	100%	100%	100%	100%
E- Context of Professional Practice:	**11**	**11**	**10**	**10**	**9**	**7**	**9.4**
		100%	**91%**	**91%**	**83%**	**64%**	**85%**
Total:	**98**	**88**	**87**	**86**	**83**	**75**	**85.3**
	X	**90%**	**89%**	**88%**	**85%**	**77%**	**87%**

** indicates the Total number of competencies that are listed at the WFOT Standards under that heading.

Table 5, *Percentage of WFOT Competencies met by University # 1*

Number of WFOT Competencies in each category/ subcategory	Knowledge	Skills	Attitudes	Average of K,S&A		
				Average of K,S&A	# of WFOT competencies	# of Competencies the University met.
The Person-Occupation-Environment Relationship:	86%	77%	75%	**82%**	39	32
1. Occupation	89%	88%	100%	**88%**	18	16
2. Person	75%	100%	0%	**72%**	11	8
3. Environment	100%	100%	100%	**100%**	6	6
4. The Relationship Between Occupation and Health	100%	100%	100%	**100%**	4	4
Therapeutic and Professional Relationships	100%	100%	100%	**100%**	6	6
Occupational Therapy Process	100%	100%	100%	**100%**	9	9
Professional Reasoning and Behaviors	85%	93%	100%	**90%**	33	30
1. Research/Information Search Process	100%	100%	100%	**100%**	6	6
2. Ethical Practice	67%	75%	100%	**72%**	11	8
3. Professional Competence	100%	100%	100%	**100%**	5	5
4. Reflective Practice	100%	100%	100%	**100%**	8	8
5. Managing self, others and services	100%	100%	100%	**100%**	3	3
Context of Professional Practice	100%	100%	100%	**100%**	11	11
University across all Categories:				**90%**	98	88

Table 6, *Percentage of WFOT Competencies met by University # 2*

Number of WFOT Competencies in each category/ subcategory	Knowledge	Skills	Attitudes	Average of K,S&A		
				Average of K,S&A	# of WFOT competencies	# of Competencies the University met.
The Person-Occupation-Environment Relationship:	95%	100%	75%	**94%**	39	37
1. Occupation	89%	100%	100%	**94%**	18	17
2. Person	100%	100%	100%	**100%**	11	11
3. Environment	100%	100%	100%	**100%**	6	6
4. The Relationship Between Occupation and Health	100%	100%	0%	**75%**	4	3
Therapeutic and Professional Relationships	100%	100%	50%	**83%**	6	5
Occupational Therapy Process	100%	100%	100%	**100%**	9	9
Professional Reasoning and Behaviors	69%	80%	100%	**79%**	33	26
1. Research/Information Search Process	100%	100%	100%	**100%**	6	6
2. Ethical Practice	33%	100%	100%	**64%**	11	7
3. Professional Competence	100%	75%	100%	**80%**	5	4
4. Reflective Practice	100%	67%	100%	**75%**	8	6
5. Managing self, others and services	100%	100%	100%	**100%**	3	3
Context of Professional Practice	83%	100%	100%	**91%**	11	10
University across all Categories:				**89 %**	98	87

Table 7, *Percentage of WFOT Competencies met by University # 3*

Number of WFOT Competencies in each category/ subcategory	Knowledge	Skills	Attitudes	Average of K,S&A		
				Average of K,S&A	# of WFOT competencies	# of Competencies the University met.
The Person-Occupation-Environment Relationship:	95%	85%	75%	90%	39	35
1. Occupation	100%	88%	100%	**94%**	18	17
2. Person	86%	50%	100%	**82%**	11	9
3. Environment	100%	100%	100%	**100%**	6	6
4. The Relationship Between Occupation and Health	100%	100%	0%	**75%**	4	3
Therapeutic and Professional Relationships	100%	100%	50%	83%	6	5
Occupational Therapy Process	100%	100%	100%	100%	9	9
Professional Reasoning and Behaviors	92%	73%	80%	82%	33	27
1. Research/Information Search Process	100%	100%	0%	**83%**	6	5
2. Ethical Practice	100%	100%	100%	**100%**	11	11
3. Professional Competence	0%	33%	100%	**40%**	5	2
4. Reflective Practice	100%	67%	100%	**75%**	8	6
5. Managing self, others and services	100%	100%	100%	**100%**	3	3
Context of Professional Practice	100%	75%	100%	91%	11	10
University across all Categories:				88%	98	86

Table 8, *Percentage of WFOT Competencies met by University # 4*

Number of WFOT Competencies in each category/ subcategory.	Knowledge	Skills	Attitudes	Average of K,S&A		
				Average of K,S&A	# of WFOT competencies	# of Competencies the University met.
The Person-Occupation-Environment Relationship:	77%	92%	100%	85%	39	33
1. Occupation.	44%	88%	100%	67%	18	12
2. Person.	100%	100%	100%	100%	11	11
3. Environment.	100%	100%	100%	100%	6	6
4. The Relationship Between Occupation and Health.	100%	100%	100%	100%	4	4
Therapeutic and Professional Relationships	100%	100%	100%	100%	6	6
Occupational Therapy Process	100%	100%	100%	100%	9	9
Professional Reasoning and Behaviors	85%	80%	60%	79%	33	26
1. Research/Information Search Process	100%	100%	100%	100%	6	6
2. Ethical Practice:	67%	75%	100%	73%	11	8
3. Professional Competence:	100%	33%	0%	40%	5	2
4. Reflective Practice	100%	100%	0%	87%	8	7
5. Managing self, others and services	100%	100%	100%	100%	3	3
Context of Professional Practice	83%	100%	0%	82%	11	9
University across all Categories:				85 %	98	83

Table 9, *Percentage of WFOT competencies met by University # 5*

Number of WFOT Competencies in each category/ subcategory.	Knowledge	Skills	Attitudes	Average of K,S&A		
				Average of K,S&A	# of WFOT competencies	# of Competencies the University met.
The Person-Occupation-Environment Relationship:	73%	92%	50%	77%	39	30
1. Occupation.	44%	88%	0%	**61%**	18	11
2. Person.	100%	100%	100%	**100%**	11	11
3. Environment.	75%	100%	0%	**67%**	6	4
4. The Relationship Between Occupation and Health.	100%	100%	0%	**75%**	4	3
Therapeutic and Professional Relationships	100%	100%	100%	**100%**	6	6
Occupational Therapy Process	100%	100%	100%	**100%**	9	9
Professional Reasoning and Behaviors	77%	60%	80%	70%	33	23
1. Research/Information Search Process	100%	100%	100%	**100%**	6	6
2. Ethical Practice:	50%	0%	0%	**27%**	11	3
3. Professional Competence:	100%	100%	100%	**80%**	5	4
4. Reflective Practice	100%	67%	100%	**75%**	8	6
5. Managing self, others and services	100%	100%	100%	**100%**	3	3
Context of Professional Practice	83%	50%	0%	64%	11	7
University across all Categories:				77 %	98	75

CHAPTER V

APPLYING THE STANDARDS OF EDUCATION OF THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS TO SELECTED OCCUPATIONAL THERAPY EDUCATIONAL PROGRAMS IN THE UNITED STATES: A THERAPIST'S PERSPECTIVE

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Literature Review

Occupational therapy (OT) focuses primarily on developing adaptive skills and improving clients' performance in order to fulfill their occupational roles, such as with activities of daily living; leisure and avocational activities. Occupational therapists work with individuals whose abilities to cope with tasks of living are threatened by physical injuries, the aging process, psychological or social disability, chronic conditions, poverty, cultural differences, and deficits in motor, sensory, cognitive, emotional or social development (Johnson, 1974). In order to practice OT in the US, therapists should be nationally certified by the National Board of Certification for Occupational Therapy (NBCOT). In order to be eligible to sit for the certification examination, practitioners must graduate from an OT program that is accredited by the Accreditation Council of Occupational Therapy Education (ACOTE). The United States Department of Education (USDE) recognizes the ACOTE as the entity that is responsible for the specialized

accreditation of OT educational programs in the US.

