PROFESSIONAL ESTEEM OF UNITED STATES OCCUPATIONAL THERAPISTS

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To the Dean of the Graduate School:

I am submitting herewith a thesis written by Patricia Kathleen Fader entitled "Professional Esteem of United States Occupational Therapists". I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in occupational therapy.

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ABSTRACT

Professional Esteem of United States
Occupational Therapists

by Patricia K. Fader, August 1989

The professional esteem of occupational therapists was measured identifying professional characteristics that occupational therapists believe they possess, and some factors that heighten the professional esteem of the occupational therapist. The Schling Professional Esteem Scale and a questionnaire were completed by 248 randomly selected members of the American Occupational Therapy Association. The results indicated that occupational therapists responded positively toward possessing Moore's five professional characteristics: commitment to the profession, representation by an established organization, possession of specialized knowledge, diagnostic skill, and autonomy of judgement. However, the respondents indicated that commitment to occupational therapy and autonomy of judgement were not strongly present. The respondents believed none of the five characteristics were strongly evident to physicians and the public. The study noted

that therapists residing in the East had higher professional esteem than therapists in the West ($p<0.04$) and that therapists who had participated in conference presentations, research, or published had higher professional esteem ($p<0.01$).

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CHAPTER I

Introduction

The nature of occupations and professions is constantly changing and the characteristics of what constitutes a profession are often unclear. Moore (1970), Schein (1972) and Etzioni (1968) have all tried in various ways to describe the characteristics of a professional as determined by our society. Etzioni recognizes that there are many disciplines on a continuum between occupation and profession. He terms these disciplines as semi-professions. It is currently unclear where occupational therapy fits on the continuum from occupation to profession. According to Fidler (1979), occupational therapists desire the recognition, acceptance and prestige of being called professional but are often uneasy with efforts to explore the nature of their identity, fearing they may fail to be proclaimed professional. However, it is important to explore the nature of this identity to determine how to plan and manage change within occupational therapy.

Purpose and Significance of the Study

The purpose of this study was to explore the professional identity of occupational therapists, specifically identifying the characteristics of professions that occupational therapists believe they possess and those they need to strengthen. The study also identified some of the factors that heighten the professional image of the individual therapist. The information from this study is of value to the leaders, educators, and members of occupational therapy. The leaders of occupational therapy organizations can use the information to further explore the issue of professionalism in occupational therapy. Educators can use the information to structure the socialization processes in schools of occupational therapy. Individual therapists can use this information to direct their career choices to promote the prestige, recognition and acceptance of occupational therapy.

Study Questions

What is the current professional image of occupational therapists within the United States as

measured on the Schling Professional Esteem Scale and what factors heighten the professional image of the individual therapist?

Research Objectives

1. This study assessed how occupational therapists perceive the profession of occupational therapy in relationship to possessing Moore's five characteristics.

2. The study also determined how occupational therapists perceive how physicians and the public view occupational therapy in relationship to Moore's five characteristics to determine if the internal self esteem of occupational therapists is greater than their external esteem.

3. The study assessed the relationship between the individual therapist's profession behavior and the therapist's professional esteem. The scores on the Schling Professional Esteem Scale were analyzed in relation to questions answered on the respondents behavioral profile questionnaire. Professional behaviors addressed by the questionnaire study were as follows: (a)

the length of time a therapist has been in the field of occupational therapy, (b) full-time employment, (c) membership in the state association, (d) involvement in their district, state or national organization, (e) participation in activities that increased knowledge and skill such as pursuing postbaccalaureate degrees, attending continuing education events, specializing in an area of practice, seeking advanced certification in professional skills, being a member of other professional organizations, having presented at a continuing education conference, published a professional paper or been involved in research which has or could contribute to the occupational therapy body of knowledge, (f) the use of standardized unmodified evaluations or formal evaluations rather than informal evaluations or not evaluating patients, and (g) the type of patient billing used by the therapist.

4. The relationship between the scores on the professional esteem scale and the degree of autonomy the therapists have in their current positions was examined by asking whether consultants, educators and therapists in private practice and therapists who receive consults

rather than prescriptive orders from physicians have higher self esteem.

5. The study assessed whether other factors were related to the professional esteem of the therapist. Additional factors that were considered in this study included sex, region of the country, and the area of occupational therapy in which the therapist has primarily worked (psychiatry, physical dysfunction or pediatrics).

6. The relationship was examined between professional esteem scores and the therapist's belief that entry level education for occupational therapists should be at the masters degree level.

Definition and Explanation of Terms

"Professional characteristics" for the purpose of this study was based on Moore's (1970) list of professional characteristics as interpreted by Schlink, Kling and Shepard (1978). Moore's criteria represent aspects of professionalization and are clusters along the scale of professionalism.

1. The professional has a strong motivation as a basis of a professional career choice and has a lifetime commitment to that career.

2. The professional is represented by an established organization which defines an acceptable level of performance, with rules and standards.

3. The professional possesses a specialized knowledge and skills that are obtained through an extended period of education and training.

4. The professional provides a service which involves diagnostic skill and the competent application of knowledge and skill to the specific needs of the client.

5. The professional demands autonomy of judgement concerning performance within the discipline. Moore states that it is extremely unlikely to achieve autonomy as a profession if criteria one through four have not already been achieved.

"Professional esteem" for the purpose of this study was defined by how a therapist views the profession in relationship to Moore's five professional characteristics and was measured by the Schling Professional Esteem Scale.

CHAPTER II

Literature Review

In 1928, Carr-Saunders, a social scientist described professionalism as a formation of professional associations, possession of specialized skill and training, requirement of financial compensation, and internalization of a code of ethics which control professional behavior. He further indicated professionals seek to establish the minimum qualifications for entry into the profession, regulate the professional conduct of the membership and improve its status in society (Vollmer 1966).

Vollmer in 1966, distinguished five elements of professionalism upon which he believed there was consensus among authors. Specifically these were: a systematic body of theory, authority, community sanction, ethical codes and a culture. Although professions require superior skills, a true profession has also developed a body of theory. Since theory is so important to professional knowledge and skill, apprenticeships are

inadequate and professional schools are developed. Medicine, law, the ministry, and university teaching are the traditional professional groups and some newer professional groups include dentistry and architecture.

Occupational Therapy Literature Review

Based on the authors in a book edited by Etzioni (1969), as well as work by Vollmer (1966) and Friedson (1970), Fidler (1979) discussed the issues of whether occupational therapy was a profession. She stated that it was not an issue of being professional versus being non-professional, but an issue of where occupational therapy is currently on the continuum from occupation to full fledged profession. Fidler further interpreted and outlined the factors that distinguished an authentic profession from a semi-profession. This list can be organized into basically two major traits of professionalism, the knowledge base and the ideal of service (Goode, 1969). The factors included by Fidler were as follows:

1. A rigorous, prolonged education and apprenticeship which requires the sacrifice of time and money to focus on

the mastery of professional content with prerequisite requirements at an undergraduate level being required. A full-fledged professional training lasts five years or more.

2. The knowledge and skills are abstract and organized into a systematic body of principles applicable to the concrete problems of living.

