The current perception of the Occupational Therapy profession in New Zealand.

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A Project submitted in partial fulfilment of the degree Master of Occupational Therapy

at Otago Polytechnic, Dunedin, New Zealand

[12 August 2019]

Abstract

The literature reviewed in relation to the research question indicated that the Occupational Therapy profession has a long-standing issue with how it is perceived within the health care sector. The literature clearly identified that Occupational Therapy adds significant value to health care and patient outcomes, however it also highlighted persistent problems with its professional identity and role identification. Underlying causes of these historical issues and previous strategies employed to overcome these were described.

This study uses interpretive descriptive methodology. Five research participants have been recruited using a purposive sampling method (snowballing). The research participants were Allied Health Professionals other than Occupational Therapists. Semi-structured interviews were used to collect the data for this study. QUAGOL, a 10-step data analysis method, was used to analyse the data and develop the findings.

The following four major categories of findings were identified: 1) The Value of Occupational Therapy, 2) Professional identity and 3) Promotion Occupational Therapy. 4) Environment and Systems constructs. The findings showed that, though overall participants thought that Occupational Therapy added significant value to New Zealand health care services, historical issues regarding professional identity and role confusion persisted, despite previous efforts to resolve them.

A key message for occupational therapists to take away from this study is to be proud of their profession and the significant contribution Occupational Therapy makes to the health care system and the health and well-being of individuals. To promote Occupational Therapy effectively on an individual level, Occupational Therapists are encouraged to clearly define their own professional identity by clearly understanding their professional boundaries to be able to confidently respond to stereotypical assumptions or perceptions of what the role of Occupational Therapy is. Occupational Therapists are further encouraged to communicate how their role contributes to service goals to further create awareness of its professional value. To overcome the historical issues the Occupational Therapy profession faces and develop effective promotional tools, further research has been recommended.

Acknowledgement

I would like to express my special thanks of gratitude to Mary Butler who has supported me with endless patience, understanding and encouragement.

Thank you!

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CHAPTER 1

INTRODUCTION AND CONTEXT OF THE STUDY

Introduction

This chapter will explain the context underpinning the research project, the aim and objectives of the study and key terms used.

There is evidence that Occupational Therapy is a highly effective profession working across a broad range of health and social services (College of Occupational Therapists, 2016). In their 2016 report, the College of Occupational Therapists (2016) state that their research showed *"Occupational Therapists improve lives and save money for the health and social care services on a daily basis".* Occupational Therapists provide expert knowledge of the importance of occupations and routines on peoples' health and wellbeing (College of Occupational Therapists, 2016). The College of Occupational Therapists' (2016) report highlighted that the value of Occupational Therapy lies within the profession's ability to:

- Reduce pressure on GPs

  Adding Occupational Therapy to primary care is an effective extension of GP services by adding holistic care through focusing on the effects of illness, accident and disability on function and participation in daily life. Occupational Therapists are highly skilled in prevention and early intervention strategies by supporting individuals in preserving healthy lifestyles resulting in disease and disability prevention, and reduction of impact of an illness. Occupational Therapists achieve this through enabling individuals to participate in their daily activities, reducing risk factors by modifying the build environment or providing strategies to maintain health and function. Proactively supporting people to maintain health, well-being and function within their communities, aids to improve population health and reduce the financial burden to the health care system (College of Occupational Therapists, 2016).

- Reduce the risk of admission and re-admission to hospitals

  Occupational Therapists as part of Accident and Emergency (A&E) services have

been shown to significantly reduce the number of admissions or re-admissions. The College of Occupational Therapists' report included a service example of an Admission Avoidance Team first piloted in 2013. In 2014, the team assessed 181 patients of whom 138 could be discharged without requiring an acute medical bed. In 2015, 134 of 175 patients assessed did not require admission (College of Occupational Therapists, 2016).

- Provide rehabilitation to improve health outcomes
  Occupational Therapy provides relevant rehabilitation goals as part of a comprehensive assessment focusing on an individual's functional ability resulting in improved functional outcomes and therefore maximising independence (College of Occupational Therapists, 2016).

- Contribute significant savings by reducing costly care packages
  Occupational Therapists' core skills are crucial to preventative services by promoting function and independence. Occupational Therapy therefore aids in the prevention of the need for hospital admission, post hospital transfer to residential care and level of home help support required – demonstrating clear cost benefits and patient outcomes (College of Occupational Therapists, 2016).

- Effectively facilitate the safe and timely transition of patients from hospital to home.
  The College of Occupational Therapists' (2016) report stated that Occupational Therapy is an essential component of the provision of continuous care to make the transition from hospital to home easier for patients. Occupational Therapy is uniquely equipped to assess and recommend the likely support and equipment required by an individual to safely return home. Occupational Therapists function as an interface between acute and community care, supporting the smooth transition of patients across health and social services (College of Occupational Therapists, 2016).

The need to publish this report to promote the value of Occupational Therapy was identified after a review of the understanding and perception of Occupational Therapy by national policy leaders, politicians and senior directors in the health and social care sector was completed (College of Occupational Therapists, 2016). This indicated that, despite all the evidence about the efficiency of the profession, there was still a problem with how the profession is perceived as late as 2016. As this research was completed in the United Kingdom, the question to be asked is does this apply within a New Zealand context? Is there a problem with the current perception of Occupational Therapy in New Zealand?

Statement of the problem

After completing my Bachelor of Health Science (Occupational Therapy) and the Bachelor of Health Science Honours programme I have been practising as an Occupational Therapist in multiple settings including acute, rehabilitation and community in both a DHB and private practice environments. After working for 2-3 years, I started to feel increasingly frustrated by frequently being placed in a position where neither other professions, nor my patients (if I am truthful), seemed to be able to understand what Occupational Therapy is and the benefits or value it can provide to the wider health care system. I was overruled by medical staff when assessments showed a patient was unsafe to return home. To overcome this, I often collaborated with physiotherapists as the medical professionals at the time seemed to view their assessments as more valid. Colleagues often reported similar experiences and feelings. Feedback from senior Occupational Therapists was often that this is the way it was and the only thing to do was to accept the hierarchy. Also, in conversation, other health professionals often admitted a lack of understanding of Occupational Therapy and how the profession contributes to patient care. As there is strong evidence that Occupational Therapy is a valuable and highly effective profession (when allowed to be), I started to ask myself where does this lack of understanding originate from?

Prior to becoming an Occupational Therapist, I completed a Bachelor of Commerce and Administration majoring in Marketing and Commercial Law. After graduating, I have worked for New Zealand charities in a variety of marketing areas such as public relations,

communications, branding and advertising. At some point, I started stepping outside of my role as a member of the Occupational Therapy profession and started looking at the identified issues from a marketing perspective: What is causing the lack of awareness and recognition of the profession? And what causes members of the profession to silently accept this situation? From my experiences and observations, I wondered if Occupational Therapy in New Zealand has these difficulties as a result of how it is perceived both by its own members, other members of the health care system and the wider public. I started to ask myself: What is the current perception of Occupational Therapy in New Zealand?

Marketing in context of this study

During my time completing this project, I often encountered difficulty in explaining what marketing means in relation to this study. In the literature review in Chapter two, Creek (2009) used the example of a well-known Occupational Therapy assessment and intervention of making a cup of tea to explain the difficulty in understanding or describing Occupational Therapy to other professions or patients/clients. The author explained that often individuals only see the process of making a cup of tea as nothing but making a cup of tea. An Occupational Therapist however, understands that the making of the cup of tea is a process of assessing an individual's functioning – be that in a physical or mental health setting. Occupational Therapists see beyond the task, considering the interaction between a person's functional components, the environment and the task as well as how this relates to other tasks the person needs to perform within their daily life.

It is much the same with marketing. Often marketing is perceived as advertisements, commercials, social media channels, posters, flyers and so on. However, these are merely promotional tools which are the tip of the iceberg (or the cup of tea), the result of a process including intensive research and careful planning. Dr Phillip Kotler, Professor of Marketing and recipient of the Award of Excellence in Health Care Marketing, stated:

> *"Marketing is the homework that we do before we have a product."*

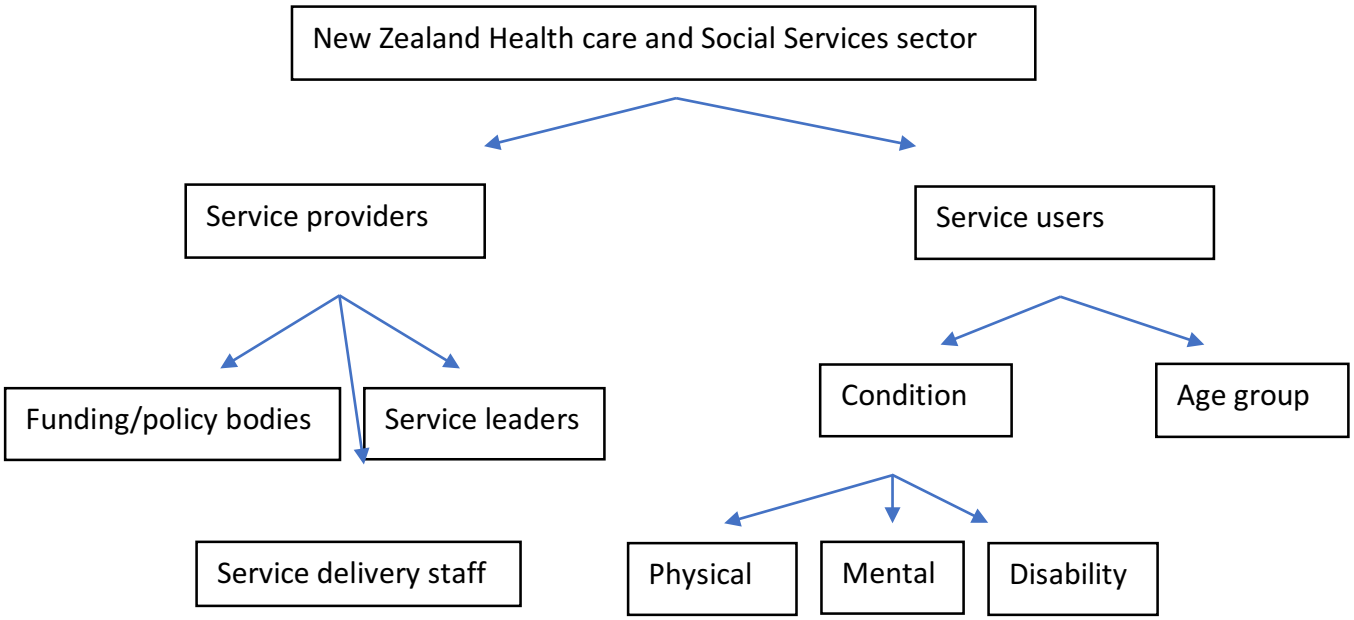
I would like to emphasise that this study is not about providing ideas for promotional tools for the Occupational Therapy profession, but rather focuses on the homework before; a concept called the segmentation, targeting and positioning process (STP). Kotler and Keller (2005, p.310) explain that to be effective all marketing plans need to be based on this process.

I. Segmentation

Market segmentation is defined by Chitty, Hughes and D'Alessandro (2012) as a marketing approach for evaluating a market so that marketing strategies can effectively target a group of consumers (a market segment) that has an identified need which can be met by the service. This is a necessary step as service providers, such as the Occupational Therapy profession, cannot expect to serve everyone in the market. The market Occupational Therapy operates in can be defined as the New Zealand Health Care and Social Services sector including both health care professionals and service users. To attract buyers for its service, Occupational Therapy needs to identify the group(s) of consumers within that market that have a high need or want for the service (Chitty, Hughes & D'Alessandro, 2012). This is called segmentation and is the first step in the STP process.

Segmentation can be completed in a variety of ways by either using demographics and value, or benefits sought and behavioural patterns (Chitty, Hughes & D'Alessandro, 2012). Table 1.1. below shows a brief segmentation of the New Zealand Health Care market.

Table 1.1. Example of Market Segmentation of the New Zealand Health Care Market



The next step of segmentation is to select one or more of these segments based on criteria such as size, purchasing power, accessibility and sustainability (Chitty, Hughes & D'Alessandro, 2012). This process is called targeting or selecting a target segment.

II. Targeting

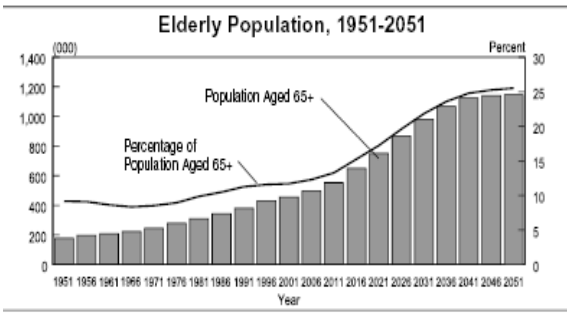
In the United Kingdom, the College of Occupational Therapists (2016) chose to place their main efforts on communicating the value and benefits of the Occupational Therapy profession to commissioners as well as those leading and delivering health and social services as their primary target segment. The college identified the need to save costs as the target segments need that Occupational Therapy could meet. Additionally, even though we do not work with members of this segment, they are the ones holding the purchase power, making this segment incredibly important for the Occupational Therapy profession. In their report, the College of Occupational Therapists often used practice examples of how including the profession into health care services can save costs, especially for services dealing with individuals 65 years and older. One practice example

highlighted the savings of 12,692 Pounds by integrating occupational therapists into a falls response service, reducing admissions into emergency departments for people over 65 (College of Occupational Therapists, 2016). Another example highlighted the reduction of the average length of stay on an elderly ward from 9.5 days to 1 day by including occupational therapists in the Active Recovery Team under a "discharge to assess" model (College of Occupational Therapists, 2016). This led me to believe that they have chosen this segment as their secondary target segment, most likely as this segment is a growing segment worldwide and is associated with high health care spending, therefore showing a high need for a service that can cut costs by improving patient outcomes.