Many foreign occupational therapists who take the NBCOT exam do so with the intention of practicing in the US. Occupational therapists who graduate from one particular country can move to another one to practice OT. This transition is facilitated by the commonalities in the standards of OT education across the world, and by the fact that the WFOT standards facilitate the recognition of qualifications among member countries. The mobility of healthcare workers is common among health professions, as the demand for these skilled workers rise in the developed countries (Yi & Jezewski, 2000). In most cases those professionals are educated to serve clients in their own native countries, and when they move to another country they may face work-related and/or personal challenges (Wither & Snowball, 2003).

As it is the case with other healthcare personnel, when occupational therapists relocate to practice in another country, they usually experience some difficulty in working and living in the foreign country. The gap between the expectations before moving, and the actual experience after the move may vary greatly (Wither, & Snowball, 2003). Researchers have explored this phenomenon with nurses, physicians, and other healthcare workers. Lopez (1990) conducted a study to describe the process of acculturation that nurses from the Philippines go through while practicing in the US. She found that nurses face common problems such as: deficiency in some technical skills; difficulties in communication especially slang; supervising nursing aides; passing the licensure exam; and, experiencing conflict between being submissive and being assertive.

Xu (2005) outlined five challenges that Asian nurses face when working in a foreign health care environment. They were: communication, especially with accents and phone orders; interpersonal relationships and management of personnel; difference in role and scope of practice; marginalization and alienation by staff and patients; and lengthy cultural adjustment.

Other scholars have studied the adjustment process of healthcare workers who work in foreign countries. Yi and Jezewski (2000) concluded that adjustment to working in a foreign country is a social and psychological process that is composed of five categories or aspects: reliving psychological stress associated with confusion, anger, fear, frustration, rejection, alienation, and depression; overcoming the language barriers in the written, verbal, and nonverbal communication; accepting the foreign country's practices, roles and focus; adopting the foreign country's style of problem-solving; and adopting the foreign country's style of interpersonal relationships.

Most of the research that has been done on the challenges and adaptation of healthcare workers included nurses and physicians as subjects. Research on the challenges and adaptation of occupational therapists who practice in a foreign country is virtually nonexistent. Even though the occupational therapy literature addresses the issues of cultural practices and beliefs of clients, and the need for therapists to be culturally sensitive and appropriate when treating clients, there is scant literature about the adaptation of therapists themselves and how they adjust in 'foreign' work settings.

This study aimed to explore the challenges and adaptation of occupational therapists who practice in foreign countries. The study attempted to explore the following

issues: The perception of the occupational therapist to his/her readiness to practice OT in a different country; the challenges that therapists face when they practice in different countries and the process of adapting to these challenges. The challenges and adaptations of the occupational therapists will be examined from the perspective of the Occupational Adaptation (OA) frame of reference. OA is based on the premise that every person has a desire for mastery, that the environment demands mastery from the individual and that the interaction between the internal desire and the external demand creates a press for mastery (Schultz & Schkade, 1992). OA also postulates that when individuals are faced with a changing life role they will face a demand for adaptation. The greater the transition, the more at risk the adaptation process will be. A person who is faced with an occupational challenge will go through a process of generating an adaptive response in order to formulate an occupational response. This adaptive response will be evaluated and subsequently integrated into that person's system to be stored and used in future challenges (Schkade & McClung, 2001).

Methods

Design

The phenomenological tradition was used to guide the design of this study. It was chosen because it describes how people experience certain phenomenon, how they perceive it, feel it and judge it (Patton, 2001). In this tradition knowledge starts by describing the self's experience of the phenomena including the sensations, perceptions and ideations (Gall, Gall & Borg, 2003). In the planning for this study, this tradition was chosen because the therapists who were going to be interviewed were going to describe

the meaning, structure, and essence of their lived experience of being a foreign occupational therapist.

Participants

Before the recruitment of participants started, this study was approved by the Institutional Review Board at Texas Woman's University. Purposeful sampling was used to find participants who met the selection criteria. The occupational therapists had to be graduates from a US program of OT and practicing in another country, or a graduate from another country and working in the US. Those occupational therapists were purposefully selected because they represented information-rich cases (Patton, 2001).To find a suffcient number of occupational therapists, different recruitment strategies were used, including: searching different online-bulletin boards, contacting international agencies that employ occupational therapists, and contacting different OT-licensing agencies. This process started in May of 2006 and lasted for about two months.

Data Collection

Before conducting each interview, the consent of the interviewee was obtained. The consent allowed the researcher to record the interview and to use it for the purpose of the study that was outlined in the consent form. An interview guide was designed for this study to ensure that the same basic lines of inquiry are pursued with each interviewee (Patton, 2001). The interview questions focused on the challenges that therapists face when they live and practice in a foreign country; the strategies they employed to deal with these challenges; and on how his/her OT education helped, or failed to help, in the adaptation process. The therapists were asked specifically about several issues: their background and

experience as therapists; challenges faced as an OT, challenges and demands of the new work environment; and their OT education and their adaptation process. Follow up probes were used to gather more information as needed, see Interview Guide at Appendix C.

All the therapists were out of town or out of the country, consequently no face-to-face interviews were conducted. After mutual agreement between the researcher and each interviewee a time was setup for a phone interview; this took several attempts to achieve because of the busy schedule of the working therapists and because of the time difference between the US and other countries. Seven interviews were done with therapists in Afghanistan, Britain, Paraguay, Texas and California. The interviews were 40 to 70 minutes in length, and the researcher took extensive notes on each response, in case the recorder malfunctioned. Fortunately this did not happen, but these detailed notes were of great utility when the researcher was transcribing some of the interviews that had bad sound quality, because of the poor international phone connection.

The interviews were tape recorded and later transcribed. The researcher had to transcribe three of the interviews because of the poor quality of the connection with some of the other countries; the other four interviews were transcribed by a professional transcriptionist but the researcher checked the transcripts for accuracy.

Data Analysis

The interviews were recorded and later transcribed verbatim, some by the Principal Investigator, and some by a professional transcriptionist. To ensure the accuracy of the process, the transcripts were read and compared with the tapes. To gain a

better understanding of the experiences of the therapists each interview was listened to, and each transcript was read several times. The content of the transcripts was analyzed using the guidelines for qualitative analysis that were outlined by Patton (2002). While reading the interviews comments were inserted in the margins using the Microsoft Word Comment menu. The comments were later organized into topics, and they were given appropriate labels. Quotations that reflected the themes were extracted from the interviews and listed under these themes.

Findings

Participants

Seven occupational therapists participated in this study. Three were from the US and currently practicing in other countries; the other four graduated from other countries and are currently practicing in the US. The seven therapists practiced in different areas of OT and in different settings such as OT education, hand therapy, outpatient, skilled nursing, general hospital, inpatient, home health, mental retardation, adult psychiatry, adult neurology and pediatrics. Their average years of experience as occupational therapists was 16.4 years, some of it was in their home countries and the rest was overseas, see Table 10 for each therapists' profile.

Themes

Three main themes emerged from analyzing the seven interviews: general challenges while working in a foreign country; OT-related challenges; and issues related to OT education. Several subthemes emerged; they are presented under each theme (see Table 11).

General Challenges Occupational Therapists Face When Working in a Foreign Country

The occupational therapists who work in foreign countries face day-to-day challenges as a consequence of having moved to an unfamiliar area. The seven therapists who were interviewed for this research have talked about these challenges. Five subthemes emerged.

It's a New Life. Almost all the therapists talked about their experience in a foreign country as being a new life. They talked about commuting, driving and just getting around as being challenges at the beginning. They also spoke about having to learn a new "money system" and a new measurement system. Some others spoke about issues of personal safety and security as being a challenge.