3. The society or its relevant members believe that the knowledge can solve life problems and accepts the professional group as possessing that knowledge (while other groups do not), establishing a trust with the occupational group and allowing it autonomy.

4. The professional group has the most highly developed body of knowledge in the relevant field and is accepted as the final judge in any disputes within its area of supposed competence. The body of knowledge is created, organized and transmitted by the profession.

5. Professionals are committed to the norms of the profession and have a strong identity. There is an internalized code of ethics, a collegial relationship with peers forming occupational communities and control is

exercised from within the group, which alone is qualified to make professional judgements.

6. There is responsibility for defining the client's needs or problems and determining appropriate intervention.

7. The professional practice deals with critical life and death matters, which involve trust on the part of the client. Society believes it suffers great loss if the members do not have sufficient knowledge and believes it is harmed by unethical or incompetent practice by members of the profession.

Fidler also reviewed and synthesized the work of Etzioni and associates (1969) which characterized the semi-professions. The semi-professions require a shorter training period, have poorly defined theoretical knowledge and skills, are not viewed by the public as essential, are similar to competitive groups, emphasize credentialing for different levels of responsibility, have a high turnover rate reducing the development of colleague groups, are supervised by outside professions or bureaucracies, and obtain prestige or are rewarded by organizational position not task performance. She related that the professional

is task oriented putting the welfare of the client before personal needs, gains or interests while the semi-professions have a holistic orientation to be helpful to others. It was noted that occupational therapy is comprised mostly of women which affects the values and norms held by the organization and its membership. Women are less likely to seek professional status and in fact, no socially accepted profession is currently dominated by women. Fidler discussed how the socialization of women in our society contributes to difficulties in shaping a professional identity. She questioned whether occupational therapy had actually reached professional status and concluded that there was a need to further explore its professional identity to provide direction to the discipline of occupational therapy.

An alternative view by Jantzen (1979) declared "if we continue with much internal discussion about professional, semi-professional, technical, or vocational, we will only bring upon ourselves the worst results we can envision (pp. 71)." However, there was no further discussion that indicated what dreadful results would occur if

occupational therapists examined professional identity issues.

Reed (1983) explored the issue of our professional image by comparing the characteristics of occupational therapists with Schein's (1972) criteria. The criteria were (a) engagement in the occupation full-time, (b) strong motivation to career choice and a lifetime commitment to the career, (c) possession of a specialized body of knowledge and skills which are learned through a prolonged period of education and training, (d) decisions made for the client based on general principles, theories or propositions, (e) a service orientation, (f) provision of a service that is based on the objective needs of the client and the relationship rests on a mutual trust between the professional and client, (g) insistence on autonomy of judgement of his or her performance, (h) professional associations which define the criteria of admissions, education standards, licensing or other formal entry lines and areas of jurisdiction, (i) knowledge that is assumed to be specific, (j) sanctions against advertising or seeking out clients. Reed concluded occupational therapists met criteria a, f, h, and j and

questioned whether occupational therapists met the other six of the criteria. She was convinced occupational therapists could meet Schein's criteria if the effort were put forth.

The level of higher education required by a profession affects the status and acceptance of a profession by society and by other professionals. Reilly (1958) and Jantzen (1958) suggested that the entry educational level of occupational therapists should be at the masters level. Since then some educational programs have offered an entry level master's degree in occupational therapy. Rogers and Mann (1980) explored the relationship of the educational level of occupational therapists to professional productivity in the areas of practice, education, research, publication, professional activities, and health care policy planning. The subjects were 409 currently practicing occupational therapists who had been students from 1966 to 1975 in either certificate, bachelor, or masters degree programs. A significant difference was noted between the productivity of therapists from bachelor or certificate programs and therapists from masters level programs. Therapists from

masters degree programs contributed more in the areas of practice, education, research, publication and professional activities, although there was no difference between an entry level professional masters degree student, a post-professional masters student and a masters earned in another field. It was noted that only 5% of the sample were therapists who had graduated from an entry level professional masters program. The study also indicated therapists differed in their professional contributions when grouped according to the occupational therapy school from which they graduated. Rogers and Mann recommended upgrading the level of occupational therapy education from a bachelors to an entry level professional masters level in order to improve the leadership potential, extend and improve services to patients, students, science and society.

Clark, Sharrot, Hill, and Campbell (1985) surveyed 346 currently practicing occupational therapists who were students, from 1970 to 1979, in either the baccalaureate or entry level professional masters degree programs at the University of Southern California. The study indicated a greater percentage of entry level professional master

graduates were involved in research, published articles, presented papers at professional conferences, held leadership positions and received grant funding. This study supported the conclusions of Rogers and Mann (1980).

In contrast, Gilkeson and Hanten (1984) published the results of a national survey comparing the professional productivity of entry level masters graduates to baccalaureate graduates and found essentially no statistically significant differences between the two groups.

Gillette and Kielhofner (1979) discussed the possible effect of specialization in occupational therapy on professionalization. Specialization occurs because of an acknowledged need for increased knowledge and skill to provide a higher quality of service to clients. Specialization can cause fragmentation within an occupational discipline if a core body of knowledge has not been developed and taught to the members. Gillette et al. (1979) suggested that occupational therapists have chosen to specialize because as evolving professionals, they have tried to develop an identifiable service. The authors believed specialization was already occurring

within occupational therapy and that occupational therapists must identify and clarify a core body of knowledge to prevent fragmentation of the discipline.

Fidler (1979) also addressed the effect of specialization on the professionalization of occupational therapy with a emphasis on the implications for education. She stated that specialization does contribute to the knowledge base but that a generic frame of reference for occupational therapy and an extended period of preparation is needed as the foundation toward professionalization. She believed the focus of occupational therapy must be on the content and design of entry level education and that occupational therapy was seriously limited by a less than rigorous basic education. She felt the issue was not actually specialization but rigorous academic preparation.

Parham (1987) asserted that occupational therapy should be considered a profession since it addresses an aspect of human functioning and is important to the well-being of society. However, she recognized that occupational therapy falls short of having the attributes of a mature profession. Her recommendations for the professional development of occupational therapists were

to pursue graduate education, form professional relationships through networking with occupational therapists, critique clinical thinking to identify underlining theory, demonstrate the value of occupational therapy concepts through relationships with other professionals, learn to analyze contradictory points of view, be a research consumer and contributor, present as a professional in appearance. She stated that it is the practitioners' responsibility to move occupational therapy towards professionalism.

Breines (1988) addressed the issue of professionalism by suggesting that occupational therapists redefine professionalism to fit the professions current characteristics. She argued that a discipline rather than society should define its' professionals.