How does this apply to the New Zealand context? Policy makers and service leaders also hold the purchasing power for Occupational Therapy services within New Zealand. In his 2015 Frances Rutherford Lecture, Dr Kirk Reed highlighted the trend of needing to do more with less. This was again highlighted in the 2017 -2018 Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ) Annual Report which stated that the pressure in the public sector to provide more with limited resources will not change. Therefore, the professions' value of reducing service costs while increasing patient outcomes will meet the same "need" of cutting costs by health service leaders in New Zealand, making this an important target segment.

Additionally, Figures 1.1 and 1.2 show the New Zealand population change over the years. It clearly shows that the number of people over 65 will continue to increase, consequently increasing the strain on the health care services.

Figure 1.1 Elderly Population



(Adapted from Statistics New Zealand, 2000)

Figure 1.2 New Zealand Population:

Table 1

New Zealand Population
Age Structure Changes, 1901-1999

Age group (years)	1901	1926	1946	1966	1986	1999
	Percentage Distribution					
Under 15	33	30	27	32	25	23
15-64	63	65	64	59	65	65
65+	4	5	9	8	10	12
Ratio of Under 15 to 65+	8:1	6:1	3:1	4:1	2.5:1	2:1
Median Age (years)(1)	23	26	30	26	30	34

(1) Half the population is below this age.

(Adapted from Statistics New Zealand, 2000)

Dr Kirk Reed (2016) highlighted additional focus areas for the New Zealand health care system besides an aging population. The focus areas included "increasing incidence of long-term health conditions and the associated complexity of multiple conditions; over representation of Maori in negative health statistics and social factors linked to income". The Occupational Therapy profession in New Zealand could investigate these groups of people as secondary target segments that promotional activities can be focused on.

The next step in the process is positioning where the focus is on understanding the primary target segment of policy makers and service leaders in more depth.

III. Positioning

Positioning relates to a customer's perception of the benefits, attributes or identity of the service, and these elements are evaluated and compared with competing services (Chitty, Hughes & D'Alessandro, 2012). Table 1.1. shows that currently the number of Occupational Therapists is low compared to other Allied Health professions. Considering the ability of Occupational Therapy in meeting the need of lowering costs for health services, the question arises as to the reason behind this. Is this caused by only a lack of awareness of the profession or does the profession struggle with how it is perceived by this target segment?

Table 1.1. Number of practitioners by profession

Number of practitioners by profession				
Year/Profession	Occupational Therapy	Physiotherapy	Social Work	Psychology
2016/17	2435°	4906*	5242^	2757#

* Physiotherapists with annual practising certificates (Physiotherapy Board of New Zealand, 2017).

^ Social workers with practising certificate (Social Worker Registration Board, 2017)

° Occupational Therapists might be working in roles that do not require a current practising certificate are excluded in above number. Including these therapists might result in a higher number of working Occupational Therapists than reported by the New Zealand Board of Occupational Therapy (2017).

Psychologists with annual practising certificate (New Zealand Psychologists Board, 2017).

Developing a position statement involves two main steps: First, the characteristics or identity of the service need to be clearly defined and related to what the target segments perceive as important service attributes. Second, the point of difference of the product/service must clearly identified to show how the service can provide these attributes better than its competitors (Armstrong et al., 2014). Once the positioning statement has been established a marketing strategy can be developed to reach the planned position (Armstrong et al., 2014).

Research aims and objectives

The aim of this small pilot study was to focus on the first initial step of developing a positioning statement by investigating how Occupational Therapy is perceived within the New Zealand health care system. The research question asked in this project was a simple one:

Does Occupational Therapy in New Zealand have an image problem?

The objective was to complete a small pilot study to identify if the need for a larger piece of work using marketing principles to increase awareness, understanding and opportunities for the Occupational Therapy profession. In order to do this, it was necessary to first understand whether there really is a problem. This can best be demonstrated initially through a literature review to identify if problem areas have been identified and what they are. This will lead into the research, where the current perceptions of the

profession by members of the market segment will be investigated. The two parts will be consolidated in the discussion chapter and recommendations on possibilities for the future will be made.

Key terms used

I. Occupational Therapy profession: For the purpose of this study, this term relates to everyone who holds a qualification in Occupational Therapy.

II. Stakeholders: The business dictionary defines stakeholders as a *"person, group or organization that has interest or concern in an organization. Stakeholders can affect or be affected by the organization's actions, objectives and policies. Some examples of key stakeholders are creditors, directors, employees, government (and its agencies), owners (shareholders), suppliers, unions, and the community from which the business draws its resources."* For the purpose of this study, this term describes any person that comes in contact with the Occupational Therapy profession. This includes but is not restricted to other health care professionals, other employees in the health care sector, government agencies and patients/clients.

The structure of the project report

In addition to the introduction chapter, this research report includes a literature review, methodology, findings and a discussion chapter.

The literature review explores literature relevant to the research question with the aim of identifying a gap in the body of knowledge to ensure the relevance of this research project. The following themes have been identified: 1) The Value of Occupational Therapy , 2) Professional Identity 3) Perception of Occupational Therapy . Overall, the literature review indicated that the Occupational Therapy profession has a long-standing issue with how it is perceived within the health care sector. Even though, the literature clearly identified that Occupational Therapy adds significant value to health care and patient outcomes, it also highlighted persistent problems with its professional identity and confidence. Aspects thought to cause the problem to persist have also been identified.

The third chapter describes the methodology and methods used in this study in detail. This study used interpretive descriptive methodology. Five research participants were recruited using purposive sampling method (snowballing). The research participants were Allied Health Professionals other than Occupational Therapists. Semi-structured interviews were used to collect the data for this study. QUAGOL, a 10-step data analysis method, was used to analyse the data and develop the findings.

Chapter 4 will provide a description of the study's findings. The findings were grouped into the following categories: 1) The Value of Occupational Therapy, 2) Professional identity, 3) Promotion Occupational Therapy, 4) Environment and Systems constructs. In Chapter 5, the findings are discussed in relation to the themes identified in the Literature Review (Chapter 2) and recommendations for further research are identified. Further, the limitations of the study are highlighted, and the project report is concluded.

CHAPTER 2
LITERATURE REVIEW

Introduction

This chapter provides a narrative overview of articles published regarding the perception (image) of the Occupational Therapy profession. The aim is to demonstrate that issues surrounding the perception of the Occupational Therapy profession have been a topic of interest and debate within the profession for many years.

Search strategy

Databases including CINAHL, ProQuest and OTSeeker, were used to complete the search for relevant articles. The limitation parameter applied was articles written in English. No publication timeframe or location restriction was set for the search to create a historic, narrative overview. Articles from 1970 to 2016 were included. The articles were reviewed by title and abstract and, if deemed relevant, items included in the selected articles. All articles selected were read thoroughly and if relevant were included in this review chapter. If relevant, articles included in the reference list of the included articles were also included.

Table 2.1: Search Strategy

Search terms	Articles found	Articles selected	Articles included
Occupational Therapy & Image	164	28	26

Evaluation of articles

Many of the articles found, reviewed and included are opinion pieces and not reporting on outcomes of research studies. The few articles available reporting on the outcome of research studies are completed in specific practice settings using a small sample size, which makes transferring or generalising the findings problematic. Also, most articles included have been published outside of New Zealand, making it difficult to state with confidence that the reports are representative of the New Zealand context.

Themes

The below opinions and statements within the chapter are representative of the information provided by the authors of the articles reviewed. The following themes have been identified in the literature reviewed: 1) The Value of Occupational Therapy, 2) Professional identity and 3) Promotion of Occupational Therapy.

The theme of "The Value of Occupational Therapy " focuses on Occupational Therapy being perceived as a profession adding significant value to the health care sector and patient outcomes. The second theme "Professional Identity" covers Occupational Therapy's well-documented difficulty with professional insecurity and identity confusion as well as identifying factors contributing to the issue. The third theme "Perception of Occupational Therapy" examines statements by stakeholders indicating their understanding and recognition of Occupational Therapy, including the effectiveness of increasing awareness of the profession through promotional efforts in the past.

I. The Value of Occupational Therapy

A common theme traditionally identified within the literature is that across its history the profession has been perceived to add significant value to the health care sector and patient outcomes (Smith, 1986; Froehlich, 1992; Hagedorn, 1995; Goren, 2002; Williams & Bannigan, 2008; Turner 2011; College of Occupational Therapists, 2016; Reed, 2016).

In 1986, Smith's mixed-method study on the perception of Occupational Therapy by doctors and ward sisters showed that both had the perception that Occupational Therapy adds value to the care of stroke survivors and wheelchair users. In her 1992 article, Occupational therapist and Assistant Professor at the University of New England, Jeanette Froehlich, stated that Occupational Therapy provides a service that is essential and valuable to society. Three years later, in her 1995 Dr Elizabeth Casson Memorial Lecture, Occupational Therapist and author, Rosemary Hagedorn, stated that the need to purchase Occupational Therapy services across the various settings of the health care sector has been well identified and recognised by purchasers (service leaders). In his 2002 opinion piece, Occupational Therapist, Adam Goren, highlighted that the provision of personalised services is a quality closely associated with the value of Occupational Therapy, making the

profession increasingly valuable to a health care market that is shifting its policy away from a one-size-fits-all approach to services that meet individual needs. In 2005, Lead Occupational Therapist in Research and Development, Hillary Williams, and her co-author, Katrina Banning, stated that the Occupational Therapy profession has valuable expertise and is an asset to multidisciplinary teams.

The message continues in 2011 when Professor of Occupational Therapy, Annie Turner, highlighted, in her Elizabeth Casson Memorial Lecture, that Occupational Therapists provide a valuable contribution to health care and patient outcomes. Then again five years later, the College of Occupational Therapists (2016) published key messages (outlined in Chapter 1) highlighting the significant value of Occupational Therapy within various health care settings and services.

Also, in 2016, the Director of National Centre for Interprofessional Education and Collaborative Practice, Dr Kirk Reed, explained the value of Occupational Therapy by highlighting the profession's capacity to take the lead in collaborating with and across disciplines and services. He also highlighted the strength of the profession in bringing a unique perspective to the planning and delivery of Health care services (Reed, 2016). He stressed the profession's unique ability to bridge medical and social models by using an enabling approach (Reed, 2016). Other professional significant contributions mentioned by Reed (2016) included the reduction of hospital admissions and overall enabling independent living by focusing on resilience and an asset-based approach. However, he stressed that to go forward the profession needs to do things differently, rethink where Occupational Therapy is going and have a clear purpose behind what Occupational Therapists are doing rather than doing things for the sake of the profession (Reed, 2016).

Despite all the positive focus on the value of the profession, there does seem to be a problem with its image. The following sections discuss problem areas repeatedly identified in the literature over time.

II. Professional Identity

Occupational Therapy 's difficulty with professional insecurity and identity confusion is well documented. The confusion regarding the nature and role of Occupational Therapy exists within the profession and consequently with external stakeholders, affecting Occupational Therapists' practice and the perceived value of the profession (Finley, 1998; Goren, 2002; Friedland & Silva, 2008; Wright & Rowe, 2005; Mackey, 2007; Turner, 2011; Brewer & Rosenwax, 2016).

In 1998, Occupational Therapist, Linda Finlay stated, as part of her PhD thesis that the diverse application of Occupational Therapy adds to 'a profound sense of confusion about the nature Occupational Therapy'. Finley is supported later by Goren in 2002 who pointed out that Occupational Therapists' difficulty in explaining their profession results in stakeholders having difficulty understanding it. Stakeholders will continue to connect the Occupational Therapy profession with the closest identifiable thing such as basket weaving, while an easy to define name and identity remain absent (Goren, 2002). Goren (2002) claims that the lack of identity causes a sense of professional insecurity in Occupational Therapists, which in turn causes a tendency for the practitioners to become over-identified with their profession, often at the expense of the profession's practice. Goren (2000) further questions the reason why health, social and educational institutions continue to engage Occupational Therapy services as due to the difficulty in defining and quantifying the nature of the Occupational Therapy profession, the profession struggles to communicate its value and benefits clearly to service purchasers (service leaders).