XP spoke about the biggest challenge that she faced, driving. She said "first thing is getting around the place, knowing the place, how to reach the work place. In general, driving was the biggest challenge" (lines 26-27). ZS spoke about the "getting your way around, learning where am I driving? and that I'm driving on the other side of the road, and manual cars" (lines 36-37). She also spoke about having to learn a new "money system" and having to learn how to budget and manage her finances using different currency and different pay scale. She remarked that one of the challenges was "I think the money system. Having to learn to set up a bank account, and in mind translating and keeping my mind on the pound system". Other interviewees talked about that being a challenge. KP said "the banking, the social security number, the driver's license and everything else was a challenge initially" (line 24).

The therapists who talked about this challenge all agreed that it was an initial challenge, or that it was a minor one. And that after a while they felt that they could function normally despite it being a hassle at the beginning. KP said that "we started working and everything started getting better" (line 25). ZS asserted that "maybe in about two months I stopped thinking "ok this X amount in American dollars, I kind switched over" (line 29).

Longing for Family, Friends and Lifestyle. Some of the interviewees mentioned this as one of the general challenges they faced when they moved to another country. They expressed that they were no longer close to their friends and families since they were physically apart from them and that familiar lifestyle. AK said that "for sure missing my family and friends, my life" (line 37). XK said that "the idea of not being able to see my family for awhile was a big challenge" (line 68).

Language Barriers. All the interviewees spoke English and they were all educated using English as a medium of instruction yet they faced communication and language difficulty to varying degrees. XP reported that she could not communicate with her clients, and she had to hire a translator, while she was taking language lessons. She says "I've been taking lessons for the last month" and "I'm beginning to understand it, and speak it a little bit more. So that'll be good to overcome the language barrier" (lines 82-84). Others faced less severe language problems. FD reported that he was fluent in using the main language of the country where he was, but he could not communicate with some clients who spoke other local languages. FD said: "I was not fluent in [Guarani] which I had to speak, especially some of my work took me to small villages and in small villages

people spoke very little other than Guarani" (lines 74-76). For other therapists some other aspects of the language were problematic, such as the accent and unfamiliarity with certain vocabularies. XP reported that she had to adjust so people could understand her "... and there I was kind of very fast in talking. That was the biggest issue because I had to slow down while I'm talking so that the people can understand me" (lines 34-35). KP reported that he was exposed to the English language while studying OT, but that was the extent of his exposure. He said: "even if all the education was in English, ... the spoken English was not very good" (lines 42-43).

Cultural Differences. The participants spoke differently about the issue of cultural differences between the home country and the host country. Some therapists brought up this issue without any prompting; others had to be probed to speak about it because they felt it was a minor issue. XP said that the biggest cultural change was her inability to wear her traditional clothing; she chose not to wear them in order not to distance herself from her clients. She said: "yes it was a big thing because change of dress and wearing clothes" she also said: "I was married but I could not wear, you know whatever, is considered as a symbol of married women ... because that will create a distance within the patient and myself" (lines 41-45). ZS spoke about the social norms, and how she had to change her social life because of the differences in these norms, she said: "what I did socially in America is different from what I'm doing socially here" (line 38). In contrast, another therapist spoke of the cultural similarities between the home country and the host country, FP said: "probably don't have as many cultural challenges ... because I came from the part of Canada mostly closely aligned with the Texas culture" (lines 41-43). AK

spoke about how the culture affects the perceptions of the client and the family of what's acceptable and what's not. She said: "some times I feel that the kids here accept challenge, accept adventure more than what happens in my country…I think in my culture this does not happen because the parents will be afraid for her or him" (lines 345-349).

Political, Governmental and Immigration Issues. Some therapists talked about the larger issue of political and governmental influence that affected their work directly or indirectly. They described it as a subtle influence that affects their work, sometimes without full awareness to it. The therapists who moved to America to work talked about the US immigration system as being the biggest challenge, as it affects therapists' eligibility to work (FP, lines 34-35). XP talked about how foreign-trained therapists who work in the US may not have as much choice in the type of work they do because of immigration regulations. She said "If there is H1B visa, you are not supposed to change it within particular time" (lines 137-138). On the other hand, American therapists who worked in foreign countries faced other challenges dealing with governmental regulations. XK spoke about her inability to voice some concerns that she had, fearing that her organization would not allow her to work in that country anymore. She commented: "I wanted to make those needs heard, I was told by other people not to do it or we'll get in trouble with the government, and that our organization won't be able to work" (lines 151-153).

Occupational Therapy/Practice-Related Challenges

The seven occupational therapists who were interviewed for this research were educated to practice OT in their native countries. Upon moving to another country they faced practice-related challenges. Three subthemes emerged when the therapists were interviewed.

The Occupational Therapy Licensing Process. Almost all the therapists who moved to the US to work talked about the OT certification and licensing process; some talked about the difficulty of the logistics involved in taking the OTR exam. Others talked about the preparation and the difficulty of the exam. On the other hand, the American therapists who moved to other countries did not face such an issue. Only one American therapist alluded to the lack of OT licensure laws in the country where he was working, and to the fact that a physical therapist can practice as an OT if he or she chooses to do so. He said: "Paraguay does not have licensure laws so if someone has the skills, they are allowed to practice whether occupational therapy or physical therapy" (lines 107-109). AK said that before she took the OTR exam she had to apply for the eligibility determination and "that was very very very very long procedure" (lines 79). One of the challenges that faced XP "was clearing the OTR exam, getting the license" (Line 29). FP reported on the difficulty of applying for the OTR exam, but not its content. She said: "and at that time it was given only twice a year, and that was a challenge, because I did not send the correct paperwork …, however I had too much experience so I did not have any difficulty…" (Lines 25-27).

Different Healthcare System. Almost all therapists talked about having to learn a new healthcare system. Issues included: different insurance regulations, documentation system, levels of productivity, and resources. For ZS one of the biggest challenges was dealing with a new healthcare system that provided different services, and paid for different equipments and procedures. She said "You're so used to Blue Cross and Blue Shield and what your insurance is covering and what it doesn't cover, it's a whole different system with the NHS" (lines 51-52). XP experienced similar difficulties when moving to the US. The second challenge she mentioned was getting familiar with the Medicare and Medicaid systems. She said "Next thing was knowing the system, health system. The insurance, Medicare and MediCal" (line 27).The same issue was of a great concern to FP who was shocked with the healthcare system in the host country. She said "I went into private practice and was immediately hit by the whole managed care insurance concept, which was very foreign to me, and I struggled" (line 47). She described how insurance regulations sometimes override the clinical judgment of the therapists; , she said: " [in her home country] there was never any question about getting paid, or any need to talk about funding, basically I was hired as an occupational therapist, and I was very autonomous in deciding what the client needed, …, and then I went into private practice here and tried to use these same principles and was constantly faced with (oh, the insurance company won't pay for that code)" (lines 56-62). To her that was a waste of resources because additional staff had to be hired to deal with the different insurance providers. She said: "In a private practice clinic here you have one person at the desk and nine people to argue with the insurance companies" (Lines 77-78). Other

therapists talked about the issue of resources or the lack thereof. XK spoke of a developing country where there was a severe lack of resources, even the basics such as pain medicine for burn patients. "I was going to the hospital, the hospital did not even have money to buy pain medication to the patients" and "it was a matter of not having the resources there, even the basic resources, not equipment or anything, but the basic resources" (lines 97-105). XP even talked about the lack of resources while she was practicing in the US; she said the issue came up in home health settings, where there was lack of employees to help with some aspects of home health. She said: "the biggest challenge is if the patient is, you know, cannot be handled by one person, there is no other help available (lines 73-74).