Prestige of Allied Health Professions

Parker and Chan (1987) did a study to determine the prestige ratings of the allied health professionals within the health field. They surveyed forty-eight physical therapists and fifty-six occupational therapists from five large urban hospitals, seventy-one nurses attending their

monthly professional association meetings in two large cities and ninety-five physicians (25% were surgery residents in a major teaching hospital and 75% were private practitioners attending their county medical society meeting). Physicians ranked speech pathologists, social workers, physical therapists, physician assistants, audiologists, and registered dieticians above occupational therapists in prestige. Rehabilitation counselors, dental hygienists, radiological technologists, respiratory therapists, and medical records administrators were ranked by physicians as having less prestige than occupational therapists. Physical therapists ranked themselves, speech pathologists, social workers, and audiologists above occupational therapists in prestige. Physical therapists ranked themselves first. Occupational therapists ranked themselves fourth, ranking physical therapists first, then speech pathologists and audiologists. Overall, speech pathologists, physical therapists, social workers, and audiologists were ranked highly on the prestige scale, (only physical therapy currently does not require a masters level education) while medical technologists, dental hygienists, respiratory therapists and radiology

technologists ranked lowest (three out of four of these require less than four year degrees). Occupational therapists ranked somewhere in the middle. Parker and Chan (1986) claim "occupational therapists and physical therapists acknowledge in their literature that they share some commonalities in philosophy and practice (pp. 249)." The authors found it surprising that occupational therapists did not perceive their status to be as high as physical therapists. They suggested that occupational therapists adopt new strategies to enhance their professional image through self-study, public relations and by reviewing postbaccalaureate credentialing and its implications for occupational therapy.

Physical Therapy Literature Review

Daniels, in 1974, encouraged physical therapists to change the basic education requirements to a masters level. She stated several factors that prompted the need for this change. Economically there was more demand and ability to pay for medical care. There had been a shift from the concept of medical care to the more comprehensive term health care with emphasis on the full range of

patient services which required additional skills of the health care worker. The changing patterns of health delivery such as self employment, community health programs, the use of health teams and the use of certified technicians required higher levels of knowledge and skill. The physical therapist was at a disadvantage in establishing peer relationships within the health care team since the physician, social worker, psychologist, speech therapist and others were graduate level professionals. Concerning the cost of the professional masters degree program, Daniels pointed out that most undergraduate physical therapy programs required 4-8 months more of training than traditional undergraduate programs. There was also noted a high level of interest and applications to current professional masters programs. Daniels felt the profession of physical therapy was still evolving as a profession and called for greater breadth and depth in educational preparation.

Hislop (1975) explained that a profession is valued by society in three spheres: scientific merit, humanistic merit and social merit. She explained to physical therapists that increasing education in the sciences does

not exclude having the qualities of sympathy and compassion. She explained that the individual therapist needs to be both scientist and humanist to provide excellent care. She encouraged physical therapists to elevate the role of the clinician, to reward clinical excellence, and to encourage therapists to remain in patient care. Hislop believed the survival of physical therapy depended on providing a service that was unique and distinct but not equaled in its excellence, breadth, and depth by any other group.

Schlink, Kling, and Shepard (1978) assessed the professional image of California physical therapists who were members of the American Physical Therapy Association using the Schling Professional Esteem Scale. This scale measured three perspectives of professional esteem, an internal perspective (how the therapist perceives herself as a professional) and two external perspectives (how the therapist thinks the physician and general public view her as a professional). The authors examined independent variables to determine their relationship to professional image. Physical therapists were found to have higher scores on the internal professional image scale than on

the external professional image scales. Therapists who were involved in consultation as a career related activity, were sent consults rather than prescriptions by physicians, were involved in physical therapy organizations, considered themselves to be a specialist, or held a masters degree had heightened professional esteem scores.

Silva, Clark, and Raymond (1981) surveyed the attitudes of California physicians toward the professional image of physical therapists by using a part of the Schling Professional Esteem Scale. Although the physicians surveyed indicated physical therapy had Moore's five professional characteristics, there was a markedly lower positive response toward physical therapists' evaluative skills and autonomy of judgement. Silva et al. (1981) felt physical therapists could enhance their professional image by involvement in the professional organization, peer interaction with physicians, and the possession of a masters degree.

Luna-Massey and Smyle (1982) surveyed California physical therapy consumers by using part of the Schling Professional Esteem Scale questionnaire. These consumers

believed physical therapists had Moore's first three characteristics but perceived the physician as having significantly higher evaluative skill. Less than 50% of the consumers recognized the physician or the physical therapist as having autonomy of judgement. The study concluded that physical therapists were recognized by consumers of physical therapy services as professionals but Silva et al. (1981) suggested that the general public needed to be surveyed.

In 1979, the American Physical Therapy Association passed a resolution to increase the entry level of education for physical therapists to a postbaccalaureate degree by December of 1990. Caston (1982) examined the implications of the change in entry level requirements. She believed the current flexible entry levels of education in physical therapy should be maintained. She cited declining enrollments in higher education, decreased federal funding, lack of qualified physical therapy faculty, manpower issues, and lack of studies on how educational level affects the professional role as reasons for reviewing the decision to increase entry level requirements.

MacKinnon (1984) reviewed the decision to change entry level education requirements in physical therapy to a postbaccalaureate degree. She stated that the American Physical Therapy Association Task Force on Evaluation of Education for Entry Level for Physical Therapists considered these issues:

1. Health care distribution issues including manpower needs, cost, quality assurance programs, and changing patterns of health care.

2. The accountability of physical therapists and the evolution of physical therapy as a profession. A few of the issues discussed were the trend toward practice without physician referral, increased professional knowledge, and the variety of environments in which physical therapists work.

3. Academic concerns including the use of resources, institutional objectives, and educational alternatives.

The emerging theme was the importance and trend toward professional autonomy. The group concluded that the skills and knowledge required to be a professionally autonomous therapist could be best achieved at the postbaccalaureate level. In 1983, the American Physical

Therapy Association reviewed the 1979 resolution and again endorsed the entry-level postbaccalaureate degree for physical therapists.

MacKinnon (1984) addressed some of the professional, economic, political, and educational issues currently facing physical therapy since the decision was made to require entry education at the postbaccalaureate level. The traditional degrees and purpose of entry level education were analyzed and MacKinnon recommended that postbaccalaureate entry level education for physical therapists result in a Masters of Physical Therapy degree.

Semi-professions Rise to Professional Status

Goode (1969) stated that many semi-professions aspiring to be professional will never actually reach the levels of knowledge and dedication to service that the society considers necessary for a profession. Others will be recognized as professional but will continue to be viewed as qualitatively different from the four traditional professions (medicine, law, the ministry and university professor). The endeavors of the semi-professions to rise to professional status or even to

maintain their positions are a source of constant social change which affects similar disciplines. A rising semi-profession, with a new packaging of high level skills, can negatively affect another discipline that possesses similar skills at a lower level. When two semi-professions are similar, the discipline given the most social prestige, power and income will be the one that can claim the most highly developed body of knowledge in the relevant field. However, it was noted by Simpson (1969) that some of the professional master programs in the semi-professions do not build on solid undergraduate foundations, and generally are making only limited progress toward rigorous education. The rise of a semi-profession toward professionalism is affected by other similar semi-professions as well as the traditional professions.

Physical therapy literature indicates physical therapists are seeking to improve their professional status by changing entry level educational requirements to the masters level. This decision will affect similar occupations. Occupational therapy literature indicates there are widely varying views on the professionalization

of the discipline including the issue of entry level education. There continues to be the need to explore the issues of professionalization with the membership of occupational therapy.