In 2005, occupational therapists Cathy Wright and Nick Rowe continued Goren's argument. In their opinion piece, Wright & Rowe (2005) wrote that professional insecurity and the lack of professional identity are limiting Occupational Therapy's ability to truly work in genuine partnership with or advocate for service users, reducing the practitioners' ability to fulfil one of Occupational Therapy's key values: client-centeredness. Wright and Rowe (2005) argued that this causes the profession to maintain a perception of "optional extra" in the eyes of stakeholders. Wright and Rowe (2005) explained that the profession's insecurity is difficult to overcome until the profession can provide a clear definition of its nature. Until then stakeholders will continue to connect Occupational Therapy with the closest identifiable thing or hold on to stereotypical images, causing Occupational Therapy

to remain in the position of an "optional extra" (Wright & Rowe, 2005). Wright and Rowe (2005) also pointed out that these stakeholders often function as gatekeepers for referrals, which the authors' identified as another factor that increases the sense of insecurity within the profession.

In 2007, Occupational Therapy Services Manager, Hazel Mackey, wrote in an Australian Occupational Therapy Journal feature article that identity confusion and professional insecurity continue to be well documented. Mackey (2007) defined professional identity as the perception of what it means to be and act as an Occupational Therapist. She outlined that so far, the profession has attempted to sculpt an identity by defining a supporting knowledge base, build professional autonomy and gain a monopoly over a specialized practice area to identify the profession's boundaries. In 2008, Judith Friedland (Professor of Occupational Therapy) and Jennifer Silva (Occupational Therapist) wrote that the fact that Occupational Therapists struggle with professional insecurity shows the need for a stronger identity within the profession. To establish a strong identity, a clear definition of the nature of Occupational Therapy is needed (Friedland & Silva, 2008).

The theme of professional insecurity and identity was again picked up by Annie Turner, Professor of Occupational Therapy, in 2011. Turner (2011) wrote in her Elizabeth Casson memorial lecture that Occupational Therapy has historically experienced difficulties with its identity and confidence. Turner (2011) highlighted that a large part of the profession's identity problems arose from the tension between the profession's heritage and the environment it developed in. She explained that identity is formed through socialisation where less than positive interactions with others can result in a poor sense of self (Turner, 2011). This issue was identified 13 years earlier by Linda Finley (1998) who wrote Occupational Therapists are challenged by the caring-power relationship and are damaged by lack of recognition. The relationship with medicine and the emphasis on science created dependence and outweighed the focus on prevention and promotion of self-health (Turner, 2011). Turner (2011) explained that due to Occupational Therapy 's focus on self-health, it is a minority group within the health care system. As a result, the profession lacked guidance and status during its development which resulted in a poor professional identity (Turner, 2011). To gain acceptance, Occupational Therapy started to focus on

remediation of impairment instead of promoting self-health, starting to adopt other profession theory bases and techniques to appear more scientific (Turner, 2011). It is this dual heritage which has caused difficulty with the development of the profession's identity in the past and the length of time this issue has been documented is an indication that things are not improving (Turner, 2011). Turner's statement appears to hold true as, in 2016, Margo Brewer and Lorna Rosenwax, from the Faculty of Health Science at Curtin University, wrote that few could answer the question of 'What is Occupational Therapy'.

a. Marginalisation of the profession

The Cambridge Dictionary defines the verb marginalise as "to treat someone or something as if they are not important". Froehlich (1992) names two concepts that have an especially strong effect on the identity of Occupational Therapists: Ablebodism and sexism. Froehlich (1992) explained that ablebodism describes the marginalisation of people with disabilities from society through negative or uninformed attitudes by persons without disabilities. She continues by outlining that sexism communicates to women that they are less capable, intelligent and important compared to men (Froehlich 1992). Froehlich (1992) supported her claim by drawing attention to the gender pay gap and sexual and family violence statistics, explaining that these facts exemplify the effects of sexism. Even though the situation has improved since Froehlich's article, recent movements such as #metoo show that women are still subject to the effects of sexism. Twenty-seven years ago, Froehlich wrote that in a world that continues to have a political and social structure dominated by men, sexism conveys to women that they are less (Froehlich, 1992).

Froehlich (1992) considered that the combined effect of sexism and ablebodism is causing the low recognition and visibility of the profession. Occupational Therapy does not only serve persons generally undervalued and oppressed by society, such as people with disabilities, but is also dominated by undervalued/oppressed workers (women). The most debilitating effect of oppression is the internalisation of negative stereotypes by the members of the oppressed group (Froehlich, 1992). For women, oppression is known to cause doubt of a person's own value and competency. For Occupational Therapists to become a proud and visible profession, the effects of ablebodism and sexism need to be

rejected to create a path for Occupational Therapists to become advocates for equal rights for all people, including its members (Froehlich, 1992).

These concepts, if not by name but in meaning, were picked up again in 2001 when Occupational Therapy Lecturer, Susan Griffin, contributed the experience of the Occupational Therapy profession being treated with less respect to the fact it is a predominately female profession. When the idea of professionalism was created, the motive was to permanently set up male characteristics such as power, control and possession. Griffin (2001) highlighted that Occupational Therapists were historically accepting, non-assertive and conflict-avoiding and that the profession accepted a submissive position, sustaining the professions' problems to draw attention from power holders and being treated less than it deserves.

This issue is mentioned again by Wielding in 2011. Her study indicated that the cultural socialisation of women to be passive, caring, accommodating and compliant to institutional structures being an underlying cause of the profession's self-limiting and overly conformist behaviour which in turn contributes to issues with professional identity and professional regard. Wilding (2011) also found that occupational therapists who participated in her study identified that through the process of professional socialisation, students and new graduate therapists received a key message that they should act in a conformist way which shaped these young therapists' perception of what being an Occupational Therapist means. Wilding (2011) explained that Occupational Therapists who are assertive are labelled as whinging, troublemakers or confronting. Together, these messages create a feeling of powerlessness under Occupational Therapists (Wilding 2011). Wilding (2011) links this feeling of powerlessness to Occupational Therapists falling silent.

Heldke and O'Connor (2004) describe powerlessness as one of the five faces of oppression. They explain that:

> *"powerlessness that creates what Freire calls a Culture of Silence. According to Freire, oppressed people become so powerless that they do not even talk about their oppression. If they reach this stage of oppression, it creates a culture wherein it is*

forbidden to even mention the injustices that are being committed. The oppressed are silenced".

Wilding (2011) wrote that the Occupational Therapy profession has fallen silent. Even experienced therapists feel powerless when wanting to offer an occupational perspective in a multidisciplinary team operating in the 'Leviathan of the health care system'. She found that Occupational Therapists have the inaccurate perception that deficits in their practice caused the lack of regard and understanding. Students and new graduates feel vulnerable and adopt the profession's conformist behaviour and culture of silence through socialisation.

In 2016, Dr Kirk Reed wrote that it is time to cast out the myth that issues in leadership are caused by the fact that Occupational Therapy is a female-dominated profession and encourages the development of fearless leadership. He acknowledges that societal oppression disproportionately affects women; however, he says that feminist leadership has much to offer, especially for the Occupational Therapy profession. He further encourages to put aside the "kiwi notion of the tall poppy syndrome" to create strong leadership to lead the profession into the future.

b. Cultural imperialism (medical model & language)

"Cultural Imperialism involves taking the culture of the ruling class and establishing it as the norm. The groups that have power in society control how the people in that society interpret and communicate. Therefore, the beliefs of that society are the most widely disseminated and express the experience, values, goals and achievements of these groups."
(Iris Young, 2004).

In the 2009 Annual College of Occupational Therapy Specialist Section Mental Health Annual Lecture, Creek explained that Occupational Therapy still accepts the rule of the medical model. Creek further argued that the medical model is established on a structuralist understanding in which knowledge is considered context free, objectively fixed and universal (Creek, 2009). In contrast, Occupational Therapy 's philosophy shows a

clear influence of pragmatism which is reflected in the profession's individualised and contextualised practice (Creek, 2009).

Occupational Therapy education is based on structuralist knowledge with the curriculum including theories, models and processes (Creek, 2009) while experienced Occupational Therapists' practice expertise is of a pragmatic and intuitive nature and therefore therapists find it difficult to explain contextual, person-centred Occupational Therapy practice using objective non-contextual theories and models provided to students in a university setting (Creek, 2009). Creek (2009) continues that a structuralist knowledge base provides Occupational Therapy with tools to think about and work with health conditions reducing peoples' ability to perform meaningful tasks; however, it should not govern or drive the Occupational Therapy process or goals. Creek (2009) highlighted that this disconnect between theory and practice is one of the main issues for developing a mature profession.

This is not a new issue. Mocellin (1995), Creek (1997), Wright (1998) and Goren (2002) argued that the Occupational Therapy profession's tendency to use biomedical science to validate itself only increases the challenge of being understood. Goren (2002) stated that to survive market forces, the Occupational Therapy profession associated itself with other, more powerful cultures within the biomedical model as a way to deal with the complexity of the profession. As a result, practitioners change into more identifiable roles with greater objectively measurable value or which are in some measure more appreciated or recognized (Goren, 2002). Goren (2002) highlighted the risk of practitioners 'becoming stuck' in one of these roles and abandoning the profession altogether or heavily investing in an area of expertise nearing its sell-by date. Hooper and Wood (2002) described the decision to align Occupational Therapy with medicine as the long conversation where pragmatism, representing returning persons' quality of life, made way for structuralism and the understanding of how to fix body parts. In 2008, Friedland and Silva queried whether the alignment with medicine distracted Occupational Therapy from its focus on occupation as the essence of the profession.

Goren (2002) argued that the duality of combining a pragmatic practice with a structuralist, scientific language and evidence base is the main cause for Occupational Therapists' difficulty articulating their interventions clearly. Brenner (1982) claimed that language that is formal and context-free could not express the complexity of expert Occupational Therapy practice. Mocellin (1995), Creek (1997), Wright (1998) and Goren (2002) argued that the Occupational Therapy profession's tendency to attempt to use biomedical science and language to validate itself only increases the challenge of complexity.

In 2009, Creek used an example of a well-known Occupational Therapy task of making a cup of tea with clients or patients to highlight the connection between language used and the understanding of Occupational Therapy. She explained that the Occupational Therapy purpose of the task was for the client to 'overcome her anxiety enough to engage in gradually expanding the range of socially appropriate activities' (Creek 2009). Creek (2009) highlighted that the exact process of how this was achieved by the task of making a cup of tea is difficult to express in words as much of the intervention involves non-linguistic thinking. Creek (2009) explains that the current use of language by the Occupational Therapy profession causes tension between what the profession perceives to be the goal of intervention by focusing on lived experience and communicating these goals using language based on a biomedical vocabulary adapted to describe these goals. As a result, many of the other professions see the purpose of the task as making the cup of tea.

Creek (2002) also highlighted two connected issues. The first one was the fact that, due to the profession's acceptance of language that has been developed by medical professionals or psychologists (Creek, 2009), differentiating Occupational Therapy from these professions is difficult. Much of what Occupational Therapists do cannot be easily translated into language, therefore using medical/psychological language to describe Occupational Therapy practice becomes reductionist as the words used shape our thinking and doing (Creek, 2009). The other issue she raised is the fast and continuous development of new Occupational Therapy terms with no clearly defined meaning. Creek (2009) explained that this indicates that the profession does not possess its own vocabulary to describe the nature and purpose of its practice. She further highlights that when

Occupational Science language is used, other professions either ignore it or 'make fun of us' (Creek, 2009).

To use Young's (2004) definition of cultural imperialism – the medical model is the ruling class within the Western health care systems and its values control how health care professionals communicate and interpret health. This causes an ongoing issue for Occupational Therapy.

III. Perception of Occupational Therapy

Another theme identified in the literature is that stakeholders often have a lack of understanding of the role of Occupational Therapy which can result in a false or damaging perception of the profession. In 1986, Smith conducted a small study on the lack of referrals to a hospital's Occupational Therapy team in the United Kingdom. The study showed that doctors were primarily concerned with the medical management of their patients and showed a lack of understanding and, at times, lack of interest in the value that Occupational Therapy can provide to patient care. In 1989, Blom-Cooper wrote a report for the Independent Commission on Occupational Therapy based in the United Kingdom. The report highlighted the fact other health care professionals often display a 'false and damaging stereotype of the function of Occupational Therapists', a fact also highlighted in later studies. In 1992, Froehlich claimed that many relatives, friends and co-workers still do not know or understand what Occupational Therapy is and questioned if Occupational Therapists are good advocates of their profession.

In 1994, Greenhill conducted a study investigating GPs' awareness of the role and services of Occupational Therapists prior and post the introduction of the General Practitioner Contract by the National Health Service (NHS) in the United Kingdom. Her findings showed that there is an inconsistency in the understanding of the role and benefits of Occupational Therapy among GPs. In 2000, Fortune wrote that Occupational Therapists are perceived as 'gap-fillers' or 'competent all-rounders. In their 2005 study, Wilkinson and Chard highlighted the fact that secondary students are often not provided with adequate information about Occupational Therapy causing a lack of awareness and understanding of the profession. In 2009, Kinn and Aas claimed that Occupational Therapists are expected to be flexible and shift between roles to support clients.