Differences in OT Role and Scope of Practice. The therapists spoke in detail about the issue of differences and commonalities between the host country and the home country. They spoke about the different roles in which OT may be engaged in different countries. One of the therapists argued that OT practice in the US is based on different perspectives of health and illness compared to his home country. He also argued that therapists focus on different areas of concern when they work in different countries. He said: "ADLs is not given as much importance in India because of the social and the family structure there...They give more importance that that limb is not working, make it work. So, you use more neuromuscular techniques to reeducate them and treat them" (lines 74-79). ZS also spoke about having to find discharge placement for her patient, and that this is something new to her. She said: "the OT role here is finding an alternative discharge destination for them .... So I think that's quite challenging, I've never been that

involved where someone should go" (lines 93-95). The therapists who moved from the US to practice in developing countries spoke about more challenges when it comes to the OT scope of practice. One therapist spoke about the fact that there were only five therapists in a country of six million people, and how he struggled to define OT to people, and the difficulty of making health professionals acknowledge and respect OT. FD said: "going along with that was lack of awareness of occupational therapy, and most rehabilitation doctors did not know what really occupational therapy was so there was not a strong system of referral" (lines 98-100). XK spoke about other challenges when dealing with the staff in a developing country; she reported that the staff did not possess the basic knowledge and skills to handle some of the diagnoses. "Even universal precautions, really; Basic hygiene issues so burns don't get infected; making sure that the range of motion is performed correctly... just making sure that patients who are bed-bound get turned every now and then so we don't see these terrible bed sores" (lines 110-115).

Some of the foreign-trained therapists with vast experience in OT spoke about having to accept entry-level OT positions upon moving to the US. AK talked about having to switch roles from an educator in her home country to a "student" in the US, and that she felt lack of control. She reported "since I practiced for a long time, and I was a therapist, and now I have to live the role of the student, and to wait until some one helped me what to do" (Lines 159-160). KP who had extensive experience as an OT, faced similar issues when he moved to the US; he felt that his valuable time was wasted in worrying about documentation, and that the employer was placing too much emphasis on

productivity, and that he was over worked. He said: "[in home country] emphasis wasn't given on productivity rather than getting the things done, … here there is lot of restraint on time" (lines 220-222).

Issues Related to OT education

The Occupational Adaptation of the Therapists. When faced with the challenges and demands mentioned above, most occupational therapists responded using modified or existing response modes. They mostly used existing modes of behavior when dealing with patients in clinical situations, and they used the modified response mode in unfamiliar situations such as managerial tasks. When ZS was asked about how she formulated her responses she answered: "Some things immediate responses, some things I wouldn't figure it out on my own, so I would ask a colleague" (lines 169-170). She also said "I draw from past learning, previous employment, because they are patient related and it does carryover so I'm able to rely on previous learning in that. But the things that I'm really mulling over are the things that are new learning, more unfamiliar territory" (lines 189-192). Another example on this issue is when AK was asked about her patterns of response, whether it preexisting or new she said: "I think this my way usually... some times it depends on the challenge" (lines 227-230). She was also asked about the amount of energy she exerts into addressing the new challenges. She described the process as not very focused or very intentional; she reported that she "give things enough time of thinking … I give it the time to think about it properly and analyze it" (lines 248-250). ZS uses a similar way when making a decision; she reported that she uses primary energy 75 to 80% of the time, and secondary energy the rest of the time. Her primary energy use is

mostly in clinical situations, and the secondary energy is used for unfamiliar tasks. She said: "I would say that the majority, probably 75-80%, of the decisions that I make are immediate...and the remainder would be where I have to really think it over, and may be take it home with me, and thought it over".

When planning a response, some of the therapists spoke about how they plan for the challenges before they happen. This process can be described as a premeditated or preplanned response mode. AK was asked about the amount of energy she had to exert to come up with the proper response to the challenge she faced, which was "having too much free time". She answered by explaining that she anticipated that challenge before it occurred, and that's why she preplanned her response. She said: "it's not just suddenly came to my mind, actually I thought of it when I was in Jordan" (lines 129-30). A similar question was posed to XP, who answered by saying that she anticipates, and plans for, the challenges before they happen. She said: "I have to think about how I am going to face that particular challenge... I kind of plan ahead" (lines 158-159).

The Interplay between OT Education and the Adaptation of the Therapists. Almost all of the therapists talked about how OT education and practice had developed their skills and knowledge base, which made it easier for them to deal with the challenges they faced. Some therapists, however, offered a contrasting view on this issue. They argued that OT as a profession attracts people with certain personality traits such as creativity and flexibility which makes the therapists more adaptive when facing challenges. An example with the first group was AK when she said: "learning to be in control and understanding that we change the environment, not the opposite, I learned

that from occupational therapy" (lines 325-327). She spoke about how OT taught her the adaptation skills that she used to tackle the challenges of being a foreign therapist; she said: "I think studying occupational therapy is the thing that helped to develop this adaptation technique or way of thinking" (lines 314-315). XP had the same notion; when she was asked whether OT education helped her in the adaptation process. She responded by saying "It helped me, It helped me pretty good" (line 210). ZS also spoke about how studying and practicing OT helped in developing her skills in communication and problem solving; she said "I think my OT background helped in … using good communication …being able to analyze a problem, and think of alternative solutions … try to adapt things" (lines 262-266). The same question was asked to XK; she reported that her education was very influential in helping her to adapt; She said that "I would've not done it, if it wasn't for my occupational therapy training" (line 224).

FP commented that occupational therapists are pragmatic and adaptive in the way they think and that has helped her greatly. She said "in general, the paradigms and ways of thinking, the pragmatic, and the adaptive way the occupational therapists think… has been a great benefit on my adaptation..." (Lines 146-148). But at the same time, FP thinks that the profession of OT attracts individuals who possess certain personality traits, and having these traits makes those individual more adaptive and creative ". People who are attracted to this profession and are successful, tend to be pragmatic, flexible generally, and creative, and those characteristics probably contribute to adaptation better than other personality types" (lines 183-187). This view is also shared by ZS who wondered if OT attracts certain personalities, or if it develops personalities to have some common traits.

She said "I don't know if it's the type of person that is drawn to OT, I think that there is a certain personality about us OTs, we go to that field because we are the type of person that we are" (Line 273-275).

Strengths and Weaknesses of OT Education. Almost all of the occupational therapists who were interviewed for this research said that their education was sufficient, and that it provided them with the needed tools to practice OT in a foreign country. XK reported that her education prepared her to deal with the diagnoses that she dealt with in the developing country where she worked. She said "having [an] understanding of basic methods and treatment modalities, understanding what to do with burns, cerebral palsy, etc" (lines 229-230). FD commented on the universality and the transferability of OT knowledge across countries; he said "Well, you know it gave me the basics of occupational therapy and I guess I believe that the basics of occupational therapy are fairly applicable across cultures" (lines 185-186). XP said that her OT education in her home country was "sufficient to practice as an OT, and I have very good knowledge in my profession" (line 222). FP shared that same view; she said that when she graduated she was a "very competent practitioner" (line 152).

The therapists were also asked about any shortcomings in the OT education, or aspects of the OT curriculum that could have been improved in their home countries. The American therapists talked about a notion of "tunnel vision" in that their OT programs prepared them to practice in the US without exposing them to any of the international issues concerning OT, such as diseases and disabling conditions in other countries, the World Federation of OT, etc. ZS said:" you do only learn one system… it wasn't until I

was working in Chicago in my first job, that I knew that there was a World Federation...but I think we are, my school at least, more of a tunnel vision. This is how we are in America" (lines 241-248). XK suggested that the OT curriculum in the US should include "learning about debilitating conditions not just in the United States" and learning about "cultural issues in case there are some occupational therapists who don't want to continue working in the U.S" (lines 245-247). On the other hand, FD provided a contrasting view; he argued that it would be difficult for the OT programs to prepare graduates to work in all possible cultures. He said that there "could have been some inclusion in the OT program on intercultural relations, but you know every culture is so different, but it is really hard to say what you would teach somebody for working in other cultures" (lines 231-233).

The foreign-trained therapists answered differently when they were asked about the shortcomings in their OT education. AK reported that the OT curriculum in her home country was adequate but that the way of teaching can be improved. She said "the point is in the approach of teaching ...other than the content of the curriculum" (lines 298-299). XP spoke about the overemphasis on theory and theoretical courses and the lack of emphasis on laboratory sessions; she said: "we have learnt much more in theory than in practical" (line 244). The same notion was shared by KP who reported that there was too much emphasis on certain medical topics, and was less emphasis on some OT related aspects of the program. He said: "we had anatomy, physiology, biochemistry, microbiology, pharmacology all those as in a medical school" and "however, at the same

time the OT syllabus, the theoretical aspect, was not as strong as I think that should be" (lines 184-188).