CHAPTER III

Methods

Subjects

The subjects were certified occupational therapists who were members of the American Occupational Therapy Association (AOTA). A list of 400 names selected randomly by computer was obtained from the Association. Thus, therapists from throughout the United States were included in the sample.

Instruments

The Schling Professional Esteem Scale developed by Schlink, Kling and Shepard (1978) was used to assess professional esteem and an author constructed questionnaire termed the Respondent Profile was used to obtain demographic and additional professional information.

The Schling Professional Esteem Scale is a copyrighted instrument designed to be used with physical therapists. Permission for the scale to be used in this study was obtained from the author (appendix A). Thus

"occupational therapist" was substituted for "physical therapist" in the questions. The instrument was based on Moore's (1970) criteria of a professional. The scale was divided into three sections: how therapists perceive themselves (OT/professional esteem), how the therapists perceive how physicians view occupational therapists (OT/physician esteem) and how the therapists perceive how the general public views occupational therapists (OT/public esteem). Each section included five statements to which the therapist responded on a Likert-like scale, indicating strongly agrees (SA), agrees (A), disagrees (D), or strongly disagrees (SD) (appendix B). Some of the statements were phrased positively and some negatively, to reduce responder bias. Schlink et al. (1978) tested the construct validity of the Schling Professional Esteem Scale scores by correlation with the Rosenberg's Self-Esteem Scale. Literature review supported the assumption that one's professional and self images are closely related. The total score of the three scales and the PT/physician esteem scale were significantly correlated with the Rosenberg's Self-Esteem Scale (appendix B).

The Respondent Profile (appendix C) requested demographic information (i.e. sex, location, education, length and type of experience). The therapists also indicated their involvement in professional activities including occupational therapy organizations, other professional organizations, continuing education, research, publication, and specialization. In addition, their opinion was elicited about whether occupational therapy entry level education should be a masters' level degree.

A pilot study was completed with five experienced occupational therapists to support the content validity and clarity of the Respondent Profile questionnaire. Suggestions for improvement in the clarity and content of the questionnaire were made by three of the therapists. Following the recommendations of those therapists the author constructed a second questionnaire including questions concerning the type of evaluation predominantly used by the therapist, the type of orders received by the therapist, and direct billing. In a second pilot study, two therapists had difficulty answering the questionnaire because they worked in multiple settings and suggested

that the questionnaire provide for that possibility. This revised Respondent Profile questionnaire was given to five other therapists with satisfactory results.

Procedure

The mailings to the 400 therapists included the Schling Professional Esteem Scale questionnaire, the Respondent Profile questionnaire, a cover letter and a self addressed envelope to improve the response rate. Complete confidentiality was guaranteed (appendix D). Forty nine percent of the random sample of therapists initially returned the questionnaires. A second mailing was sent only to therapists who had not responded to the first mailing. A follow-up cover letter, both questionnaires and a return envelope were included in the second mailing.

Analysis of Data

The technical analysis of the data was done using StatPac-Statistical Analysis Package for the IBM computer. Initially, the Schling Professional Esteem Scale responses were scored on a one to four scale with one representing a high presence of professional characteristics and four the

relative absence of the professional characteristics. The scores were calculated for OT/professional esteem, OT/physical esteem, and OT/public esteem with a score of five representing a high degree of professional esteem and twenty the absence of professional esteem. An overall score on the Schling Professional Esteem Scale was also calculated with 15 representing the highest score and 60 the lowest score. The percent of response was determined and analyzed for each characteristic in part A (OT/professional esteem) to determined which characteristics of a professional are currently possessed and recognized by occupational therapists. The scores on the three parts of the Schling Professional Esteem Scale were analyzed for intercorrelation between each part using Spearman's rho correlation coefficients. This information was used to determine if OT/professional esteem scores correlated with the OT/physician esteem and OT/public esteem scores. The Schling Professional Esteem Scale questionnaires were divided into high, median and low scores based on the OT/professional esteem score. High esteem was represented by a score of 5 to 6, median 7-10 and low 11 to a possible 20. The relationship of these

grouped professional self esteem scores and the responses on the Respondent Profile were determined using Chi-square analysis of data. Significant data were analyzed further using Student's t test to compare the means. The locations of the therapists were divided into four regions: West, Midwest, Northeast, and South (appendix E) based on the same divisions used by the U.S. Bureau of the Census (1983). The relationship of OT/professional esteem scores to therapists' belief concerning entry level education for occupational therapists was also analyzed using Chi-square analysis of data.

CHAPTER IV

Results

A total of 287 of the 400 questionnaires (71%) were returned, with 248 questionnaires completed and usable for analysis (62%).

Results of the Schling Professional Esteem Scale

The responses to the individual questions on The Schling Professional Esteem Scale were scored on a 1-4 numerical scale with 1 representing a high presence of the professional characteristic and 4 an absence of the characteristic. A respondent with the score of 1 (strongly agree) or 2 (agree) when combined were classified as agree while respondents with a score 3 (disagree) and 4 (strongly disagree) when combined were classified as disagreed (Table 1).

Professional Characteristic 1. The occupational therapist has a strong motivation and a lifetime commitment toward a career in occupational therapy.

The responses indicated 81% of the occupational therapists agreed that occupational therapists have this

Table 1

Respondents View of Occupational Therapy in Relationship to Five Professional Characteristics

Category	SA*	A	D	SD	Mean±SD**
		Characteristic 1 Commitment to Occupational Therapy			
OT/Professional	30.6%	50.4%	14.1%	4.8%	1.9±0.8
OT/Physician	2.8%	65.3%	30.2%	1.6%	2.3±0.5
OT/Public	6.9%	71.4%	19.0%	2.8%	2.2±0.6
		Characteristic 2 Representation by an Established Organization			
OT/Professional	43.5%	49.2%	7.3%	0.0%	1.6±0.6
OT/Physician	5.6%	66.1%	23.8%	4.4%	2.3±0.6
OT/Public	3.2%	61.5%	31.9%	4.4%	2.4±0.6
		Characteristic 3 Possession of specialized Body of Knowledge			
OT/Professional	65.7%	28.2%	4.4%	1.6%	1.4±0.7
OT/Physician	7.3%	62.1%	27.4%	3.2%	2.3±0.6
OT/Public	12.9%	58.1%	24.2%	4.8%	2.2±0.7
		Characteristic 4 Occupational Therapists Evaluation of Patients			
OT/Professional	80.6%	18.6%	0.8%	0.0%	1.2±0.7
OT/Physician	25.4%	62.5%	10.9%	1.2%	1.8±0.6
OT/Public	6.5%	67.5%	23.0%	2.8%	2.2±0.6
		Characteristic 5 Autonomy of Judgement			
OT/Professional	29.8%	60.5%	8.5%	1.2%	1.8±0.6
OT/Physician	5.6%	64.5%	25.4%	4.4%	2.3±0.6
OT/Public	4.0%	34.7%	54.8%	6.5%	2.6±0.7

* SA=strongly agree A=agree D=disagree SD=strongly disagree
** mean ± standard deviation

characteristic although only 30.6% stated they strongly agreed. Only 2.8% of the respondents felt that physicians strongly agree with the statement with an additional 65.1% believing physicians would agree. The perceived public view approached the OT/professional view in the total positive responses (78.3%) but only 6.9% thought the public would strongly agree. The most common answer for all three categories was agree.