IV. Recognition (low status)

The lack of recognition of the service was also a common theme over the years. In 1989, Blom-Cooper stated that due to the difficulty in measuring outcomes of Occupational Therapy interventions, it is a profession that is likely to be perceived as peripheral or judged as luxurious by a financially strained health care system. In 1992 Froehlich stated that the profession continues to struggle with having the value of its service recognized, even though considerable energy has been committed over the last century to develop and promote the profession. In 1995, Hagedorn stated that the profession continues to fail in sufficiently raising its awareness and profile. As a result, recommendations to employ more Occupational Therapists are not taken seriously (Hagedorn, 1995).

In his 2002 opinion piece, Goren voiced concern that Occupational Therapy, like any other service operating in any market, is required to convince purchasers (service leaders) and users of its service value (Goren, 2002). He explained that this is strongly connected to the ability to clearly describe the characteristics of the service and proof of its value for money as it is difficult to be measured by quantitative scientific data (Goren, 2002). This is a persistent issue for Occupational Therapy as the profession continues to struggle to clearly define itself and the Occupational Therapy process is not simply described or demonstrated (Goren, 2002).

In 2005, William and Bannigan reported that occupational therapists often express frustration over the fact that members of other disciplines do not understand the role of the Occupational Therapist. Therapists further expressed that they feel undervalued and misunderstood by their team members (William & Bannigan, 2005). Hagedorn (2005) described the profession as invisible and having failed to raise an adequate public profile. She described the public image of the profession as distorted and that the understanding of the role of Occupational Therapists is restricted to 'limited circles of influence' (Hagedorn, 1995).

In 2009, Kinn and Aas state that previous research indicated that occupational therapists experience job satisfaction if their role is central, however that there seems to be a connection between a strong sense of self-value and the lack of recognition by others (Bellner, 1995; Duffy & Nolan, 2005; Finlay, 1998; Moore et al., 2006; Sachs & Jarus, 1994 as cited in Kinn & Aas, 2009). Even though studies showed that many therapists have a

positive self-image, many described feeling invisible, misunderstood, undervalued and stereotyped by a historic image (Kinn & Aas, 2009).

In 2011, Turner again drew attention to the fact that, throughout time, members of the Occupational Therapy profession have felt unappreciated and misunderstood by both colleagues and the public. She claims that at times, Occupational Therapists are not perceived as equals due to their struggles to communicate clearly within multi-professional teams and the perception of Occupational Therapists being gap fillers (Turner, 2011). Also, in 2011, Wilding stated that the occupational therapists who participated in her study felt that the profession is not awarded the regard that it deserves. After an investigation into service leaders' perception of Occupational Therapy in 2016, the College of Occupational Therapists reported that there continues to be a lack of understanding of the value that Occupational Therapy is adding to health care and patient outcomes

V. Promoting Occupational Therapy

In 1986, Smith highlighted the need to improve communication with other health professionals to improve the understanding of and interest in the Occupational Therapy profession. In 1994, Greenhill recommended that Occupational Therapists develop new marketing strategies, particularly information on Occupational Therapy services and their benefits, to ensure the need and the benefit of Occupational Therapy services can be identified and utilised accordingly. Beside multiple recommendations and examples over the years, in 2002 Goren stated that 'a solution to the problem of marketing a professional image and function remains elusive'.

Authors continued to examine the issue and provide recommendations for improvement. In 2005, Wilkinson and Chard recommended increasing the awareness of Occupational Therapy as a career choice by providing informational material to career advisors and through communication channels preferred by secondary students. In 2008, Friedland and Silva recommended following the example of Thomas Kidner, the president of the American Occupational Therapy Association (AOTA) post World War 1, who the authors describe as excelling in his efforts to promote the profession to the public and other health care professions. Kidner believed in the adoption of political reformers' motto "organise,

agitate, educate" (Friedland & Silva, 2008). During his time as president of the AOTA, he travelled widely to speak to and create close relationships with a variety of people, groups and associations including the American Medical Association which as a result included lectures on Occupational Therapy into the curriculum for medical students (Friedland & Silva, 2008). He further used print media and radio to increase the awareness and understanding of Occupational Therapy by the public. Friedland and Silva (2008) reflected on Kidner's work and recommended to continue to apply his strategies to give Occupational Therapy a presence.

In 2011, Turner and Wielding provided different explanations for the lack of marketing/awareness of the profession. Turner (2011) wrote that Occupational Therapy has a lack of passion and ability to promote itself and stressed the importance of making strategic 'friendships' to create awareness. Wilding (2011) on the other hand wrote that Occupational Therapy as a profession has overly promoted the traits of nice, passive and compliance as desirable traits to the detriment of gaining respect and acknowledgement of the profession. Therefore, Wilding recommended focussing on developing therapists' skills to be assertive and stand up for their professional convictions when opposed or doubted (Wilding, 2011). Wilding's statements align with Griffin (2001) who called for Occupational Therapists to improve management skills, negotiation skills, conflict resolution and policymaking skills. Griffin (2001) urged the profession to develop internal power through confidence and assertiveness.

However, it seems that these goals might require some consciousness-raising on the part of the profession. In 2001, Griffin raised concerns about the ability of occupational therapists to support one another. Griffin (2001) claimed that when therapists who applied well established accepted principles, such as the promotion of independence and the maximisation of potential for themselves or their profession, they were often met with hostility from their peers.

The journey to find an answer continued and in 2012, Jacobs described in the Eleanor Clarke Slagle Lecture the promotional tools and strategies used to promote Occupational Therapy not only in the United States but by Occupational Therapy bodies across the world and the profession's existence. From the early days of the profession, these methods

included networking (such as aligning the profession with local and national associations or the use of 'ambassadors'), encouraging interdisciplinary work/education and publishing science-driven evidence that guides best practice with the aim to gain respect and understanding within the science-driven health care system (Jacobs, 2012). Other methods in the early years included travel exhibitions, not unlike the poster displays used during current OT month celebrations. Other common methods were and still are the distribution of professional publications or holding events and conferences as well as the use of brochures, posters and fact sheets. More recent methods include National Awareness campaigns or client group-specific campaigns.

Jacobs (2012) also stated that over the course of the last 100 years, Occupational Therapy as a profession seemed to have under-utilised new technology. She explained that it took several years after its development until Occupational Therapy was mentioned on television and to this day, unlike other health professionals, is not well represented in films or series alike (Jacobs, 2012). This pattern did not appear to be broken since the introduction of social media. 90% of member countries of the World Federation of Occupational Therapy (WFOT) reported using printed promotional material while only 62% of these member countries used materials online to promote their profession, however many of them indicated they were interested in growing their social media presence (Jacobs, 2012). Walsh (2018), who investigated the visibility and perception of the Occupational Therapy profession in selected media outlets, continued to highlight that Occupational Therapy should have a stronger representation in news and online platforms. She encouraged individual practitioners to drive the promotion of the profession by combining using grassroots advocacy with accessible social media channels.

The persistent issues with getting the profession valued and recognised across time, and within most countries and healthcare systems indicates that it is timely to ask the question again: Does Occupational Therapy in New Zealand have an image problem?

Conclusion

The literature showed that there are several longstanding issues that contribute to the image of Occupational Therapy. Overall, it seems that Occupational Therapy is perceived to have value. However, the lack of an easily understood name and definition of the

profession makes Occupational Therapy's value and benefit difficult to measure and promote to service purchasers. Occupational therapists continue to feel undervalued and misunderstood, struggling to explain their practice to stakeholders and feel professional insecurity and identity confusion. It is hardly surprising, therefore that stakeholders continue to misunderstand the profession and its value, perceiving Occupational Therapy as an 'optional extra' as described by Wright and Rowe (2005). This creates a vicious cycle, where occupational therapists have negative experiences, further damaging professional confidence and identity.

Occupational Therapy has status as a profession, and yet it seems that as a largely female profession, it continues to be affected by various forms of oppression, abelbodism and sexism. Generally, these are issues for vocations with low status and lack of recognition in a patriarchal system. Cultural imperialism and the dominance of the medical model over pragmatism and focus on well-being were outlined as reasons for occupational therapists falling silent and adopting conformist behaviour instead of advocating for their profession and patients/clients, further reducing the feeling of confidence. Promotional methods have been discussed and the literature reviewed showed that even though efforts have been made, Occupational Therapy is not achieving the levels of awareness other health professions achieve within mainstream media and the public.

The literature reviewed indicates that further research on the image of Occupational Therapy would be beneficial to investigate if any change has occurred and how stakeholders perceive Occupational Therapy within a New Zealand context.

CHAPTER 3
METHODOLOGY

Introduction

In this chapter, a detailed description of the methodology is provided, outlining the process and design of the study. These, in turn, correspond with the methods chosen to achieve the aim of the study. Further, the methods employed in this study are discussed, and the justification given on how these will provide answers to the research question. Finally, this chapter reviews ethical considerations and how these have shaped the study design and process as well as strategies applied to ensure the rigour of the study.

What is Interpretive description?

Interpretive description is a comparatively new qualitative methodology particularly useful for studies conducted within applied health sciences (Thorne, Kirkham & MacDonald-Emes, 1997; Hunt, 2009). Thorne (2016) claims that interpretive description is useful to researchers who feel that the traditional methodologies do not meet the needs of research questions in terms of developing and applying the findings to practice.

What interpretive description considers 'interpretation' takes inspiration from the formal interpretive hermeneutic tradition, without becoming a confirmed believer. It recognises that a clinical mind tends not to be satisfied with 'pure' description, but seeks to discover associations, relationships and patterns within the phenomenon that has been described. It also carries the assumption that there are other cases with relevant similarity, which moves the findings and analysis closer to general knowledge. Interpretive description suggests that there is inherent value in a careful and systematic analysis of any phenomenon, combined with a pressing need to put that analysis back into the context of the practice field with all its inherent social, political and ideological complexities. In this way, it becomes possible to shift the angle of vision from which one customarily considers that phenomenon.

Interpretive description was developed with the aim of overcoming the tension between theoretical integrity, and the production of knowledge that can be put to applied use. It does not aim specifically to contribute to social theorising, which means that it steps outside of the theoretical traditions of social science. The applied nature of this methodology means that it cannot be carried out using a prescriptive and restrictive sequence of steps, but rather derives its integrity from the need to meet an actual practice goal. It further derives its strength by being carried out by a practitioner/researcher, who understands both the knowledge and the knowledge gap within the field. As such, interpretive description provides the potential to examine the views on which previous evidence has been established, while also creating insights that shape the application of evidence to practice.

Philosophical and theoretical context

Interpretive description does not follow the traditional ways to create theoretical integrity. It was deemed useful for the reader to understand the ontological and theoretical perspective this study was based on as the views about reality and how a person develops knowledge significantly influence the study design, process and findings.

This study draws from the philosophical underpinnings that support the perspective that "reality doesn't exist externally as an object or entity that can be discovered but is rather socially constructed, subjectively by people who experience it" (Mottier, 2005 as cited in Thorne, 2008). Research studies based on this philosophical stance respect the perspectives of others while focusing on the context in which experiences or perspectives develop and become meaningful (Thorne, 2008). This study's design was built on the belief that knowledge cannot be outlined as simply objective or subjective but is established through interactions between people and their world. The world and its objects are indeterminate, and knowledge or meaning is constructed when people consciously engage with the world they are interpreting (Crotty, 1998). Therefore, all knowledge and meaning have been developed through interpretation. Consequently, the approach the study's design was built on aimed to learn of the attitudes, feelings and perceptions regarding the Occupational Therapy profession through conversation and interaction with the participants.

Both the methodology and its philosophical and theoretical context are purposefully chosen to align itself with the pragmatic approach representing Occupational Therapy. Pragmatic thinkers assume that knowledge is created within a specific context while structuralists presuppose that knowledge is objective and generalizable (Hooper & Wood, 2002). In earlier years, Occupational Therapy adopted both pragmatist and structuralist beliefs about human knowledge, which produced different interpretations on appropriate tools, methods and outcomes. This has been identified as a contributing factor in its ongoing professional identity issues (Hooper & Wood, 2002). The methodology of interpretive description is an opportunity for Occupational Therapy to produce knowledge that can be applied in the professions' practice context.

The research question:

Does Occupational Therapy have an image problem in New Zealand?