In summary, three main themes emerged from analyzing the interviews. The general challenges that therapists talked about while working in a foreign country were language barriers, cultural differences, longing for family and friends. The therapists also talked about challenges they faced while practicing OT, challenges such as obtaining an OT license, the differences of OT scope of practice and the different healthcare system with which they have to deal. Finally, the occupational therapists talked about the strengths and weaknesses of the education they received as occupational therapists and about the interaction between OT education and their adaptation as therapists.

Discussion

The occupational therapy literature is rich in research that addresses the culture of OT clients, and how the therapist should handle clients from different cultural backgrounds. This research focused on another aspect of culture as it relates to OT practice. It explored the challenges that occupational therapists face when they practice in foreign countries, how they occupationally adapt to these challenges, and the impact of their OT education and practice on their process of adaptation.

This study revealed that occupational therapists face two types of challenges when working in a foreign country: general challenges that may be common among immigrant workers in general and challenges pertinent to the occupational therapist, but may be relevant to other healthcare workers. The final theme that emerged from the interviews may be unique to occupational therapy practitioners. This theme was pertinent

to OT education and how it affected the practitioners' ability to adapt. The interviews with the therapists revealed that OT education and practice is unique in a way that it may have provided the therapists with greater ability to adapt to the challenges they faced. Some therapists spoke about preplanned or premeditated adaptation that happens when the therapist anticipates a challenge before it occurs and he or she preplans for a response. Most therapists attributed their greater sense of ability to adapt to their OT education and practice. They argued that being occupational therapists developed their ability to be flexible, open-minded, and adaptable. Other therapists argued that they were attracted to OT because of their personality traits of being flexible and adaptable, and that OT reinforced these characteristics.

The therapists who were interviewed for this research generally agreed that they were well-prepared to work in another country, and that they had most of the skills that they needed to do the work. They also agreed that their OT education in their home countries could be improved in one way or another, some made suggestions to improve it.

Limitations

The sample size for this research was relatively small; it was purposefully selected to represent a certain group of therapists, so the trends and themes that emerged from this research need to be studied more before they can be generalized. This research should serve as a starting point for further research on these topics.

Table 10. *Profiles of the Participants*

Participant's Code	Countries where s/he Practiced OT	Areas of Practice	Approximate Years of Experience as an occupational therapist.
XP	USA, India	OT education, Sub-acute, Out-patient, Home health, Long-term care.	12
KP	USA, India	OT education, Hand therapy, Outpatient, Skilled Nursing, General Hospital Inpatient	14
FD	USA, Paraguay	Home health, Nursing Home, Mental retardation	25
FP	USA, Canada	Physical Medicine Adult Psychiatry, Adult neurology, Pediatrics, OT education	28
AK	USA, Jordan	Adult Rehab., Pediatrics, OT education	12
XK	USA, Afghanistan, Angola, Haiti	Psychosocial, Acute care & Burn, Pediatrics, Home health.	10
ZS	USA, UK	Acute care, Traveling therapist Hospital setting	14

Table 11. *Main Themes and Subthemes*

General Challenges Occupational Therapists Face When Working in a Foreign Country
It's a New Life
Longing for Family, Friends and Lifestyle
Language Barriers
Cultural Differences
Political, Governmental and Immigration Issues
Occupational Therapy/Practice-Related Challenges
The Occupational Therapy Licensing Process
Different Healthcare System
Differences in OT Role and Scope of Practice
Issues Related to OT Education
The Occupational Adaptation of the Therapists
The Interplay between OT Education and the Adaptation of the Therapists
Strengths and Weaknesses of OT Education

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

This study was conducted to explore the differences between the standards of education of ACOTE and the WFOT, and how these differences might affect graduating therapists. The intent was to answer the following questions:

1. To what extent do syllabi for the selected OT programs, in the US, meet the WFOT standards?
2. To what extent do OT syllabi for the selected OT programs emphasize the substantial knowledge, skills and attitudes in the WFOT Revised Standards?
3. What areas, if any, of the OT syllabi in the US are underemphasized from the WFOT Revised Standards' point of view?
4. What conclusions and recommendations can be made regarding OT education in the US based upon a comparison with WFOT standards?
5. What is the perception of the occupational therapist to his/her readiness to practice OT in a different country?
6. What challenges do therapists face when they practice in different countries?
7. How do therapists adapt to such challenges?

This research consisted of three research studies that were separate but interrelated. The first study was an extensive literature review that described the following issues: first, the subject of higher education in the US, its development, the current challenges it faces, and the topic of quality of education; second, standards of OT

education in the US, its history and present status; third, the WFOT standards of OT education, the history, and recent development of these standards and; fourth, the challenges that healthcare workers face when they practice outside their native countries. This extensive literature review was provided to give the essential background relevant to standards of OT education and to help in understanding the issues pertinent to the second and third studies.

The second study applied the WFOT Revised Standards of OT education to a selected sample of OT programs in the US. The aim of this study was to explore the extent to which OT programs in the US meet the WFOT standards of OT education. The five universities that agreed to participate in the research, on average, covered 87% of the WFOT competencies. The five universities ranged in their coverage from 77% to 90%. Some competencies, such as the "Occupational Therapy Process", were covered at 100%. The area of least coverage was the "Professional Reasoning and Behavior".

The third study explored the challenges that occupational therapists face when they relocate to other countries to practice OT and how they adapt to these challenges. The researcher interviewed seven occupational therapists, three from the US and currently practicing in other countries, and four who were educated in other countries and are currently practicing in the US. Interviews were recorded, transcribed and analyzed for themes and trends. Three main themes emerged: general challenges occupational therapists face when working in a foreign country; occupational therapy/practice-related challenges, and issues related to OT education. Several subthemes emerged under each of the main themes.

This chapter discusses the significance of the three studies and extent to which they can contribute toward improving OT education. This chapter presents: implications of the research findings to OT education; implications for occupational therapists who practice in foreign countries; limitations of this research; and recommendations for future research.

Implications of the research findings for OT education

In the US, not only is accreditation voluntarily sought by institutions of higher education and is generally thought of as a peer-review process, but also it has been incorporated into other vital aspects of higher education such as grants, funding and licensure. In addition, accreditation has been known to be the most potent lever for curricular reform (Greiner& Knebel, 2003). Consequently, in order for ACOTE to ensure that OT education in the US reflects the global trends of OT education, ACOTE would need to incorporate some of the WFOT standards into its own. This incorporation is especially important for the standards that were least covered by the participants of this research. Examining Tables 4 and 5 reveals that some competencies were not sufficiently covered by some of the universities. For example, 25 of the categories or subcategories were covered at or below 50% by the five universities individually at the levels of Knowledge, Skills or Attitudes. Moreover, 16 of the same categories or subcategories were covered at 51% to 75% (Table 4). When the averages of the Knowledge, Skills or Attitudes were combined for each university, the universities covered 16 categories or subcategories at or below 75% (Table 5). As stated in Chapter III, the OT programs that participated in Study Two were accredited using the ACOTE 1998 standards, so it will be

interesting to repeat this research with OT programs that have been accredited using the 2006 ACOTE standards. At a "grass root" level, OT educators can start incorporating some of the WFOT standards within their syllabi, even before the ACOTE requires educators to do that. OT educators can designate part of their syllabi, or one assignment of the class to examine the topic being studied from a global view. For example a class that deals with pediatrics, can assign one session to deal with disabling conditions in other countries. Alternatively, the instructor can require the students to present about health systems in other countries. The WFOT provides a forum to occupational therapists from across the globe to share ideas, ask questions, or participate in special interest group. This forum is called Occupational Therapy International Outreach Network (OTION); OT educators in the US should encourage their students to access that forum to familiarize themselves with OT practice in other countries.