Professional Characteristic 2. The occupational therapist is represented by an established organization which defines the acceptable level of performance with rules and standards.

This professional characteristic was responded to by the therapists with nearly total agreement (93%) being almost equally divided between strongly agree and agree. The respondents thought physicians would agree (71.7%) and the public would agree (63.7%) that occupational therapists have this characteristic. However only 5.6% of the respondents felt physicians would strongly agree and 3.2% thought the public would strongly agree. The most common response for all three categories was agree.

Professional Characteristic 3. The occupational therapist possesses a specialized body of knowledge and skill obtained through an extended period of education and training.

A strongly favorable response was obtained from the respondents with 65.7% strongly agreeing and an additional 28.2% agreeing to the concept. Only 7.3% believed physicians would strongly agree with the statement but an additional 62.1% believed physicians would agree. The therapists felt the public would agree (71.0%) but only 12.9% thought the public would strongly agree. The most common response to the professional characteristic from the OT/professional view of the therapist was strongly agree and from the OT/physician and OT/public view was agree.

Professional Characteristic 4. The occupational therapist evaluates the patients' needs prior to treatment.

The respondents agreed strongly with this statement with 80.6% marking strongly agreed and 18.6% agreed (total agreement 99.2%). The therapists believed physicians overall would agree (87.9%) with many of these therapists

believing physicians would strongly agree (25.4%). The respondents believed the public would also agree (74.2%) with only 6.5% of those respondents believing the public would strongly agree. The most common response to the statement from an OT/professional view was strongly agree and from the OT/physician and OT/public view was agree.

Professional Characteristic 5. The occupational therapist demands autonomy of judgement concerning performance within the discipline.

This professional characteristic was strongly agreed to by 29.8% of the respondents with an additional 60.5% agreeing. The respondents (70.1%) believed physicians would basically agree with the statement with only a few of those respondents believing physicians would strongly agree (5.6%). The respondents (60.3%) believed the public would disagree with this statement. The most common response from the OT/professional view and OT/physician view was agree and from the OT/public view was disagree.

Analysis of Parts A, B, and C. The sum of the three parts (OT/professional esteem, OT/physician esteem, and OT/public esteem) was analyzed for the mean (Table 2).

Table 2

Schling Professional Esteem Scale Score Totals

Category	Mean±SD*
OT/Professional (internal esteem)	8.0±1.8
OT/Physician (external esteem)	11.0±2.0
OT/Public (external esteem)	11.6±2.3

* Mean±standard deviation

Table 3

Mean Professional Esteem Scores by Region of the Country

Region	Number	Percentage	Mean±SD*	p Value **
East	56	22.5%	7.70±1.41	-
Midwest	90	36.3%	8.17±2.10	not significant
South	46	18.5%	7.76±1.77	not significant
West	56	22.5%	8.23±1.63	<0.04

* Mean±standard deviation
** p value determined by Student's t test

The respondents' internal professional esteem was greater than their external esteem.

The significance of the intercorrelations between the scores of each sub-part was assessed using the Spearman's rho correlation coefficients. No significant correlation was found between parts A, B, or C.

Analysis of Part A with Respondent Profile Variables. The Schling Professional Esteem Scale questionnaires were divided into high, median and low scores based on the sum of part A (OT/professional esteem). The relationship of these grouped professional self esteem scores and the variables represented by questions on the Respondent Profile was determined using Chi-square analysis of the data. When the relationship was significant further analysis using the Student's t test was done to compare the means. The region in which a therapist resided was a significant factor using Chi-square analysis ($p<.04$). The respondents in the East region had the highest self esteem, followed by the South, Midwest and West regions. The analysis comparing the means (Student's t test) indicated the difference between self esteem in the East and West region were statistically significant at the

$p<0.04$ level. There were no significant differences between the means of the other regions (Table 3).

The response to the question concerning the sharing of professional knowledge (i.e. presentation at a continuing education conference, publication of a professional paper in a newsletter, journal or book or involvement in a research project which could or has contributed to the occupational therapy body of knowledge) was also found to be significant using the Chi-square analysis ($p<0.004$). A Student's t test was done to compare the means of the two groups. The mean score of therapists answering yes was 7.69 ± 1.80 and no 8.22 ± 1.79 ($p<0.01$).

Although not significant by Chi-square analysis, a trend was noted toward therapists with a post-professional masters degree to be more positive in professional esteem than therapists with a bachelors degree, professional masters, or masters in another field. However, the only statistical significance was found between the means of post-professional masters (7.00 ± 1.8) and the professional masters, (8.22 ± 1.8; $p<0.05$). Only 23 therapists with

professional masters degrees and seven with post-professional masters degrees appeared in this sample.

None of the other factors on the Respondent Profile were found to relate to the scores on the sum of part A (OT/professional esteem) using Chi-square analysis.

Description of the Respondents

The percentage of respondents by region of the country is shown in Table 3. The Midwest represented the largest group of respondents with the South representing the smallest. Females represented 98.4% of the sample. The majority of the respondents had a bachelors degree or certificate in occupation therapy (76.2%), two therapists had a Ph. D and the remainder had various forms of masters degrees (Table 4). At least one continuing educational event was attended within the last year by 81.9% of the sample.

The experience level of the respondents was equally divided between 0-5 years, 5-10 years, and over 10 years of experience (Table 5). All of the respondents belonged to AOTA (due to design of study), 69% belonged to their state occupational therapy association, and 33.5% of the

Table 4

Educational Level of Respondents

Highest degree earned	Number of Respondents	% of total
Bachelors or Certificate	189	76.2%
Professional masters	23	9.3%
Post-professional masters	7	2.8%
Masters in another field	27	10.9%
Ph. D	2	0.8%

Table 5

Professional Experience of the Respondents

Years of experience	Number of Respondents	% of total
0-2	16	6.5%
2-5	69	27.8%
5-10	79	31.9%
>10	84	33.9%

Table 6

The Respondents Identity with an Area of Practice

Area of practice	Number of Respondents	% of total
Physical dysfunction	98	39.5%
Psychiatry	42	16.9%
Pediatrics	70	28.2%
Generalist	38	15.3%

respondents belonged to other professional organizations. Active involvement in an occupational therapy organization (district, state, or national) was noted by 34.7% of the sample, minimal involvement (eg. only attending conferences) by 39.1%, and almost no involvement other than membership by 26.2% of the sample. The respondents profile indicated that 41.9% had presented at a continuing education conference, published a professional paper or been involved in a research project which could or has contributed to the occupational therapy body of knowledge (shared professional knowledge).

The area of practice with which the therapists most closely identified are listed in Table 6. Physical dysfunction had the highest percentage followed by pediatrics, psychiatry, and generalist (i.e. gerontology, adult developmental disabilities or varied careers). In this sample, 59.7% of the respondents were full-time occupational therapy practitioners, 25% part-time, 6.9% worked in a different field, and 8.5% were currently unemployed for a variety of reasons (retired, staying home with children, etc.)