Study design

I. Sampling and Recruitment

a. Interview participants: The inclusion criteria for the interview participants were as follows: Participants who work within the New Zealand Health Care sector and work or have worked with Occupational Therapists in some form. The exclusion criteria for the interview participants were as follows: Participants holding an Occupational Therapy tertiary qualification.

b. Terminology for sample members:

The term ‘study participants' is used to refer to individuals included in the sample and recruited to participate in this study. This is based on Thorne (2016) who stated that the term study participants has become somewhat standard as it is relatively neutral in its implications and does not carry the implicit unintended baggage such as the term of "respondents", "informants" or "co-researchers" used in other qualitative research.

c. Sample size

Thorne (2016) stated that most studies using this approach use a relatively small sample from 5 to 30 participants. However, the approach is also applicable to large samples and single case studies. As this study is an exploratory study, a relatively small sample size has been chosen. In total, five study participants were recruited. This seemed appropriate for a study to complete a Master's project.

d. Sampling method used

Thorne (2016) states that there are three main sampling methods associated with interpretive description: convenience sampling, purposive sampling and theoretical sampling. This study is using a combination of purposive and convenience sampling.

i. Purposive sampling

The strategy of purposive sampling is to try to identify, in advance of the study, the main groupings or conditions that you will want to include in your study so that the eventful findings you produce have the potential of ringing true or seeming reasonable to your intended audience (Robinson, 2014 as cited in Thorne, 2016). A particular and important form of purposive sampling is the strategic identification of key informants such as has long been the hallmark of ethnographic study (Pelto, 2013 as cited by Thorne, 2016). The rationale for key informants is that some members of a community will be better equipped than others to provide you with access to what is happening and why it is happening. In health practice, the underlying idea of the key-informant might cause one to seek out individuals with extended experiential backgrounds or who would have had exposure to a group of people with backgrounds similar to their own.

ii. Purposive sampling in the context of this study

Using this sampling method, the researcher contacted the administrators of two private health companies. The administrators of these companies forwarded the invitation to its employees.

iii. Convenience sampling in the context of this study

The researcher used snowball sampling, a form of convenience sampling, in order to reach possible participants. The researcher invited the recipients of the invitation to participate to forward the invitation to peers, colleagues or managers whom they think would be interested in participating. All five participants who contacted the researcher were included in the study.

e. Profile of selected Participants

Table 3.1: Demographics of Interview Participants

(Please note that participants' names have been replaced by pseudonyms to maintain privacy and confidentiality)

Name	Jane	Sarah	Sharon	Ellen	Theresa
Gender	Female	Female	Female	Female	Female
Age	26	45	26	33	30
Years practising	4	15	1	5	4
Job title	Physiotherapist	Social Worker	Speech language Therapist	Psychologist	Physiotherapist
Setting	Private Practice	DHB	DHB	Private Practice	DHB

Ethics

Ethics Approval for this study was granted by Otago Polytechnic Ethics Committee on 3 February 2017 (Appendix 1). The Office of the Kaitohutohu was consulted to ensure the research study observes the Treaty of Waitangi and its principles as well as the data collection from human participants, particularly Māori participants. The Office of the Kaitohutohu supported the ethics application but advised the researcher to contact the office for further consideration should any of the participants be of Maori ethnicity or descent. This was not necessary as none of the participants identified with Maori ethnicity.

Confidentiality & Information storage.

All participants were given an information sheet and have signed a consent form (Appendix 2). The forms were scanned and kept in electronic form on a password-protected computer. The transcriber also signed a confidentiality form and all transcripts were stored online on a password-protected computer.

Data Collection

The data was collected through semi-structured interviews (Thorne, 2016). The aim of the interviews was to gain an understanding of the perception of Occupational Therapy by stakeholders who were external to the Occupational Therapy profession. A total number of five interviews were conducted. All of the interviews were conducted in person. The interviews followed an interview schedule (Appendix 3) with semi-structured questions and were recorded on two devices and transcribed for data analysis.

Data Analysis

The Qualitative Analysis Guide of Leuven (QUAGOL) was used to guide the data analysis of this study. The QUAGOL is a theory and practice-based guide supporting and facilitating the qualitative data analysis process (Dierckx de Casterle, Gastmans). The guide uses a systematic, yet not rigid, two-part process which each consists of five stages.

Stage 1 included the thorough reading and re-reading of the interviews to capture essential features and identify information relevant for the research question by underlining key phrases, tentatively interpreting the meaning of some words and passages with thoughts or reflections noted in the margin (Dierckx et al., 2011) (Appendix 4). The objective of Stage 1 is to gain a holistic understanding of the respondent's experience, leading into stage 2 where this understanding is attempted to be articulated.

Stage 2 consisted of re-reading the interview transcripts again. In order to capture the essence of the stories a narrative report was written for each interview (Appendix 5)

identifying central characteristics of the stories that could contribute to a greater insight into the research topic (Dierckx et al., 2011)

In stage 3, the most important information was identified and sorted into concepts that captured the essence of the stories regarding answering the research question (Dierckx et al., 2011). The concepts were illustrated in a scheme with the key concepts highlighted. The analysis moved away from the participant's experience to a conceptual level by developing a conceptual interview scheme from the narrative report. The aim of the conceptual interview scheme was to establish concepts that gave insight into the research topic by clustering the most important data into concepts (Appendix 6). This provided a more abstract level of the information provided during the interviews. The concepts were helpful in developing the structure of the research answer in step 9 (Dierckx et at., 2011).

In stage 4, I used what Dierckx et al. (2011), described as a "forward/ backward movement". The interviews were reread and compared to the conceptual schemes in order to determine if the concepts accurately reflected the interview data and to ensure that no concepts had been overlooked (Dierckx et al., 2011).

Stage 5 expanded on stage 4 by applying the backwards-forwards process from within case to across case analysis in order to identify common concepts throughout the interviews. These concepts were then accumulated in one overarching conceptual scheme. Memos were used to record the analytical and reflective process of developing and refining the common concepts and the common conceptual scheme resulting in a greater conceptual understanding of the data as a whole while maintaining the integrity and individuality of each interview (Dierckx et al., 2011).

Stage 6 drew out the general concepts (without hierarchy) based on all the interviews and developed concept schemes (Appendix 7).

In stage 7, I revisited each interview with the list of concepts in hand to determine if the concepts helped to reconstruct the storyline, highlighting the important passages and linking a concept to the significant parts of each interview. This helped to test the quality

of the concepts and explained why some concepts were present in some but not all interviews (example in Appendix 4).

In stage 8, I engaged in a cross-case analysis of all concepts. The concepts were formulated in my own words to further define the concepts and develop a clear description of the meaning, dimensions and characteristics of the concepts (example in Appendix 4).

In stage 9, the concepts were integrated into a conceptual framework responding to the research question. Using the interview schemes separately, all concepts were organised and structured in a framework. This framework was also verified against all interviews to ensure all individual interview stories were described.

In stage 10, the essential findings were described regarding the research questions, starting with the core findings before moving to related and interconnected concepts. Quotes were added where they could add further understanding and clarity. Even though this is the final stage, continuous comparison was used to further develop insight into the findings (Appendix 9).

Transferability

Transferability is concerned with the extent to which research findings can be used in other contexts, settings or groups (Krefting, 1991). Lincoln and Guba (1985) argued that to allow for comparison the researcher needs to present sufficient descriptive data (thick description). To support transferability, detailed information on all aspects of the research process have been included in this report.

Dependability

Dependability relates to the ability to show that findings are consistent and can be repeated (Lincoln & Guba, 1985). This refers to the evaluation of methodological consistency within the study. This was achieved by drawing on the philosophical and theoretical underpinnings of interpretive descriptive methodology to instruct the research design and process. The methodology and research design were presented to the primary

supervisor for scrutiny of the design of the research study and to ensure theoretical and methodological consistency throughout the process.

Confirmability

Confirmability refers to the degree to which a study's findings are created by the participants and not by the researcher's bias about the neutrality of the data and measures, and how well the data collected supports the research findings (Lincoln & Guba, 1985). Confirmability is attained with the establishment of credibility and transferability (Lincoln & Guba, 1985). The use of memos documenting the decision trail and the researcher's thoughts, ideas and assumptions allow the reader to understand and follow the principles applied during data analysis. The memos were included in the documents describing the stages of data analysis.

Reflexivity

To maintain objectivity throughout the research project I used memos, outlining my thoughts, feelings and decision-making process during the data analysis process. I used these reflections to keep my own experiences and preconceived ideas separate from the participants' descriptions in order to allow the findings to emerge out of the data collected from participants.

CHAPTER 4

FINDINGS

Introduction

This interpretive descriptive study aimed to identify if there are issues with the current image of the Occupational Therapy profession in New Zealand. The themes identified in the analysis were catalogued into four categories:

i. The value of Occupational Therapy
ii. Professional Identity
iii. Recognition
iv. Environment and System constructs

The category ‘value of Occupational Therapy' highlights the knowledge and insight of participants regarding the contribution and benefit that Occupational Therapy can provide. The second category, ‘Professional identity,' highlights issues with professional insecurity, role confusion and boundary concerns together with the profession's difficulty of working within a medical model. The next category, ‘Recognition', highlights issues caused by a lack of understanding of Occupational Therapy and the promotion of the profession. The last category, ‘Environment and System constructs' illustrates how the physical & institutional environment shapes other health professionals' understanding and perception of Occupational Therapy.

Themes

i. The value of Occupational Therapy

All participants perceived Occupational Therapy as valuable. Participants used descriptive words such as "invaluable", "important", "most useful thing", "practical" "undervalued" and "underestimated" when asked to describe Occupational Therapy. Several ways that the Occupational Therapy profession adds value were identified during the interviews. The profession's ability to increase a person's independence by restoring function after illness or injury, will consequently reduce support services costs and the number of re-admissions

was identified as valuable to the New Zealand health care system as it directly relates to contributing to a decrease in health care expenditure.

> *"So, I think the biggest thing is going to be trying to improve discharge planning. And I think that is a really key thing, because if you can get someone independent with functional tasks that they need to do day in and day out, you're going to reduce the burden on their private care agencies, or public-funded care agencies that have to then provide help for people who may not need it. […] that's a saving for the healthcare system, isn't it? And getting people discharged I guess sooner, rather than thinking, they're just not making any functional gains because somebody else is doing it for them all the time. "*

The profession's ability to see the bigger picture was also identified as a strength characterising Occupational Therapy. Participants mentioned that it is helpful that Occupational Therapists have a holistic picture of people as it aids other professions to target their treatment to the areas that will increase the people's independence and enable them to manage their daily lives to the best of their ability.

> *"And I think that is the most important thing at the end of the day, that somebody is able to live their life and manage that in as independent a matter as they possibly can."*

The profession's capability to assess a person's ability and safety with completing daily tasks was deemed valuable for discharge planning. Another strength of the profession was to assess a persons' independence versus need for support services and therefore reduce admissions or readmissions to hospitals. Without Occupational Therapy 's contribution to discharge planning, participants thought that more people would be re-admitted to the hospital, and more people would struggle in silence. Without Occupational Therapy, people were believed to have a reduced chance to return home or back to work after an injury or illness.

"They might say, "Oh, this person will be okay. I think they'll manage." Whereas, the OT can say, "well, actually, I've been doing all the small daily tasks and they can't manage." In that sense, it's invaluable because it's preventing people being at risk."

Collaborating with occupational therapists was perceived as very valuable and positive. Participants perceived collaborating with an Occupational Therapist as beneficial as it provided a wider perspective and helped in validating their own clinical reasoning.

"So, I'll do […] assessments, but they'll also be doing a whole load of functional assessments. And so I guess it's important that we talk to see if what we're finding kind of matches up, or if there are big gap, which might indicate something's gone wrong in either of those processes or we are capturing something that is not there or something different"

Participants described the flexibility of Occupational Therapists to work across different areas as useful. Occupational Therapists are perceived to be guided by a functional approach to treatment that can provide other health professionals with valuable support or guidance to their treatment approach.

"I think having that flexibility around what you do probably means that you're more useful. I think that's maybe a good perception that people can say, "All right, well the OTs can do this. We can work with the OTs on this." Because you can work across all the different areas."

Unfortunately, even though participants described Occupational Therapists as useful and beneficial, a theme emerged that showed that this flexibility of Occupational Therapy could also hinder collaboration as it creates role and boundary confusion and uncertainty of what type of tasks Occupational Therapists perform.

ii. Professional Identity

The fact that there is significant confusion around the role of Occupational Therapy was highlighted. It was identified that health professionals as well as patients/clients tend to

associate Occupational Therapists with the tasks that they perform rather than the profession. Examples given were "providing equipment" or "assisting in the shower".

> *"I would think that maybe OT isn't a generally understood profession, but maybe they are the ones that's helping me with my equipment, or they're the ones that's helping me in the shower, or attached more, related to a task, rather than what profession."*

Participants also highlighted that Occupational Therapists are often confused with other health care professionals such as nursing staff or assistants. The perception was that due to the tasks that Occupational Therapists do, the difference between professions is not obvious. Examples were given, that nurses help patients shower and dress and often the focus on independence that Occupational Therapists have when performing these tasks with patients is often not seen or understood as therapy and therefore people assume that Occupational Therapists assist nursing staff with showering and dressing people.

> *"I think that people often confuse occupational therapists with nursing staff or assistants because they're there to maybe assist them with washing, dressing, grooming tasks. Which they might not realize is an actual task to practice as part of their therapy. They might just think you're there to help them. And then they might think, well, why is this person making me do it? So, they might think you're a really crappy assistant."*

Some comments were made labelling Occupational Therapy as a non-therapeutic profession but rather a profession holding an overarching key working role, coordinating other health professionals interventions to collaborate in achieving an overall goal. Occupational Therapy interventions were described as activities that "lead into therapy" or other health care professionals "add therapy in to".

> *"[..] that might mean that you're looking after them from the first thing that they do in the morning, which might be having breakfast, to having a shower, to leading into their therapy, to then having lunch. And you're often liaising the whole day with*

an occupational therapist, because that's their main role is to sort of help with those activities of daily living. And we add therapy in to assist those things."

