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Occupational Therapy Values and Beliefs: PART V

1986–2000: Is This Really Occupational Therapy?

Part five of this series continues the process of identifying and organizing the beliefs, values, and ideas gleaned from the historical foundations of the profession.

Isn't it a bit unnerving that occupational therapy practitioners call what they do "practice"?

The late comedian George Carlin referred to physicians when he said this, but the phrase applies equally to occupational therapists. During the years 1986 to 2000, issues related to practice occupied much of the literature. Five themes are identified from this timeframe: (1) professional role identification (educator, clinician, administrator, advocate); (2) credentialing versus membership; (3) sponsorship by medicine versus a self-defined profession; (4) labor force needs versus job satisfaction; and (5) the question of what is and what is not an appropriate occupational therapy modality and process.

ROLE IDENTIFICATION: ACADEMIC FACULTY VERSUS CLINICAL THERAPIST

Jantzen first raised the issue of academia as a practice area in occupational therapy.[1] She identified that the responsibilities of academic faculty were different from those of clinicians and required different expertise. The academic role, according to Jantzen, included teaching, research, and service. These criteria reflect current faculty responsibilities. In contrast, clinical practice involved executing theoretically based treatment and preventative measures, as well as evidence-based practice.

Yerxa further stated that occupational therapy faculty must gain competency in research and teaching.[2] Yerxa believed that without qualified academic faculty, educational programs would be in serious jeopardy of being discontinued in university settings. Research in occupational therapy had been originally viewed as a clinical responsibility.[3–5] Clinicians, ideally, were working directly with clients using theoretically formulated treatment methods and modalities of occupational therapy. However, many did not identify their work as theoretically grounded, but rather as practical solutions. This perception may have related to the baccalaureate entry-level degree or to limited educational preparation, time, or permission to do research in many clinical settings. In contrast, academic faculty members were being encouraged to undertake such research efforts and to publish the results of their work.

Most of the textbooks or chapters on occupational therapy published from 1906 to 1947 were written by physicians, with some written by occupational therapists who did not hold academic positions.[6–11] However, starting in 1947, academic leaders began writing.[12,13] No career is absolutely linear, and it is important to note that some writers moved freely between clinical, academic, and AOTA leadership positions at various times in their careers (e.g., Fidler and Brunyate).[14] Thereafter, writing and publishing became increasingly viewed as an academic responsibility.[15]

CREDENTIALING VERSUS MEMBERSHIP

For many years registration (later certification), and membership had been tied together in the American Occupational Therapy Association (AOTA). Yearly dues included both a renewal of registration or certification to practice occupational therapy and a continuation of membership in AOTA. In the 1980s, legal challenges were made to other professional organizations that controlled both the accreditation of educational programs and the credentialing of professionals. To preempt potential legal action, in 1986 AOTA's Representative Assembly adopted a motion to create an autonomous certification board.[16] Thus, the American Occupational Therapy Certification Board (AOTCB) was created, officially separating certification from the Association. In 1996 the AOTCB became the National Board for Certification in Occupational Therapy (NBCOT), a totally separate organization that administered the initial or entry-level certification examination. Some Association members found the differentiation between the Association and NBCOT confusing at first and were uncertain how to deal with two organizations as opposed to one.[17,18]

The separation of certification and Association membership, along with an increase in the number of states requiring licensure, changed the dynamics of the Association. No longer did occupational therapy practitioners have to belong to the Association to maintain their certification to practice. The Association could not count on autonomic membership but needed to appeal to therapists, assistants, and

students to join because of what it had to offer. The Association had to rely more on emphasizing the value-added benefits of membership, such as publications; continuing education courses; advocacy for the profession in Congress; public awareness initiatives; and assistance to state associations on state legislative issues, especially licensure.

Credentialing by a separate body did not occur without a hitch. The Association assumed that it would continue to own the rights to the title and emblems for the terms *occupational therapist*, *registered (OTR)* and *certified occupational therapy assistant (COTA)*. However, the terms are designed to identify practitioners of occupational therapy, not members of the Association, and thus they belong to NBCOT.[18]

SPONSORSHIP BY MEDICINE VERSUS A SELF-DEFINED PROFESSION

Occupational therapy and the medical community had forged an uneasy alliance in 1933, when the American Medical Association (AMA) adopted a resolution to develop accreditation standards for occupational therapy education programs. Occupational therapy needed the help of a stronger association and profession to provide clout and manpower to encourage occupational therapy educational programs to meet minimum standards and to recognize the graduates as qualified occupational therapists, especially in hospital settings. At the same time, physicians in physical rehabilitation settings had difficulty understanding what occupational therapists really did and sometimes saw occupational therapy as a special kind of physical therapy or as an adjunctive therapy. When the AMA disbanded the umbrella organization that accredited several allied health programs in 1992, the Association took the step to break the alliance with the AMA and created an independent accreditation agency.[19]

With the development of the Accreditation Council for Occupational Therapy Education (ACOTE®),[19] the profession had separate and independent organizations for membership, credentialing, and accreditation. Developing independent organizational structures was one issue; creating a self-defined profession was another.

The profession of occupational therapy increased its understanding of its own roles and functions, and its ability to communicate the core concepts of the profession to other professionals and consumers.