Specialization in an area of occupational therapy was claimed by 78.6% of the respondents. In this sampling, 42.7% of the respondents indicated that at some time during their career they had been involved in private practice, and 64.9% identified being a consultant as at least a small part of their career as an occupational therapist. The question concerning the roles the respondent had as an occupational therapist was limited to consultant because consultancy roles as well as private practice represent autonomy within the discipline of occupational therapy.

The percentage of respondents who felt the entry level for occupational therapy should be at the bachelor level was 81.0% and the remaining in 19.0% identified masters level (Table 7). Entry level bachelor education was the overwhelming majority opinion regardless of the educational level attained by the respondent.

The question concerning "advanced certification" in professional skills was deleted from the analysis of the study because of varying interpretations of the question by the respondents. The respondents answers of yes or no did not give the researcher two distinctly different

Table 7

Subjects Respondent to Entry Level Education Issue

Respondents Level of Education	Entry Level Bachelors Degree		Entry Level Masters Degree	
	Number	Percent	Number	Percent
Bachelors	161	95%	8	5%
Professional masters	14	61%	9	39%
Post-professional masters	6	85%	1	15%
Masters in other field	20	74%	7	26%
Ph. D	2	100%	-	-
Total Sample	203	81%	25	19%

Table 8

The Type of Evaluations the Respondents Predominantly Use

Type of evaluation	Number of Respondents	% of total
Standardized	13	14.6%
Formal	57	63.8%
Informal	19	21.6%
None	0	0%

Table 9

Type of Orders Received By the Respondents

Type of orders	Number of Respondents	% of total
Prescription	10	11.2%
Consult of Referral	51	57.3%
Blanket referral	17	19.1%
Physicians order not required	11	12.4%

groups. Some of the respondents viewed any continuing education event as "advanced certification", others included institutional degrees, while others included only courses such as neurodevelopmental treatment (NDT), or sensory integration.

The following data were based on the respondents who were employed full-time in one setting and worked directly with patients. The type of evaluation, billing and orders received were analyzed for 89 therapists. The majority (63.8%) used predominantly formal evaluation with the remaining using either standardized or informal evaluations (Table 8). Direct patient billing for occupational therapy services was the current practice of 58.4% of the therapists while 41.6% did not currently bill directly for their services. The consult/referral type of order was the practice of most of the therapists (57.3%), 11.2% received prescription, and 12.4% reported working without physician referral (Table 9).

Analysis of Incomplete Questionnaire

There were 39 incomplete questionnaires. Analysis revealed that the major difference noted in this

population was 11 (28%) of the respondents as compared to 15.4% in the other sample were currently unemployed or employed in another field. In this group, 27 completed part A of the Schling Professional Esteem Questionnaire with a mean score of 8.67 (slight lower esteem than the sample of completed questionnaires), 11 completed part B with a mean score of 10.55 and 23 completed part C with a mean score of 11.04 (both slightly higher esteem than the sample of completed questionnaires.)

CHAPTER V

Discussion of the Results

The first objective of this study was to assess how occupational therapists perceive the profession of occupational therapy in relationship to possessing Moore's five professional characteristics. The respondents to this study indicated most occupational therapists believe occupational therapists possess, in some degree, all of Moore's professional characteristics.

An interesting result was that although 80% of occupational therapists are committed to the profession, 20% were clearly uncommitted (commitment to a profession was determined by question 1A on the Schling Professional Esteem Scale). In a similar study done with California physical therapists (Schlink, Kling and Shepard, 1978), the results indicated that 90% of the respondents were committed to the discipline of physical therapy. In comparing these two studies no other marked differences were noted in the internal esteem of physical therapists and occupational therapists. It should be emphasized that

the study of physical therapists was done in 1978 and it is possible that the internal professional esteem of physical therapists may have changed in the last 10 years. Another possible explanation for the difference noted in commitment may be that 31.3% of the physical therapy respondents were male while the current study of occupational therapists included only 1.6% male. (The AOTA membership in 1986 was 5.1% male.) It is generally accepted that a higher percentage of females are committed to family needs and some of the respondents indicated they were committed to staying home with children. This does not account for all of the uncommitted occupational therapists and was probably true of some of the physical therapists as well.

Although occupational therapists felt positively toward possessing Moore's professional characteristics, many did not feel strongly. Only 30.6% of the respondents were strongly committed to the discipline, 43.5% were strongly convinced that the occupational therapy organization sets rules and standards defining the acceptable level of performance, 65.7% strongly supported occupational therapy as having a specialized body of

knowledge, 80.6% believed strongly that occupational therapists evaluate patient needs, but only 29.8% strongly believed occupational therapists should have autonomy of judgement. This indicates need for further growth and development in all five areas affecting occupational therapy's internal professional image, especially in the characteristics of commitment and autonomy of judgement.

The second objective of the study was to determine how occupational therapists perceive the physicians' and the public's view of occupational therapy in relationship to Moore's five characteristics and to determine if the internal self esteem of occupational therapists was greater than external esteem. The analysis indicated the respondents' internal esteem was greater than external esteem but there was no significant correlation between the OT/professional esteem, OT/physician esteem and OT/public esteem. Thus, the respondents did not base their opinion of how physicians and the public view occupational therapy on their personal view of occupational therapy. Several respondents with incomplete questionnaires did not respond to physician based questions stating they did not work directly with

physicians. It appears that the respondents based their opinions on experiences with physicians and the public. The physician view on occupational therapy professionalism is important since physician referral is often needed to gain access to patients with special needs that can be evaluated and treated by occupational therapists. The public view is important since these are the consumers of occupational therapy services and the public opinion actually determines whether or not occupational therapy is valued as a profession. The OT/physician esteem and OT/public esteem results were compared with similar results from the Schlink, et al (1978) study of California physical therapists. The results were similar with the exception of Moore's characteristics of diagnostic skill (evaluation) and autonomy. In both of these areas, the occupational therapists' esteem rating was higher than that of physical therapy. One explanation again could be the fact the physical therapy study was done 10 years ago, and their esteem in these two areas might be higher if the study were done in 1988. A second explanation for a higher esteem score in evaluation might be the wording of the question concerning physicians. The question

associates physicians using specific orders with a negative view of a therapists' ability to evaluate patients needs. This assumption may be useful in the physical therapy study since 34.8% received prescriptive orders; however, only 11.2% of the occupational therapists received prescriptive orders. This may not be because physicians have a more positive view of occupational therapists' diagnostic skill but because of physicians being less aware of what occupational therapists actually do. This vague notion of what exactly an occupational therapist does may increase autonomy but certainly not the professional recognition and therefore prestige and position of occupational therapy on the continuum of professionalism. The results may indicate occupational therapists currently do have a degree of autonomy in a variety of positions. It was noted in this study that 10% of the full-time therapists working in one setting are working without physician referral while 57.3% are consulted and only 11.2% are given specific orders. Another indication of autonomy in occupational therapy is that 42.7% of the respondents surveyed claimed to have been involved with private practice at sometime during

their career. The AOTA 1986 Member Data Survey; Summary Report (1987) indicated that 7.8% of the membership had significant experience in private practice. It is possible a fairly high percentage of therapists have had an occasional private practice patient but do not consider private practice to be among their most significant experiences.