The profession's name was identified as a cause of the confusion regarding the Occupational Therapy profession. The word "Occupational" was thought to cause people to interpret this as a profession related to vocation.

"[…] often they might have physio. So, they already know what physio does, they might have OT as an additional thing. They still quite don't understand what that role is. Where a social worker, obviously, that seems more self-explanatory, and obviously that's helping them sort out their social situation, and that kind of thing. And speech is obviously self-explanatory, whereas Occupational Therapy is, kind of could be anything. And I think people kind of wonder why I need help with my occupation. The name I guess doesn't give people any clue as to what they actually need to do. And so, I think that in itself is kind of, change the name of OTs."

Additionally, participants felt that patients might not perceive some of the therapeutic interventions of Occupational Therapists as therapy as the tasks are either seen as basic or do not have a high priority for clients/patients at the time of intervention. One participant was unable to identify any benefit of Occupational Therapy in an inpatient mental health setting.

"And obviously, they do provide therapy as well, but people might not realize that that is therapy, like providing a certain piece of equipment. Might be just, they're just seen as an equipment provider or something like that. Whereas I don't think they see it as an actual therapist."

Participants reported that they did not feel that Occupational Therapy has specific domains that the profession has taken ownership of except for the provision of equipment. Participants reported that the role of Occupational Therapists varies between different settings and often between Occupational Therapists within the same setting.

"I think in here, it's that (cognitive assessments) seems to go more to the psychologist, whereas another setting the psychologists I guess are not easy to access so OT's will do it. I think sometimes there's a bit of overlap in whose roles which is a bit confusing."

This was perceived to cause a feeling of uncertainty in other health care professionals who would like to collaborate with Occupational Therapists. One participant mentioned that the overlapping boundaries with other health professions may contribute to the difficulty with the profession's identity and therapists' professional insecurity. It was assumed that this causes a lack of ownership of tasks and an appearance of being easily replaceable. It was also mentioned that it can cause animosity with other health care professionals as they feel Occupational Therapists overstep the professional boundaries of these disciplines.

"I think just because they're across so many different things, and there's also a lot of overlap with other allied health, from my understanding, anyway. {…} So, I think it must be hard sometimes, for OTs, trying to forge your own identity too, when you're across so many different things."

iii. Marginalisation of the profession - Cultural imperialism

Some participants' described that the New Zealand health care system operates predominantly under the medical model and that it fostered a historical hierarchy that favours professions that operate within this model, such as doctors and physiotherapists, to move to the top of the hierarchy. Professions that operate on a psycho-social model such as Occupational Therapy, Social Work or smaller professional groups such as Speech-Language Therapy or Psychology are perceived to be lower in the hierarchy.

"{…} I see it time again about the medical model where it can be overruled and I feel as though when that happens, and it's happened to me as a {…}, I've seen it happen. It can be very undermining. And it can be very much, you feel a bit disrespected. It's not because you're saying you're an OT or a social worker that your view must be listened to. But it's when it feels it's not listened to. You're not saying you shouldn't

be disagreed with or the team shouldn't talk about it. But sometimes, you can feel as though a medical decision is made without fully trying to understand the professional's opinion and what's behind it. And yet, when they want you to do something, they talk as if they know your job inside out. And that you should do this because they know you should do this. But actually ..."

The effects of this social norm were described as hurting role satisfaction and identity through feelings of being disrespected and undermined.

"Is I feel as though, the sensitised identity as a {…} is really absorbed as in the medical model. And it makes the job quite vague and difficult to get your head around. {…} it can be really difficult when you're in that hierarchal system where it's just the norm. It's accepted. It's ingrained that the doctors, and the nurses, and the medical professions know more than (others). It's really hard to change that."

iv. Recognition

A lack of understanding of Occupational Therapy impedes any efforts to create recognition for the profession. The lack of understanding of the role of Occupational Therapy by health professionals, patients/clients and the public was a clear theme emerging from the data. As a result, Occupational Therapy was perceived as being undervalued.

"I think it's an undervalued and unknown kind of profession."

Most participants explained that they are still not clear on what the role of Occupational Therapy is. Though most participants had worked with Occupational Therapists throughout their career, there was still uncertainty and confusion concerning the role and tasks that Occupational Therapists perform. These tasks were perceived to vary between health care settings and even between therapists leaving a sense of confusion and insecurity regarding the scope, boundaries and value of the profession and how or when to collaborate with Occupational Therapists.

"I can't say I knew the job of what an OT did inside out. I didn't feel like that."

There was a common perception among participants that the role of Occupational Therapy is to use a broader range of knowledge to allow for a holistic approach when assessing the practical implications of daily living. Occupational Therapists were recognised for completing a variety of specific tasks such as helping people regain their ability to complete activities of daily living such as showering and dressing to more broader concepts of returning home or back to work.

> *"My understanding of it [OT] is they help people with adjusting, adapting to changes they have in their life. {…} how they return home successfully, how they potentially return to work successfully."*

However, even if participants could describe the overall concept of the role of Occupational Therapists within their setting; there seemed to be a level of uncertainty around fully understanding the role and tasks of Occupational Therapists. One participant stated that she was not sure why the tasks Occupational Therapists perform in their service are Occupational Therapy-specific tasks as they seem to be able to be performed by other disciplines.

> *"I think I understood, in general, what the concept is, maybe not all the individual components of it."*

Another theme that emerged from the data was the perception that understanding of Occupational Therapy only results when people are exposed to the profession. Some participants explained that, at best, they had some basic understanding of Occupational Therapy after completing their training, while others had not heard of Occupational Therapy until starting in a service that employed an Occupational Therapist. The understanding of Occupational Therapy changed and deepened with continued exposure in varying services or settings. The highest level of understanding was shown by health care professionals that have had experience of working with an Occupational Therapist in a rehabilitation setting.

"Again, as I said, OTs one of these roles that I think that until you're actually involved with working closely with OT or receiving OT, it can be a bit muddy in your head what they do."

v. Promoting Awareness of Occupational Therapy

The data showed that Occupational Therapists themselves are not perceived as being very effective in promoting their profession, mainly due to a lack of assertiveness. One participant provided an example of how Occupational Therapists seem to lack confidence in speaking up or answering questions within a multidisciplinary or interdisciplinary team environment. It was pointed out that at times, Occupational Therapists often do not seem confident in their clinical reasoning skills and as a result, struggle to answer questions by medical professionals. A lack of focus on medical conditions during the education/training of Occupational Therapists was perceived to be the cause of this and was considered as putting Occupational Therapists at a disadvantage as a health care professional, mainly as it seems to limit Occupational Therapists' ability to communicate their reasoning clearly and promote their profession.

"*When you're in meetings with doctors and staff, I don't know whether ... Like, some OT colleagues have sort of not quiet, felt that they can answer some of the questions, and things like that as well, and I think that that's a shame, because it's not from lack of brains or anything like that. It's just from lack of, that's just not what's taught in the curriculum."*

In contrast, the complex nature of the issues that Occupational Therapists deal with was identified as a cause of the lack of assertiveness of Occupational Therapists in communicating their clinical reasoning when answering questions in team meetings. Occupational Therapists were seen to deal with more complex issues that do not allow for straight forward and definitive answers.

"If I think about like the different services, and the people there. Often, clinical psychologists are much more confident, a bit like doctors. They're often more confident or more assertive in their decision making, in their A plus B equals C kind

of thing, whereas OT is ... And I would think OTs, physio, maybe, so we'll go with social workers, 'cause I can't think that OT, PT, that there's not necessarily a clear cut answer for a clear cut problem."

On the contrary, Occupational Therapists are perceived as being assertive when they feel the need to advocate for their patients or clients. This can be to provide additional services or a referral to another discipline, health professional or service.

"*Advocating, they need more input, whether other people need to be involved, or when they need different services, or, I guess the ones that probably have more experience, and they know what a person needs, that they're not just saying, "Here's a piece of equipment. We'll leave it there," kind of thing, that they have the ability to advocate and say whether it's appropriate, whether it's not appropriate, whether they need more, whether they need other services. That probably ... But that's potentially experience as well, but being able to refer on to other people, and know when more needs done."*

A different perspective on Occupational Therapy and assertiveness was expressed by describing Occupational Therapy as a profession that has to master the difficulty of focusing on rebuilding people's independence with daily activities in cultures where the belief that people who are unwell need to be cared for, dominates. They need to be compassionate to build rapport but also assertive to encourage people to complete tasks themselves.

" OTs, PTs are compassionate, but you still have to get people to help themselves, right?[…]. You're not doing it for them. They need to do it for themselves, whereas, with psychologists, they have to talk about it, that they don't always have to do something, and with social work, they can be compassionate, because they're not making them do something, so OTs have to be the right amount of empathetic, I guess, to the situation, but also, a little bit forceful enough to get them to do something, so maybe more assertive than what I have met in with the social workers[…]"

Another reason identified for the Occupational Therapy 's difficulty in promoting itself was the fact that health professionals who promote themselves have often been met with judgement or hostility. A common perception was that promoting their profession lies with the individual professional rather than being the responsibility of governing bodies.

vi. Environment and System constructs

The participants described elements of the physical and institutional environment that impacted on how they perceived the role of Occupational Therapy. The policies and systems of health services were highlighted as controlling factors which either enabled or limited the opportunities for collaboration between professions

> *"In my previous role, we didn't really get to work so much across teams as much. Allied health and psychology we were kind of separate […]. I think it was probably more the service I was working in. It didn't really, maybe' kind of promote those sorts of working relationships as well. […] I was across five or six different wards, I just didn't really have those same relationships, and we didn't probably work really that well together. Not in the sense that we didn't get on, but that we just worked quite separately."*

Environmental factors do not occur in isolation, and the participants also mentioned elements of the built environment such as separate offices and or workspaces as contributing factors.

> *"[…] here you're working in a very similar environment. You see each other quite regularly, it's easier just to stop and have an informal chat about something, whereas, down there I found ... the SLT offices down on the second floor and I don't even know where the OT office is."*

The World Health Organisation (2001) described environmental factors as "all aspects of the external or extrinsic world that form the context of an individual's life: physical, social and attitudinal." The physical environment reducing contact of other health professionals

with Occupational Therapists reduces the opportunities for exposure that create understanding and recognition for the profession. Consequently, other health professionals' perception of Occupational Therapy can be misinformed, and opportunities for referrals might be lost.

Summary

The findings gained from the data collected align with the findings documented in the literature to date. An additional theme identified in the findings was the effect of the institutional and build environment on the perception of Occupational Therapy. Both the findings of the literature review and the study's findings point towards that issues with the image of Occupational Therapy are present and current for the Occupational Therapy profession within New Zealand.

CHAPTER 5
DISCUSSION

The importance of professional identity

The aim of this study was to complete the first stages of developing a position statement for the Occupational Therapy profession. As stated in the introduction chapter, positioning relates to a customer's perception of the benefits, attributes or identity of the service and how these elements are compared with competing services (Chitty, Hughes & D'Alessandro, 2012). The two steps of developing a positioning statement are to clearly describe the characteristics or identity of the service and highlight the point of difference and how the service will meet the needs of its target segment (Chitty, Hughes & D'Alessandro, 2012).

Both the literature review and the findings identify that Occupational Therapy can add significant value to the health care sector and patient care. The following benefits should be used to highlight the point of difference of the Occupational Therapy profession, which is one part needed to develop a positioning statement.

The key value of the profession was perceived to be its ability to cut costs of health and social services by improving individual's well-being and independence (College of Occupational Therapy , 2016; Reed,2016). Occupational Therapy achieves this by placing a strong focus on self-management and enablement, a person-centred approach that bridges the gap between the medical and social model. The profession has a strong focus on building resilience using an asset-based approach to build personal competencies (College of Occupational Therapy, 2016; Reed, 2016). The profession is skilled in reducing hospital admissions, cutting support services' costs, reshaping care and enabling a proactive approach to transition home after a hospital stay (College of Occupational Therapy, 2016; Reed, 2016).