Another implication for OT education could be in the form of adding an "international touch" to the American standards of OT education. This "international touch" is especially important, since ACOTE sets standards for OT programs to graduate practitioners to serve clients in one country, with somewhat comparable healthcare systems, health care priorities, and health conditions. Those therapists may not be familiar with health care practices, beliefs or priorities in other countries. Incorporating some background about international healthcare philosophies, beliefs and practices into ACOTE standards could facilitate the preparation and mobility of American occupational therapists when working in other countries. Two of the three American occupational therapists who were interviewed for Study Three suggested that their OT education could

have been improved if their universities had included more coverage about healthcare issues, systems, and conditions in other countries.

Implications for foreign occupational therapists

Study Three focused on exploring the challenges and adaptation of occupational therapists who decide to leave their native countries to practice in another country. This issue has not been addressed by other OT researchers, which makes it an area of research that needs further exploration at many levels. The challenges of occupational therapists can be examined and compared to the challenges and adaptation of other heath care professionals. Furthermore, the educational process that produces competent therapists can be examined to investigate what factors lead to better adaptation by the therapists in other countries.

One of the ways that the findings of the third study can be beneficial to therapists is by having employers made aware of the different challenges that may face their prospective foreign recruits. As the demand for occupational therapists rises, so does international recruitment. Potential employers need to be aware of the general and practice-related challenges that may face their future employees. Issues included language, political and cultural differences, having to practice in a different healthcare system, and adapting to different OT roles.

Another implication pertinent to occupational therapists is their need to understand the challenges they may face when moving to another country and to be prepared to tackle such potential challenges. If therapists are made aware of the possibility of facing such challenges, they might preplan a response, and these challenges

will not come as a complete surprise. The third study revealed that some occupational therapists preplanned their responses to challenges that they anticipated, even before facing them. These findings need to be explored further to see if they are shared with other healthcare professionals, or only unique to occupational therapists. Furthermore, the extent and types of challenges that occupational therapists experience need to be explored in relationship to the OT curricula that shaped the thinking of the OT students.

The process that occupational therapists experience as they face demands by their new environment, coupled with the desired from within, produces responses that meet the immediate challenges. Later, these responses are integrated within the person to facilitate future adaptation. This process is typical of an adaptive response, as described by the theory of Occupational Adaptation that was outlined by Schkade and McClung (2001). A unique concept to which study three alluded was the concept of preemptive adaptation, where some of the therapists anticipated a challenge, and then they preplanned a response based on this anticipation. This concept warrants further exploration..

Limitations of this research

It is worth mentioning that the sample size for the quantitative survey research was small, and that in order to generalize the findings to the approximately 150 OT programs in the US, the research would have to be repeated with a larger sample size. Furthermore, the five universities that participated in the quantitative research may have not accurately represented the diversity of OT academic programs in the US insofar as the geographic location, the Carnegie Classification, or the university's locus of control i.e. private versus public universities. The principal investigator tried different strategies,

but was unable to recruit more participants who were welling to share their Self-Study Documents.

Another limitation that the researcher faced was the scarcity of literature on studies that used WFOT Standards as a benchmark to examine the standards of OT education. This made it difficult to compare or contrast findings to those of other researchers. The same notion is true of study three that investigated the challenges and adaptation of the foreign-trained occupational therapists. Virtually, no research has been conducted on the subject.

Another limitation that needs to be stressed is that study two evaluated the curricula of OT programs in the US using the WFOT standards as a benchmark. Study two did not examine whether there were any additional standards that were covered by the universities, but were not part of the WFOT standards. A possibility exists that some of the universities may have had included OT standards beyond the emphasis of the WFOT Revised standards. Exploring the standards of OT education in the US that are emphasized beyond the WFOT standards was not one of the aims of Study Two.

Another limitation of Study Two was that the methodology was confounded by several layers of subjectivity. For example, the syllabi that were analyzed were written by faculty in a subjective manner. Moreover, the analysis of these syllabi was from the subjective perspective of the principal investigator.

Recommendations for future research

The researcher was unable to find similar studies that were done to investigate the extent to which syllabi of OT programs in the US matched the WFOT standards of

education. Thus, further studies need to be conducted to confirm or negate findings of this research. If future studies are to be conducted, the researcher feels that a larger and more representative sample of OT programs may yield data that are more generalizable. Another recommendation for future research is to include findings of research in other healthcare professions that compare national and international standards, if such research exists.

Lack of literature was also a limitation for the third study. Virtually no literature exists that explores the challenges and adaptation of occupational therapists when practicing in foreign countries. In other healthcare professions, this issue has been explored. However, no literature was found that addressed the issues of how the healthcare workers adapted, or how their academic preparation helped, or failed to help, in their adaptation process.

Future research could be conducted to explore the competencies that may be required or recommended by ACOTE but not part of the WFOT Revised Standards. Exploring these competencies would be beneficial but was beyond the scope of this research. The principal investigator feels that there are many commonalities between the standards of education of the WFOT and ACOTE, and that each organization may emphasize certain competencies over others for a variety of reasons unique to their purpose.

As stated earlier, the syllabi used for this study were those from OT programs accredited using the 1998 ACOTE standards. Future research can be conducted to match

the WFOT Revised Standards with syllabi of OT programs that had been according to 2006 ACOTE Standards.

Personal reflections

Conducting a dissertation research is similar to a tough and arduous journey, where the road is full of twists and turns, and where unexpected surprises are around each corner of that road. This journey teaches one the value of hard work, dedication, attention to details, and that the rougher the journey the sweeter the reward will be at its end. Simply put, it is a life-changing experience.

Conducting the three studies of this dissertation took about two years, including obtaining IRB approvals, recruiting participants, collecting the data, analyzing the data, and writing the dissertation. The most notable difficulties that I faced were the recruitment of the participants and the "writing up" of the entire dissertation.

Recruiting for any research project and finding the needed sample that is sufficient in quality and quantity and representative of the group is not an easy task and it is expected to take time. For example, for studies two and three, I faced extreme difficulties in finding an adequate number of participants. For Study Two, the difficulty stemmed from the unwillingness of some OT programs to submit their Self-Study Document to be evaluated or examined for research purposes. In addition, it took several trials to get in touch with directors of OT programs, and most of the time the directors were simply inaccessible. Some of them took the time to listen to me, and few of those who listened did agree to participate.

Recruiting for Study Three was difficult because of the lack of an established way to do get in contact with foreign-trained therapists. I knew that there were foreign-trained occupational therapists who are currently working in the US, and that there are US-educated occupational therapists who are currently working overseas. The problem I faced was how to get their contact information, and how to get an adequate number of them to participate in the research.

The second notable problem was the writing of the dissertation. Writing professionally in a language that is not one's native tongue is challenging. To a certain degree this problem was unexpected, because as a practicing occupational therapist I am used to comfortably and professionally communicating with clients and colleagues in verbal and written format. However, writing a dissertation requires a different set of language skills that may magnify one's weaknesses when using a nonnative language. This problem required extra effort for the committee members, as they were reviewing my work not only for content, but also for language and grammar. I also had to solicit more assistance and resources to ensure that my work was meeting the professional standards expected at a PhD level.

Overall, I feel that conducting PhD-level research and writing a dissertation is the end of a "receiving stage" and the beginning of a "giving stage" in one's academic experience. I also believe that the PhD students are expected to go through this "rite of passage" to become future scholars.