The third objective of the study was to assess whether there is a relationship between the individual therapist's professional behavior and the therapist's professional esteem. It was found that the sharing of professional knowledge was significantly related to higher esteem. It could be that therapists with higher esteem become involved in presenting at conferences, publication and research or that therapists' professional esteem improves when involved with these activities. The relationship is most likely in both directions. The relationship between high esteem and shared professional knowledge was especially interesting since such a high number of therapists (41.9%) believed they had participated in sharing knowledge by presenting at a conference, professional publishing or involvement in

research which contributed to the occupational therapy body of knowledge. Clark, Sharrot, Hill and Campbell (1985) indicated approximately 21% of the therapists had presented at a professional conference, 10% had published a professional paper, and 9% had written a funded grant (with overlap expected in these three categories). It should be noted that therapists responding to surveys tend to be therapists who are actively involved in the profession.

In addition, it was noted that there was a trend toward the professional esteem of therapists with a post-professional masters to be higher than therapists with bachelor/certificate, professional masters or a masters in another field. Although the difference in professional esteem means was significant only between the categories of post-professional masters and professional masters, the numbers involved were too small to suggest this was more than a trend.

Although not a significant factor in relating to professional esteem, it is interesting to note that 78.6% of the respondents claimed they had specialized in an area of occupational therapy. This confirms Gillette and

Kielhofner's (1979) statement that most occupational therapists have chosen to specialize.

Direct patient billing (fee for service) was also not significantly related to professional esteem of occupational therapists but does represent an important step in the professionalization of occupational therapy.

The fourth objective was to explore the relationship between the scores on the occupational therapy professional esteem scale and autonomy. In this study, therapists with the role of consultant, therapists in private practice and therapists who receive consults rather than prescriptive orders from physicians were not found to have higher esteem. A high number of therapists claimed to have been involved in private practice (42.7%), indicating that occupational therapists do need the knowledge and skill to work in positions with a degree of autonomy. The role of educator was not reviewed because of the high number of therapists who identified with this role. It was apparent that many therapists who supervise students claimed the role of educator. The supervision of students is not an autonomous position compared with an educator in higher education. The respondents identity

with the role of consultant was also high indicating therapists doing only a small amount of consultancy work identified it as part of their role as a therapist. The broad interpretation of these roles may have not created distinct categories of therapists with a high degree of autonomy.

The fifth objective was to assess whether sex, location or the area of practice in which a therapist has primarily worked had any relationship to the therapists' esteem score. It was found that the area of the United States in which a therapist currently resided did affect OT/professional esteem. It is not clear why the professional esteem of therapists in the East is higher than therapists in the West.

There was not any significant difference in professional esteem between the groups in various practice areas. Sex as a factor was not statistically analyzed in this study because of the small number of males represented.

The last objective was to examine whether professional esteem scores were related to the belief that entry level education for occupational therapists should

be at the masters level. No significant difference in the esteem scores of the two groups was found. It was noted that therapists with graduate degrees were more likely to believe entry level professional education should be at the masters level, but the majority of these therapists still believed entry level professional education should remain at the bachelor level. It was interesting that the majority of entry level professional masters students (61%) believed entry level professional education should be at the bachelor level. This could reflect that the current professional master programs may not provide a more rigorous education than bachelor programs thus not providing professional master students with greater depth of knowledge and skill which is recognized by other occupational therapists.

Park and Chan (1987) suggested that occupational therapists adopt new strategies to enhance their professional image by engaging in self study, public relations and reviewing postbaccalaureate credentialing. Extending occupational therapist education may increase commitment to the profession; however, the mandate to increase entry level education for occupational therapists

to a professional masters was not currently supported by the members of the American Occupational Therapy Association. Public relations may increase physician and public awareness of occupational therapy as an organized profession. Public relations may also increase physician and public awareness of the specialized body of knowledge and skills required of the occupational therapist. Further credentialing however is required to convince physicians and the public that this knowledge and skill is acquired through an extended period of education and training. The prestige of prolonged education is important in maintaining our relationship to other medical disciplines, especially as our peers in physical therapy move toward requiring a masters degree. (Speech pathology, audiology, and social work already require masters degrees.) Furthermore, the expanding and strengthening of our specialized body of knowledge is important in providing competent application of our knowledge to the special needs of clients. According to Rogers this can be accomplished best at a postbaccalaureate level. Self study is currently being encouraged in occupational therapy by AOTA and

accreditation boards, to increase diagnostic skills and competent application of general knowledge to the special needs of the client. Professional autonomy is the highest professional characteristic to be obtained and is achieved after a discipline possesses the other professional characteristics (Moore 1970).

CHAPTER IV

Conclusions and Recommendations

The occupational therapists surveyed in this study responded positively in their perceptions of possessing Moore's five professional characteristics. However, the respondents indicated there was need for further growth and development by indicating some of the five characteristics were not strongly present (commitment to profession and autonomy of judgement) and indicating none of the five characteristics were strongly evident to physicians and the public. The results of this study noted that therapists residing in the East had the higher professional esteem than therapists residing in the West, and therapists that participated in presentation at conferences, published or were involved in research had higher professional esteem as a group.

A further exploration of how physicians and the public perceive occupational therapy in relationship to Moore's professional characteristics needs to be done by surveying these two groups directly in order to measure

more accurately their perception of occupational therapy's professional status. Additional data, such as generated in this study, should be sought to guide professionals in mentoring students and new therapists as well as designing public relation and marketing strategies.

Based on the literature review of this study, occupational therapists need to more seriously consider entry level education at the graduate level of study with rigorous undergraduate requirements. Literature review also supports the need to encourage occupational therapists to pursue graduate level degrees which will increase public and other professionals recognition of the knowledge and skill possessed, and encourage better peer relationships with health professionals. Current entry level masters programs need to become more challenging, to reflect graduate level work, recognizably surpassing bachelor level work in professional content. Doctoral educational programs in occupational therapy need to be further encouraged to create, organize and transmit the knowledge base of occupational therapy. Occupational therapists need to dare to evaluate and question tradition as the discipline continues to evolve. Discussion and

action on new strategies to enhance the image of occupational therapy and provide high quality patient services needs to continue.

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APPENDIX A

October 24, 1987

Pat Fader, O.T.R.
Department of Occupational Therapy
School of Allied Health Sciences
University of Texas Medical Branch
Galveston, Texas 77550

Dear Ms. Fader:

You have my permission to use the copyrighted Schling Professional Esteem Scale in your research project, being done to obtain your Master's at Texas Women's University. Enclosed is a copy of the scale for your use.

Sincerely,

Mike Schlink, ~~L.P.T., M.A.~~ MA, PT

APPENDIX B

THE SCHLING PROFESSIONAL ESTEEM SCALE

designed and copyrighted by M. Schink and R. Kling

DIRECTIONS: When responding to the questions below, please indicate whether you.....