The literature review and findings also identified areas of improvement by highlighting some long-standing issues that have persisted to this date and even though the profession has attempted to resolve these issues, they were not able to be resolved. Considering the aim of the study of developing a positioning statement for the profession and the need to

have a clear description of the service's characteristics or identity, the main issue identified is the profession's difficulty defining identity. The literature review highlighted the following issues with the professional identity of Occupational Therapy:

a) a continued confusion over the nature of Occupational Therapy both with the profession and from external stakeholders

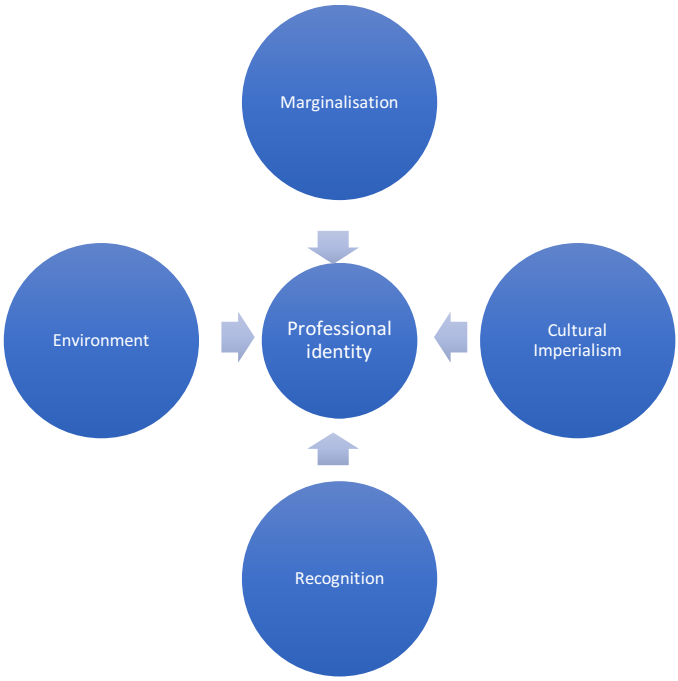
b) professional insecurity caused by the ambiguous professional identity

c) an incorrect association of the profession with other disciplines due to lack of understanding of the profession

d) the tension between the profession's heritage and its environment

The study's findings confirmed these issues, revealing that Occupational Therapy continues to struggle. Figure 5.1 shows the four factors identified to contribute to the issues of professional identity of the profession: 1) the marginalization of the profession, 2) issues arising from cultural imperialism, 3) the level of recognition of the profession and 4) the environment the profession works in.

Figure 5.1: Factors influencing Occupational Therapy 's professional identity



The marginalisation of the profession

The literature review highlights two concepts thought to cause marginalisation of the profession: abelbodism and sexism (Frohlich, 1992). Abelbodism is related to the oppression of people with disabilities (Frohlich, 1992). Sexism was described as the lesser treatment of women and female values (Frohlich, 1992). A comparison was drawn emphasising that both groups, women and people with disabilities, are perceived as passive and dependent and their contributions undervalued (Frohlich, 1992, Griffin, 2009, Wielding, 2011). Members of oppressed or marginalised groups often internalize the negative stereotypes they are confronted with, causing them to doubt their value and competence (Wielding, 2011). It can accordingly be argued that both concepts contribute to the issues with developing a strong professional identity by causing Occupational Therapists to feel disempowered and adopt conformist ways and falling silent. The question was raised how a profession consisting of members of an oppressed group who is working with clients of another oppressed group can be expected to become a proud and visible profession (Frohlich, 1992). Working towards overcoming (or at very least becoming aware of) both ablebodism and sexism is imperative for the development of a strong and clear professional identity of Occupational Therapy.

Cultural imperialism

Another aspect that affects the profession's identity is the current dominance of the medical model, scientific evidence and language (Mocellin, 1995; Creek, 1997; Wright, 1998; Goren, 2002; Friedland & Silva, 2008; Creek, 2009). The findings of this study show that the dominance of the medical model continues to cause issues for Occupational Therapy, identifying that this causes feelings of being disrespected and undermined, further negatively affecting the profession's identity.

Scientific evidence is based on a structuralist understanding of knowledge which does not accommodate the pragmatic and contextualised Occupational Therapy practice (Creek, 2009). The literature review and this study's findings identified that the profession's trend to use biomedical language only increases the issue of being misunderstood. In the literature review, this was acknowledged as a disconnect between theory and practice

(Creek, 2009). Occupational Therapy students are provided with a scientific, structuralised knowledge base that they are expected to use to express their clinical reasoning. Considering that most of Occupational Therapy practice is pragmatic and contextual, this causes problems for therapists to clearly communicate their clinical reasoning and benefits of their interventions using objective, context-free evidence and language (Creek, 2009). In the attempt to overcome this barrier, the profession has adopted language used by disciplines that are more anchored in the medical model, making the differentiation between Occupational Therapy and the other disciplines difficult (Creek, 2009). In another attempt, the profession has started to develop its profession-specific language, which is either ignored or misunderstood by other professions.

The findings of this study identified that these issues still exist by identifying that occupational therapists are perceived to lack confidence in answering questions from the medical team and speaking up to promote their profession. However, there is a difference in reasoning provided by the literature review and the findings of this study as to why this is. The literature very clearly outlines the disconnect between theory and practice, and the use of biomedical language as the cause. The findings point towards a gap in education, recommending that the Occupational Therapist further moves toward the medical model by being taught to understand the medical conditions they work with. It would be worth investigating the cause of the difficulty in communication further because, to develop a strong and clear identity the profession, promote itself and overcome the dominance of the medical model, the profession will need to be able to communicate its value and benefit.

Recognition

The literature review identified that many people including health care professionals do not understand the role and value of Occupational Therapy and often use false and detrimental stereotypes such as describing Occupational Therapists as gap-fillers, peripheral and luxurious in a financially strained system (Blom-Cooper, 1989; Turner, 2011). The study's findings indicated that this lack of understanding causes the lack of recognition of the profession itself as well as its value. An issue that has been a common

theme for the profession over the years. This often leaves therapists feeling misunderstood and undervalued. Turner (2011) explains that socialisation and positive interactions with others are required to develop a clear and strong identity. Occupational Therapist's feelings of being undervalued combined with the negative stereotypes and low value attributed by other professionals can only be described as less than positive interaction contributing to the issues with their professional identity.

Environment

The Canadian Model of Occupational Performance and Engagement splits the environment into four different areas: Physical, institutional, cultural and social (Townsend & Polatajko, 2007). The model places the environment as an outer circle around a person showing that person and their occupational performance are influenced by the context of the environment which functions either as an enabler or a barrier (Townsend & Polatajko, 2007. Applying this model to the profession that is using it, several barriers have been identified in the physical environment. The impact of the physical environment showed to be an important theme within the study's findings, especially when considering Occupational Therapy within hospital settings (both acute and rehabilitation). The findings showed that understanding of Occupational Therapy is currently created through exposure to members of the profession. Unfortunately, the findings show that the built environment does not seem to promote this exposure but rather keeps professions separated. Allied health professions and medical teams are in separate offices or even floors within the hospital building and do not interact with each other. This seems to be less of an issue in rehabilitation and community settings. However, on acute wards, the lack of exposure to Occupational Therapy currently leads to reduced consultation or joint sessions resulting in possibly longer stays or unsafe discharges for patients due to lack of understanding of the role of Occupational Therapy and what it can contribute.

The other issue with the built environment of current health care facilities is that it is not set up for occupational practice. This causes difficulty for Occupational Therapists to complete assessments and interventions effectively. It could even be said that the medical model has a strong influence on the built environment of hospitals and care facilities. This

contributes to Occupational Therapists having difficulty in communicating the value assessments and interventions, further promoting feelings of being invisible and misunderstood, which in turn affects their professional identity.

The College of Occupational Therapy's (2016) report highlighted that if Occupational Therapy is integrated effectively within services the result is better patient outcomes and financial savings. It can, therefore, be said, that this is an important issue to highlight when planning for the future of the profession.

What does this mean?

The literature review showed that previous attempts to promote Occupational Therapy did not increase awareness and recognition to allow Occupational Therapy to be a proud and visible profession. The profession has some clear strengths, which function as a point of difference in terms of value that the profession can provide compared to its allied health competitors.

It is necessary to break the historical cycle that the profession has found itself in almost since its inception and to develop an effective promotional strategy that will enable the profession to secure its survival in the increasingly competitive health care market. It can do this by positioning itself as an invaluable profession, and it is recommended for the profession to look to its members in order to understand their perception of their profession and identify any issues they might experience with their professional identity within the context of the New Zealand health care system. This may enable the professional bodies to support their members in developing a clear and strong identity by overcoming the historical issues identified in both the literature review and this study. Only once the profession itself is clear about who it is and what it has to offer will promotional efforts take effect.

Recommendation for further research

To overcome the historical issues the Occupational Therapy profession faces and develop an effective positioning and promotional strategy, further research has been recommended:

- Further research should explore occupational therapists' current perception of their profession.
- Further research should investigate how the profession itself would describe its identity.
- This study could be repeated using a maximum variance sampling method and a larger sample to confirm the study's findings are representative of its population's thoughts and opinions.
- Future research might also be done into how stakeholders would compare Occupational Therapy and its competitors in the two main points of difference of reducing costs of health care services and improving patient outcomes by increasing independence.

Recommendation for practice

Occupational Therapist Wendy E. Walsh (2018) has again picked up themes historically appearing in both the literature over time and this study. These themes included the profession's persistent identity crisis, the need to communicate a clear identity not only by making use of public communication channels including social media platforms and for the therapist to be politically savvy and driven to promote the profession and remain competitive in the market place (Walsh, 2018). Walsh further promotes the combination of grassroots advocacy (which has traditionally been applied in the past) with social media channels, describing this as key to safeguarding a foothold in the health care market.

In general, encouraging occupational therapists to promote their profession as individual advocates is a valuable recommendation for practice. The continued issues around the identity of the Occupational Therapy profession have lessened the effectiveness of these efforts. This is not to say that Occupational Therapists should dismay and give up promotional efforts altogether. A key message for Occupational Therapists to take away

from this study is to be proud of their profession as there is plenty of evidence in the literature that Occupational Therapists are making a significant contribution to the health care system and the health and well-being of the individuals they work with. To promote Occupational Therapy effectively on an individual level, Occupational Therapists are encouraged to clearly define their own professional identity by clearly understanding their professional boundaries to be able to confidently respond to stereotypical assumptions or perception of what the role of Occupational Therapy is. Occupational Therapists are further encouraged to communicate how their role contributes to the service goals from increasing health outcomes, reducing hospital stays, and re-admissions to name only a few.

Lastly, Occupational Therapists are encouraged to create awareness within the profession about these historical issues in order to support each other as therapists and enable change. However, to promote Occupational Therapy as a profession using channels that can reach a larger audience, it would be prudent to complete further work. This work should aim to create a clear and defined identity of the profession as multiple, individual identities communicated to a larger audience can further enhance the confusion about the profession, further feeding into the historical cycle of promotional efforts with only little effect.

Limitations of the study

There are several limitations to this study.

I. Lack of previous research in a New Zealand context

   Even though there is a good body of literature on the perception and image of Occupational Therapy available, only limited literature could be found on the topic within a New Zealand context, historically or current, leaving uncertainty as to the knowledge foundation and the interpretation of the findings of this study.

II. Sampling size and profile

   The sample size used for this study is small; only five participants were recruited using convenience sampling. Considering the size and make-up of the

population of this study, it cannot be said with certainty that the outcome of the study is a true reflection of the population's perception of the Occupational Therapy profession.

III. Data Collection Process

The data for this study was collected by an Occupational Therapist. As the study investigated the perception of the Occupational Therapy profession, participants may not have been fully comfortable describing their true perceptions.

IV. Resource constraints

This study was completed as a Master's project. As such, there were time and financial constraints which impacted the study, for example sample size and makeup, and location of data collection.

Conclusion:

The research question this study was investigating was "Does the Occupational Therapy profession in New Zealand have an image problem". The literature review shows that even though Occupational Therapy adds significant value to the health care sector and patient outcomes, it further indicated areas of the long-standing struggle for Occupational Therapy. The main issue identified is the difficulty defining the nature and identity of the profession. A repeating cycle of inter-related aspects of the profession shows that it's professional identity is reinforcing, and in turn is caused by, the marginalisation of the profession, issues arising from cultural imperialism such as the dominance of the medical model, the level of recognition of the profession and the environment the profession works in. Even though much effort has been made over the years to resolve the issue, Occupational Therapy continues to struggle in promoting its profession.

Using a marketing perspective and terms, the issue lies with the positioning or the profession in the marketplace. Chapter One introduced a marketing concept called STP process (segmentation, targeting and positioning), which is the underlying foundation

work that all effective marketing campaigns are based on. Chapter one discussed the segmentation and targeting aspects, identifying that its primary target segment is the purchasers of Occupational Therapy services within the New Zealand health care sector. The third step, positioning, is related to a customer's perception of the identity of the service, and how customers evaluate and compare these elements to other services (Chitty, Hughes & D'Alessandro, 2012).

Positioning includes two steps: First, the characteristics or identity of the service needs to be clearly defined and related to what the target segments perceive as important service attributes. Second, the point of difference of the product/service must be identified to highlight how the service can provide these attributes better than its competitors (Armstrong et al., 2014). The second step has already been achieved as the value of Occupational Therapy has been identified.
However, step one of clearly defining the profession's nature is something that Occupational Therapy has struggled with for a long time. Without being able to define a positioning strategy that clearly distinguishes Occupational Therapy from its competitors indicates that Occupational Therapy does have an image problem.

Further research is recommended to investigate these issues further to be able to provide recommendations on how occupational therapists can increase their opportunities to promote their profession. It is recommended to re-produce this study using a larger sample, including a wider variety of the profession's stakeholders with a focus on stakeholders with purchasing power. This would provide a more in-depth understanding of the current perception of the Occupational Therapy profession by this group. Further, a study should also be carried out to investigate the perception of occupational therapists of their profession. This would provide the opportunity to identify areas of excellence as well as areas of growth.