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APPENDIX A

IRB Approval

IRB APPROVAL FORM

Name of Investigator(s)	Husny Amerih
TWU ID# (s)	0475597
Name of Research Advisor(s)	Gayle Hersch, PhD, OTR
Address:	1130 John Freeman Blvd.
	TWU School of OT
	Houston TX 77030
Type of Review:	Full ☐ Expedited ☒

Dear: Mr. Amerih

Your study entitled: Applying the standards of education of the World Federation of Occupational Therap selected occupational therapy educational programs in the United States: A therapist's perspective
(The applicant must complete the top portion of this form)

has been reviewed by the **Institutional Review Board** - Houston Center and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health and Human Services regulations typically require that signatures indicating informed consent be obtained from all human subjects in your study. These are to be filed with the **Institutional Review Board** Chairman. Any exception to this requirement is noted below. Furthermore, according to HHS regulations, **another review by the IRB is required if your project changes or if it extends beyond one year from this date of approval.**

Any special provisions pertaining to your study are noted below:

_____The filing of signatures of subjects with the Institutional Review Board is not required.

_____Other: see attached sheet.

_____No special provisions apply.

Sincerely,

Gretchen Gemeinhardt, PhD
Chair, IRB - Houston Center

02/03/06
Date

IRB–H 2004–31

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
Institutional Review Board
1130 John Freeman Blvd., Houston, Texas 77030 713/794-2074

MEMORANDUM

TO: Gayle Hersch
Husny Amerih TWU ID #0475597

FROM: IRB

DATE: February 2, 2006

SUBJECT: IRB Application

Proposal Title Applying the standards of the World Federaion of Occupational Therapists to selected educational programs in the United States: A therapist's perspective

Your application to the IRB has been reviewed and **approved.**

This approval lasts for 1 year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.

Any changes in the study or informed consent procedure must receive review and approval prior to implementation unless the change is necessary for the safety of subjects. In addition, you must inform the IRB of adverse events encountered during the study or of any new and significant information that may impact a research participant's safety or willingness to continue in your study.

REMEMBER TO PROVIDE COPIES OF THE SIGNED INFORMED CONSENT TO THE OFFICE OF RESEARCH, MGJ 913 WHEN THE STUDY HAS BEEN COMPLETED. INCLUDE A LETTER PROVIDING THE NAME(S) OF THE RESEARCHER(S), THE FACULTY ADVISOR, AND THE TITLE OF THE STUDY. GRADUATION MAY BE BLOCKED UNLESS CONSENTS ARE RETURNED.

Gretchen Gemeinhardt, Ph.D.
Chairperson

APPENDIX B

Consent Forms

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICPATE IN RESAERCH

Title: Applying the Standards of Education of the World Federation of Occupational Therapists to Selected Occupational Therapy Educational Programs in the United States: A Therapist's Perspective.

Investigator: Husny Amerih, MSc, OTR ..... (469)733-6109, hya01@yahoo.com
Advisor: Gayle Hersch, PhD, OTR ..... (713)794-2153, ghersch@mail.twu.edu

Explanation and Purpose of the Research:

You are being asked to participate in a research study for Husny Amerih's dissertation at Texas Woman's University. This study aims to explore the adaptation process of occupational therapists who graduated from occupational therapy (OT) schools with one set of educational standards and are practicing in another country with a possible different perspective on OT services. The study will try to explore the following issues: 1) the perception of the occupational therapist to his/her readiness to practice OT in a different country. 2) The challenges that face therapists who practice OT in different countries, and 3) the process of adapting to such challenges.

Research Procedures:
The investigator will recruit approximately six to eight occupational therapists for this study. You will be interviewed once; other interviews may follow if needed to verify or clarify themes. The length of each interview is estimated to be 45-60 minutes. Follow up interviews may be conducted if necessary, for additional 30 minutes. Total time for the interviews is estimated to be 45 to 90 minutes. No more than two follow up interviews are expected. Follow up interview/s, if any, is/are expected to take place within 6 months after the first interview.

The interviews will be conducted face-to-face or over the phone. They will be audiotaped and later transcribed verbatim. Questions will focus on your perception of your readiness to practice in other countries, and on the strategies you have employed to deal with the challenges of the new environment. Probes may follow the set questions if needed.

Potential Risks:
Potential risks related to your participation in this research include loss of confidential information. Confidentiality will be protected to the extent that is allowed by law. To minimize this risk your name will be kept confidential; you will be identified by a code

name or code number. Only the investigator, his advisor and the transcriber will have access to the audiotapes. The tapes and transcripts will be kept at a locked file cabinet at the researcher's house, and will be destroyed at the end of the data collection and analysis period.
Another possible risk is the loss of your time; the researcher will arrange interviews at a time (and a place, if the interview are conducted face-to-face) that is convenient for you.

The researcher will try to prevent any problems that could happen because of this research. You should let the researcher know at once if there is a problem and he will help you. However, TWU does not provide medical or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits:

This study will potentially contribute to the existing knowledge about OT education and to the knowledge about therapists' abilities to adapt to working in challenging environments. Participation is voluntary and you may withdraw from the study without penalty.

Questions regarding the Study:

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researcher; his contact information is at the top of this from. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact Texas Woman's University Office of Research at 713-794-2480.

_____ _____

Signature of Participant Date

The above consent form was read, discussed and signed. The person signing this consent form did so freely and with full knowledge and understanding of its content.

_____ _____

Signature of Investigator Date

CONSENT TO RECORD

Texas Woman's University

Applying the Standards of Education of the World Federation of Occupational Therapists to Selected Occupational Therapy Educational Programs in the United States: A Therapist's Perspective.

You consent to have your voice recorded by Husny Amerih, acting under the authority of the Texas Woman's University, for the purpose of the research project entitled "Applying the Standards of Education of the World Federation of Occupational Therapists to Selected Occupational Therapy Educational Programs in the United States: A Therapist's Perspective".

You understand that the material recorded for this research will be made available for research purposes and consents to such use.

_____ _____

Participant Date

The above form was read, discussed and signed. The person signing this consent from did so freely and with full knowledge and understanding of its content.

_____ _____

Representative of the
Texas Woman's University Date

APPENDIX C

Interview Guide

Interview Guide:

Tell me about your background and experience as an occupational therapist.

When you moved to a different country to practice occupational therapy (OT), what challenges did you face?

Describe the challenges of the new work environment.

Describe your desires to overcome those challenges.

How did you respond to those demands?

Describe the processes that led you to respond in the way you did.

What was/were the outcome/s of your responses?

How did your education as an occupational therapist help, or fail to help, you in your adaptation process?

APPENDIX D

WFOT Revised Standards of Education

WFOT Standards of Education Competent Occupational Therapy Practice

A	The Person-Occupation- Environment Relationship: A-1: Occupation:	Knowledge	Skills	Attitudes	Is competence covered at K, S or A level? 1=Yes, 0=No
Knowledge	What occupation is.				
	Cultural influence on occupation				
	Why people engage in occupation				
	How occupation is performed and organized				
	The characteristics of skilful performance				
	The Temporal aspects of occupation				
	The subjective experience of occupation				
	The outcome of occupation for the individual, the group, the society and the environment.				
	How occupation can be used therapeutically				
Skills	Assessing individual's and group beliefs about occupational goals				
	Assessing occupational performance skills				
	Assessing capacity for occupation				
	Assessing activity limitations				
	Assessing participation				
	Assessing the outcome of participation				
	Analyzing, adapting and grading occupations				
	Using occupation therapeutically				

Attitudes	Attitudes toward individual and cultural differences in beliefs about occupations				
	A-2. Person:				
Knowledge	People as occupational beings				
	Feelings about participation in occupation/s				
	The relationship between occupation and human development				
	The relationship between psychological factors and occupation				
	The relationship between body structure and function and human capacity to participate in occupation				
	The experience and expression of personal meaning through occupation				
	How changes may alter people participation in occupation or the experience of participation				
	How do people manage in order to preserve the potential to participate in occupation				
Skills	Skills in assessing personal factors that affect participation				
	Applying theories, research findings, and principles to provide occupational therapy for individuals, organizations or communities.				
Attit*	Attitudes about the value of every person ability to adapt and change.				