SA (strongly agree)
A (agree)
D (disagree)
SD (strongly disagree)

Choose the ONE appropriate response by checking the box.

Part A	SA	A	D	SD
As an occupational therapist I am represented by an established organization which sets rules and standards defining the acceptable level of my performance.	[ ]	[ ]	[ ]	[ ]
In my area of health concern, I evaluate the patients' needs prior to treatment.	[ ]	[ ]	[ ]	[ ]
Other occupational therapists may evaluate my work, but the best judges of my performance are physicians.	[ ]	[ ]	[ ]	[ ]
The services I provide as an occupational therapist do not reflect a specialized body of knowledge and skills acquired through extensive education and training.	[ ]	[ ]	[ ]	[ ]
I am strongly motivated, that is I have essentially a lifetime commitment towards my career, occupational therapy.	[ ]	[ ]	[ ]	[ ]
Part B				
Most physicians believe that occupational therapists, in their area of health concern, are the ones to best judge the performance of other occupational therapists.	[ ]	[ ]	[ ]	[ ]
Most physicians believe occupational therapists are represented by an established organization which sets rules and standards defining the acceptable level of performance for its members.	[ ]	[ ]	[ ]	[ ]
Generally physicians believe the services most occupational therapists provide do not reflect a specialized body of knowledge and skills acquired through extensive education and training.	[ ]	[ ]	[ ]	[ ]
In general, physicians use specific treatment orders because they believe most occupational therapists, in their area of health concern, do not evaluate patients' needs.	[ ]	[ ]	[ ]	[ ]
In general, physicians believe most occupational therapists are strongly motivated, that is, they have essentially a lifetime commitment towards their career.	[ ]	[ ]	[ ]	[ ]
Part C				
Generally, the public believes most occupational therapists are strongly motivated, that is they have essentially a lifetime commitment toward their career.	[ ]	[ ]	[ ]	[ ]
In general, the public believes most occupational therapists carry out physicians' orders and therefore, in their area of concern, do not evaluate patients' needs.	[ ]	[ ]	[ ]	[ ]
Generally, the public believes the services most occupational therapists provide do not reflect a specialized body of knowledge and skills acquired through extensive education and training.	[ ]	[ ]	[ ]	[ ]
In general, the public believes the performance of occupational therapists in their area of health concern, is best judged by physicians.	[ ]	[ ]	[ ]	[ ]
Generally, the public believes occupational therapists are represented by an organization which sets rules and standards defining the acceptable level of performance for its members.	[ ]	[ ]	[ ]	[ ]

APPENDIX C

RESPONDENT PROFILE

In what state do you currently reside?_____

Are you male or female?(circle one answer) Female Male

What is your level of education?(circle one answer)

a. Bachelors or certificate in occupational therapy
b. Professional Masters in occupational therapy
c. Post professional Masters in occupational therapy
d. Masters of Arts or Sciences in a field other than occupational therapy
e. Doctoral degree in occupational therapy or another field

Within the last year, how many continuing education events have you attended?(circle one answer)

a. none
b. one
c. two or more

How many years have you worked as an occupational therapist?(circle one answer)

a. less than two years
b. two to five years
c. five to ten years
d. more than ten years

Are you currently a member of your state association?(circle yes or no)

YES NO

Other than A.O.T.A., your state and district associations, are you a member of any other association or society for professional reasons?(circle yes or no) If you circle yes please specify organizations on the back of this page.

YES NO

Have you been involved in any of the following ways with your district, state or national occupational therapy association?(circle as many as apply to you)

a. have attended within the last two years at least one conference sponsored by an occupational therapy association
b. have attended within the last two years at least two business meetings
c. have served within the last five years or are currently serving on at least one committee or task force
d. have served within the last five years or are currently serving as an officer of an occupational therapy organization

Have you ever presented at a continuing education conference, published a professional paper in a newsletter, journal or book or been involved in a research project which could or has contributed to the occupational therapy body of knowledge?(circle yes or no)

YES NO

Do you have an area of practice in which you specialize?(circle yes or no)

YES NO Please specify_____

Have you sought any advanced certification in professional skills?(circle yes or no)

YES NO Please specify_____

In what area of occupational therapy have you primarily worked?(circle one answer)

a. physical dysfunction
b. psychiatry
c. pediatrics
d. generalist(have worked in several of the above areas and do not feel more identity with one over the other)

Are you or have you been involved in private practice?(circle yes or no)

YES NO

Which of the following roles have you had as an occupational therapist?(circle as many as apply to you)

a. patient care provider
b. administrator/manager
c. supervisor
d. consultant
e. educator
f. none of the above

What is your current work status?(circle one answer)

a. full-time occupational therapist
b. part-time occupational therapist
c. employed but not as an occupational therapist
d. unemployed

If you answered c or d on the last question skip to the last question on this questionnaire. If you answered a or b complete all of the following questions.

If you work as an occupational therapist, do you work in more than one setting?(circle yes or no)

YES NO If you circled yes, specify the number of occupational therapy settings you work in_____ and how many hours a week do you work in your primary setting?_____

In your primary work setting do physicians usually order occupational therapy services by.....(circle one answer)

a. prescriptions-with specific orders for services
b. consult or referral-with general orders for services
c. blanket referral
d. a physicians order/prescription is not required by occupational therapy
e. patients are not evaluated or treated in primary setting

In your primary work setting do you.....(circle one answer)

a. predominantly use standardized evaluations and unmodified published evaluations
b. predominantly use formal evaluations designed for your facility or modified evaluations
c. predominantly use informal evaluations
d. treat patients but are not involved with evaluations
e. do not treat patients in primary work setting

In your primary work setting are patients billed for occupational therapy services?(circle yes or no)

YES NO

Do you think entry educational level for occupational therapy should be.....(circle one answer)

a. Bachelor level degree
b. Masters level degree

APPENDIX D

August 14, 1988

Dear Colleague:

As an occupational therapist you are probably interested in promoting the professional image of occupational therapists. The purpose of this study is to explore the current professional identity of occupational therapists, specifically identifying the characteristics we feel we possess and those we need to strengthen. It also assesses occupational therapist's beliefs concerning how physicians and the public view occupational therapists. The study will be of value to the leaders of occupational therapy organizations, educators and to the individual therapist.

You are one of a small random sample of therapists within the United States being asked to provide information for this study. It is important that each questionnaire be completed and returned so that the results will represent occupational therapists as a whole. Please return the questionnaire by September 21, 1988.

You can be assured of complete confidentiality of your questionnaire. An identification number has been placed in the right hand corner so that we may check your name off the mailing list when we receive your questionnaire. This will prevent us from contacting you if a follow up mailing is required.

If you desire the results of the study please place your name and address on the back of the return envelope. Please do not place this information on the questionnaire.

If you have further questions, please contact me by letter. My address is as follows: Pat Fader, O.T.R., Department of Occupational Therapy, School of Allied Health Sciences, University of Texas Medical Branch, Galveston, Texas, 77550.

Thank you for your time and assistance.

Sincerely,

Pat Fader O.T.R.
Post-professional Masters student at Texas Women's University