As Yerxa pointed out, the central organizing idea for occupational therapy remained a topic of concern.[20] The question was whether occupational therapy was one of many rehabilitation therapies with no unique purpose beyond the general goals of medical rehabilitation, or whether occupational therapy practitioners were autonomous professionals who advocated for healthy, satisfying lives through engagement in occupation "to enable persons to achieve self-organization and mastery of their environments" (p. 365).[20] Practitioners were unclear whether occupational therapy should be grounded in a view of health as the elimination or reduction of disease and disorder, or whether the profession should be grounded in a view of health as the promotion of health and wellness (disease-focused versus wellness-focused). Health promotion "is the practice of informing, educating, and facilitating behavioral change, and using cultural support so people can assume responsibility for living a lifestyle that is centered on optimal well-being" (p. 806).[21] Wellness is a lifestyle one designs to achieve the highest potential for well-being.[21] Based on a prevention and wellness focus, health is then redefined as the "possession of a repertoire of skills" that enables a person to achieve individual goals rather than the elimination or reduction of a disease state (p. 365).[20] This shift away from dependence on a disease model once again showed occupational therapy's continued attempts to broaden the theoretical and conceptual understanding of the profession.[22–25]

LABOR FORCE NEEDS VERSUS JOB SATISFACTION

Labor force needs continued to be a major concern during the 1980s and 1990s. In 1986, the Association completed a manpower needs study for occupational therapy personnel.[26,27] The study showed significant underrepresentation and misdistribution of occupational therapy personnel across the United States. States without an established occupational therapy education program were most likely to have a limited supply of therapists and assistants. Students were recruited to attract a variety of ages, ethnic backgrounds, and academic preparedness in terms of previous degrees obtained and/or previous major areas of study.[28,29] But faculty members were also in short supply, which limited the number of students who could be admitted. Other issues, including a lack of fieldwork training sites, an increase in the number of older clients seen in practice settings, new service delivery models including shorter hospital stays and more outpatient and home care, and the need to validate practice through research were also noted as areas to address in order to increase occupational therapy faculty and students.[26,27]

The profession also gained knowledge and experience of how to function without the protection of medicine and to speak for itself in legislative and regulatory activities.

During this time, studies were being completed on what characteristics and rewards resulted in job satisfaction and better retention of occupational therapy personnel in their jobs. Doing tasks that were viewed as significant, having adequate resources to complete tasks, and having autonomy in how the tasks were performed were

considered most important and of high value.[30,31] Conversely, Bailey found that occupational therapy practitioners who left the field said they did so due to lack of respect for occupational therapy by other professionals, lack of understanding of what occupational therapy is or does by other professions, and too much paperwork.[32] Barnes classified job satisfaction into extrinsic and intrinsic factors.[33] The major extrinsic factor in job satisfaction was productivity expectations. Important intrinsic factors were opportunities for program development, diversity of practice, direct client care, feelings of competence, meaningful work, and accomplishing career objectives. These concepts of work satisfaction, meaning, and purpose reflected parallel aspirations of self-empowerment in the workforce as a whole.[34,35]

WHAT IS AND WHAT IS NOT OCCUPATIONAL THERAPY?

Discussion about the "true" nature of the occupational therapy process was approached from two vantage points. First was the selection of an approach. The idea that occupational therapists generally use two different approaches to help clients gain or regain occupational performance is not new. Upham discussed this concept using the terms *direct* and *indirect*.[36] Direct approaches occur with remedial or restorative interventions, and indirect approaches occur with adaptive or compensatory approaches. What was new was the recognition that the two approaches use different clinical reasoning skills. The remedial approach focuses on exercises or drills to improve the subskills of functional performance based on sensorimotor, perceptual motor, and cognitive paradigms.[37] The adaptive approach uses occupational areas such as self-care, work, or community-living activities that clients define as purposeful, goal-directed, and functional.[37] Dunn, Brown, and McGuigan agreed with Neistadt that both remedial and compensatory approaches are used in occupational therapy practice and suggested additional approaches, including (a) create (i.e., health promotion) and (b) prevent.[38]

The second issue involved the use of occupational therapy modalities. Should occupational therapy personnel use occupations exclusively, or could activities and tasks that were separated from the total occupation be used? The argument was that using parts of an occupation did not provide a real purpose, leading toward an identifiable goal, such as an adaptive process leading to mastery of the environment,[39] or "doing" as a means of self-actualization.[40] Parts of an occupation would not satisfy or motivate the client to engage in the action for a longer period.[41] Several articles supported "occupation as a whole" as the better approach for occupational therapy.[42–44] These studies increased the knowledge about the use of occupation as the keystone of occupational therapy and may ultimately be reflected in changes in the understanding of how to practice.[20]

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CONCLUSION

Role identification, credentialing, sponsorship (medicine verses autonomy), work force capacity, and goals of practice emerged as historical themes in the literature between 1986 and 2000. All of these themes dovetailed into ideas that had already emerged during the history of the profession. The profession of occupational therapy increased its understanding of its own roles and functions, and its ability to communicate the core concepts of the profession to other professionals and consumers. The profession also gained knowledge and experience of how to function without the protection of medicine and to speak for itself in legislative and regulatory activities. In addition, the problem of labor force numbers and distribution was acknowledged, but correcting the problems continues to challenge the profession and the Association. ■

To read the previous articles in this series, go to http://www.aota.org/Pubs/OTP/OT-Values.aspx

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