	A-3. Environment:				
Knowledge	How aspects of the social and cultural environment affect people's participation in occupation.				
Knowledge	How resources in the environment affect people's participation in occupation.				
Knowledge	How aspects of the institutional environment affect people's participation in occupation.				
Skills	Assessing how the environment facilitate or creates barriers to participation in occupation				
Skills	Modifying aspects of the environment to promote participation				
Attit*	Attitudes towards factors that presents barriers to participation and attitudes about the environments in which people chose to live.				
	A-4. The Relationship Between Occupation and Health:				
Knowledge	How Activity limitations and participation in occupation affects health				
Knowledge	How health conditions affects participation in occupations				
Skill.	Skills in assessing health in relation to occupation				
Attit*	Attitudes towards others' beliefs about health and causes of illness				

B	Therapeutic and Professional Relationships:	Knowledge	Skills	Attitudes	
Knowledge	The characteristics of therapeutic relationship and communication processes				
	The importance of teamwork, how to establish effective working relationships				
Skills	The skills needed in establishing relationship with different people, and communicating wit them in a culturally appropriate ways.				
	Working within an organization, and establishing effective working relationships with different people				
Attit*	Respecting other's cultural beliefs and practices.				
	Attitudes toward other team members to maximize outcome for recipients of occupational therapy				
C	Occupational Therapy Process:	Knowledge	Skills	Attitudes	
Knowledge	Screening the need for occupational therapy				
	Assessment of occupational needs				
	Collaborating with the recipient(s) to define their occupational need(s) and goal(s)				
	choosing and planning relevant occupational intervention to promote health and well-being				
	Implementing the intervention and monitoring its effectiveness				

	evaluating the outcome of intervention				
	Maintain records of O.T. referral, assessment, intervention, and outcomes				
Skills	Skills in carrying out the O.T. process, engaging the recipients in the process and documenting the interventions				
Attit*	Attitudes toward implementing the process in a thorough and professional manner				
D	Professional Reasoning and Behaviors: D-1: Research/Information Search Process:	Knowledge	Skills	Attitudes	
Knowledge	Find theoretical information and research results				
	Evaluate the consistency of theories and research findings with OT philosophy				
	Evaluate the relevance and trustworthiness of information and research findings.				
	Make judgments between conflicting information.				
Skills	Effectively locating, understanding, evaluating and applying, information, to practice, and justifying practice using theory and research results.				
Attit*	Attitudes toward ensuring that practice is informed by the best available information				

	D-2: Ethical Practice:				
Knowledge	Ensuring that the recipients of services are informed.				
	Consent to assessment and intervention processes.				
	The confidentiality of client information.				
	The public need to know about possible risks.				
	Determining eligibility for O.T. services.				
	Determining when to stop O.T. intervention.				
Skills	Recognizing ethical dilemmas.				
	Identifying the moral attributes and characteristics that should be demonstrated.				
	Deciding on an ethical course of actions.				
	Justifying perspectives and actions.				
Attit*	The value and necessity of ethical practice.				
	D-3: Professional Competence:				
Kno*	Knowing one's own knowledge, skills and attitudes, and how current and acceptable they are.				
Skills	Evaluating the adequacy of own knowledge, skills and attitudes.				
	Recognizing when knowledge, skills, attitudes need improvement.				
	Continually improving knowledge, skills and attitudes.				

Attit*	Attitude towards continually improve knowledge, skills, attitudes throughout professional life.				
	D-4: Reflective Practice				
Kno*	Knowledge about theories of reflective practice.				
Skills	Skills in systematically reflecting on the quality of one's own practice				
	People experience of receiving O.T.				
	The effectiveness of O.T. for recipients.				
	The impact of O.T. on recipient's human and physical environment				
	Interactions with members of the health care team				
	The impact of O.T. on the community.				
Attit*	The need to think about how effective one's actions are.				
	D-5: Managing self, others and services				
Knowledge	Knowledge about expectations and processes for accountability, quality improvement, service development and promotion, and effective management of resources.				
Skill.	Monitoring and preserving health while practicing OT.				
	The ongoing improvement of services.				
Attit*	Attitude toward the importance of managing own and others performance.				

E	Context of Professional Practice	Knowledge	Skills	Attitudes	
Knowledge	Knowledge about human rights in relation to health and well-being				
	Cultural understanding of health and well-being				
	Determinants of health and well being				
	National health needs, priorities and goals				
	Health, welfare and disability systems				
	Relevant health, welfare, disability, consumer, access and workplace legislations.				
Skills	Planning and delivering accessible OT.				
	Influencing the development of relevant services and legislation				
	Working within different health, welfare and disability services				
	Managing the delivery of services				
Attit*	Attitudes toward people's right to receive health services.				

Attit*: Attitudes. Kno*: Knowledge.

APPENDIX E

Publication Correspondences

Subject:	Occupational Therapy International # 151
Date:	Fri, 1 Jun 2007 09:12:09 -0500
From:	"Stein, Frank" <Franklin.Stein@usd.edu>
To:	"Husny" <hya01@yahoo.com>

Dear Husny:
This letter is to acknowledge receipt of an e-mail attachment of your manuscript: A Literature Review of the Accreditation Council of Occupational Therapy Education and the World Federation of Occupational Therapists Standards for Occupational Therapy Education, for possible publication in Occupational Therapy International. After receiving the hard copies, two referees will evaluate your manuscript and the reviews should be sent to you in about three to four months. I have attached the author's acknowledgement form. Please sign the form and return it to me at: Dr. Franklin Stein, Editor, Occupational Therapy International, 7334 New Washburn Way, Madison, WI, 53719-3010.

Best wishes,

Franklin Stein, PhD, OTR, FAOTA
Editor, Occupational Therapy International
fstein@usd.edu
----Original Message-----
From: Husny [mailto:hya01@yahoo.com]
Sent: Fri 6/1/2007 2:16 AM

To: Stein, Frank
Cc: g hersch
Subject: Research submitted to OT international

Hello Dr Stein,
I'm attaching my research entitled: " A Literature Review of the Accreditation Council of Occupational Therapy Education and the World Federation of Occupational Therapists Standards for Occupational Therapy Education" to be reviewed for possible publication in Occupational Therapy International.
I have ready two identical copies that I will mail to you tomorrow, in addition to the required Copyright Transfer Agreement and the Copyright Permission Request Form.

Please confirm receiving this email.

Thank You.
Husny Amerih, MSc,OTR

Date:	Thu, 24 May 2007 12:58:01 -0400 (EDT)
From:	occupationaltherapy@blackwellpublishing.com
To:	hya01@yahoo.com, husny@twu.edu
Subject:	Australian Occupational Therapy Journal - Manuscript ID AOTJ-2007-048

24-May-2007

Dear Mr. Amerih:

Your manuscript entitled "Applying the Standards of Education of the World Federation of Occupational
Therapists to Selected Occupational Therapy Schools in the United States" has been successfully submitted online and is presently being given full consideration for publication in the Australian Occupational Therapy Journal.

Your manuscript ID is AOTJ-2007-048.

Please complete the attached Exclusive Licence Form and return to the Editorial Office by post as soon as possible. This form can also be found in the 'Instructions and Forms' link of the site.

Please mention the above manuscript ID in all future correspondence with the Editorial Office. If there are any changes in your street address or e-mail address, please log in to Manuscript Central at http://mc.manuscriptcentral.com/aotj and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Centre after logging in to
http://mc.manuscriptcentral.com/aotj .

Thank you for submitting your manuscript to the Australian Occupational Therapy Journal.

Sincerely,
Martha Rundell
Australian Occupational Therapy Journal Editorial Office

Date:	Tue, 26 Jun 2007 08:03:21 -0500
To:	"Husny" <hya01@yahoo.com>
From:	"Marcia Finlayson" <cjoteditor@caot.ca> Add to Address Book Add Mobile Alert
Subject:	Re: Fwd: Reserch Submitted for Publication at CJOT- Husny Amerih

Husny Amerih,

I received your submission and am currently reviewing it to determine if it fits with our publication. I will be in touch.

Marcia Finlayson

At 12:55 AM 6/26/2007, you wrote:

Dear Dr. Finlayson

I'm submitting this research entitled "The challenges and adaptation of foreign-educated occupational therapists" for publication at the CJOT.

I sent you a hard copy yesterday .
** Please confirm receiving this email.

thank you,
HA