Meanwhile, a take-away message for occupational therapists in Aotearoa/New Zealand is to be proud of the profession and the contribution its members make within the New Zealand health care system in general and to their patients or clients' outcomes. Occupational Therapists should feel encouraged to use the information in this study to

understand how the repetitive cycle of professional insecurity is fuelled and use this knowledge to take steps into becoming more confident, speaking out and proudly standing up for their profession and the valuable work its members do.

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Appendices

Appendix 1: Ethics Approval

3 February 2017

Nadja Armitage
School of Occupational Therapy
Otago Polytechnic
Forth Street
Private Bag 1910
Dunedin

Dear Nadja

Re: Application for Ethics Consent
Reference Number: 704
Application Title: *The current and desired perception of the Occupational Therapy profession in New Zealand*

Thank you for your application for ethics approval for this project.

The review panel has considered your revised application including responses to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

Many thanks for your careful responses to our recommendations.

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings and/or conclusions to the Ethics Committee. All correspondence regarding this application should include the reference number assigned to it.

Regards

Richard Humphrey
Chair, Ethics Committee
Otago Polytechnic

Otago Polytechnic
Forth Street
Private Bag 1910
Dunedin 9054
Freephone 0800 762 786
Phone +64 3 477 3014
Email: info@op.ac.nz
www.op.ac.nz

Appendix 2:

Participant Information Sheet – Interviews Date Information Sheet

Produced: 24 November 2016

"The current and desired perception of the Occupational Therapy profession in New Zealand"

An Invitation

I moved to New Zealand in and completed a Bachelor of Commerce and Administration, majoring in Marketing and Commercial Law at Victoria University Wellington. I have worked in various Marketing roles including communications/media liaison, event management, fundraising/sponsorship, branding and advertising. In 2010, I started training as an Occupational Therapist and graduated with a Bachelor of Health Science (Honours) in 2013. Since then I have worked as an Occupational Therapist in various settings including acute care, rehabilitation and community. This background has led me to have a passionate interest in the image of Occupational Therapy and ultimately I aim to develop a strategy to promote the image of Occupational Therapy in New Zealand in ways that will help our clients to better access to services. I have taken the opportunity provided by doing a Master's of Occupational Therapy to closely examine the perspective of key stakeholders on the image of Occupational Therapy.

Who is invited to participate in this research?

I would like to take this opportunity to extend an invitation to all senior members of the New Zealand Health Care sectors to participate in the study.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

To agree to participate to the research please reply to the invitation stating that you would like to participate in the study and dates and times you would be available. You will receive a confirmation email, which will include a confirmed date, time and location of the interview. Further, you will need to sign the consent form. You can either bring both forms to the interview or email the forms to armin2@student.op.ac.nz

If I agree to take part, what will be involved?

You will be asked to participate in one interview session. Within the session you will discuss your perception of the image of Occupational Therapy and how these compare to the image of other selected allied health professions. The interview will be recorded and later transcribed. All information shared during the interview will be held confidential and will only be used for the purpose of this study.

What do I do if I want to participate?

If you would like to participate, please reply to this invitation by emailing Nadja Armitage (armin2@student.op.ac.nz) by xx.xx.2017

Can participants change their minds and withdraw from the project?

You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate, you may withdraw from the project at any time, without giving reasons for your withdrawal. You can also withdraw any information that has already been supplied until the stage agreed on the consent form. You can also refuse to answer any particular question and ask for the audio/video to be turned off at any stage.

Who should I talk to if I have any concerns about this research?

This research has been passed by the Ethics Committee at Otago Polytechnic. Any concerns regarding the nature of this project should be notified in the first instance to either myself as the primary researcher (armin2@student.op.ac.nz) or to my Project Supervisor, Dr Mary Butler, PhD, RNZOT, GDTE, mbutler@op.ac.nz 03 4796073

Consent Form

Interviews

Project title: The current and desired perception of the Occupational Therapy profession in New Zealand **Project Supervisor:** Mary Butler

Researcher:

Nadja Armitage

- I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio- taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I will have the opportunity to check the transcripts and make any changes I wish within two weeks of receiving the transcript.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes! No!

Participant's signature: Date:

.....

Participant's name:

.....

Participant's preferred contact details for summary of research findings:

.....

.....

.....

.....

Approved by the Otago Polytechnic Ethics Committee on (type the date on which the final approval was granted)

Note: The Participant should retain a copy of this form.

Appendix 3: Interview Schedule

INTERVIEW SCHEDULE

Research Question:
Does Occupational Therapy in New Zealand have an image problem?

Aim of the interview:
To understand the participants' perception of Occupational Therapy and compare it to the main Allied Health professions that Occupational Therapy have professional overlap with.

Name of Participant: Date:
Consent form: ☐ yes Verbal consent: ☐ yes

Introduction:
• Introduction researcher
• Introduction topic
• Consent for participation, recording and note taking
• Purpose of the interview

Start of interview:
Introductory question:
• Can you tell me a little bit about your current role?
• How long have you been working in your current role?
• How do you work with Occupational Therapists in your current role?

Main questions on topic:
• Can you describe your first experience or contact with Occupational Therapy/Occupational Therapist?
• (when you think back to that moment) What was your first impression of Occupational Therapy?
• What did you know or understand about Occupational Therapy prior to your first contact/experience with the profession? (Have you heard of OT before this moment?)
• Since this first experience - What is your understanding of what role or purpose of Occupational Therapy now? Are there any key experiences that you remember that changed your understanding?
• if/How have these experiences changed your impression/thoughts/feelings about Occupational Therapy?
• What do you consider is the value of Occupational Therapy?

• How would you describe your understanding of Physiotherapy? How would you describe the profession?
• How would you describe your understanding of Social Work? How would you describe the profession?
• How would you describe your understanding of Psychology? How would you describe the profession?
• What do you think of the current staff ratios within your team?

Follow-up questions: You mentioned …..
• Can you tell me more about this?
• Could you clarify this?

The research question for this study is, does occupational therapy in New Zealand have an image problem? The aim of this interview is to understand your perception of occupational therapy, and also to compare that perception to your perception of other health professions that occupational therapy work quite closely with. So you know me. I'm Nadya. Are you okay for this to be recorded?

Yes.

The recording's later gonna be transcribed. I will send you the transcript for you to read. If there's anything that you don't like to be included in the study, you can let me know then. You can withdraw from the study at any point, and ask for your data not to be included, up until the point where the findings have been included into the report then [crosstalk 00:01:12] to pull it out. You don't have to answer any of the questions. If you feel uncomfortable about answering any of those questions, you can just say so. You can stop the interview at any point, and you can also ask to have the recording stopped at any point. Any questions?

No.

No? You're happy about that?

Yes. Sounds great.

Brilliant. All right. Just to start off with, can you tell me a little bit about the current role that you're working in, and what previous roles you had?

Yep. So I'm currently working at [ICE's 00:01:48] Rehabilitation Center. So, brain injury rehabilitation. Within my role as a clinical psychologist, partly involves doing neuropsychological assessments. People like a TBI or a stroke, or even things like MS, and seeing if there's been any changes compared to how we think they would have been before that, and then looking at recommendations that they might need to use for going about their day-to-day lives, or work, after that, or driving.

The other part of my role is, I guess, more what people think of when they think of a clinical psychologist, so that's more kind of a support role around helping people to adjust to life after pretty massive things have happened with their health. And for some people, they might have long-standing mental health difficulties that might be exacerbated by what's happened to them, or for other people, they're just really struggling as a result of trying to adapt and change to what they're facing.

Prior to that, I worked in a hospital setting, as well. I wasn't doing neuropsych assessments there, but more of a counseling role. That was for people ... it was a

rehabilitation service, but it also included age care as well. Before that, I worked in youth mental health, and then before that, I worked in a student counseling center. And I've also worked in private practice throughout these roles, as well.

adja: How long have you been working in your current role?

Current role, about 11 months.

11 months?

Yeah.

In all the roles that you had, did you always work with occupational therapists, or is that just-

No, this is the second time I have, so this role and the previous hospital role.

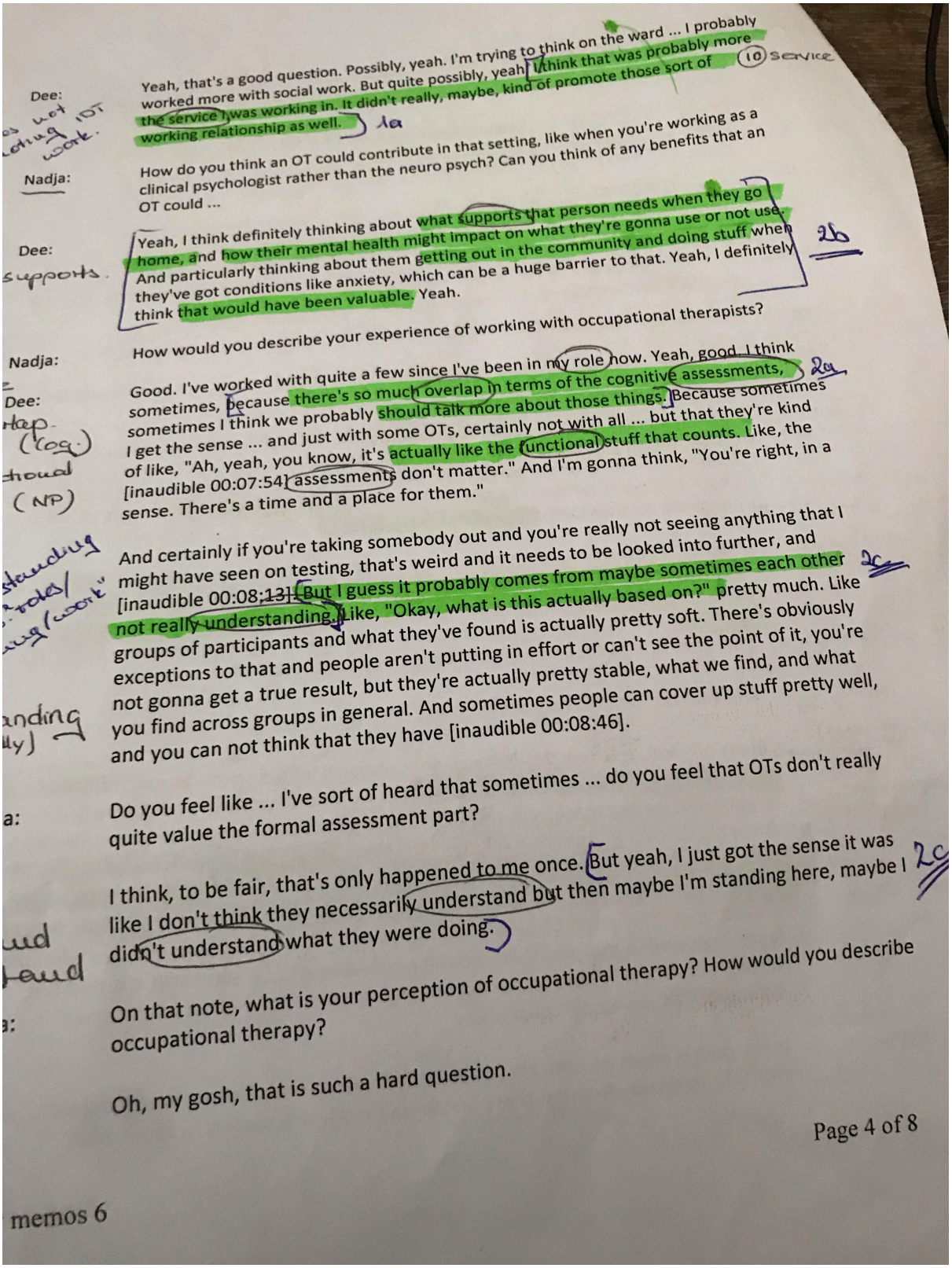
In your previous role and in your current role, how do you work with the occupational therapist?

In my current role .. it's across two teams, which I probably should mention. Also, one's a ward team and one's a community team. There's OTs on both of those. I guess it really varies depending on the patient, but part of what I do on the ward with OT is looking at cognition, so I'll do like ... I guess my SEN does neuropsych assessments, but they'll also be doing a whole load of functional assessments.

And so I guess it's important that we talk to get in and see if what we're finding kind of matches up, or if there's some big gaps, which might indicate something's gone wrong in either of those processes or we're capturing something that's not there, or something different. And then getting to go and talk about how it might impact them going home and what kind of supports need to be put in place around that.

Was that the same in your previous role?

In my previous role, we didn't really work so much across teams as much. Allied health or psychology, we were kind of separate. So we kind of came in and did stuff across lots of different wards, so we probably didn't have those same kind of relationships with OT. And I also wasn't in a neuropsych role. So I think neuropsych role has lent itself a lot more to working together with OTs, but the clinical psych role, it's a little bit hard to, with patient confidentiality, and I guess getting a sense of



Dee: Yeah, that's a good question. Possibly, yeah. I'm trying to think on the ward ... I probably worked more with social work. But quite possibly, yeah, I think that was probably more the service I was working in. It didn't really, maybe, kind of promote those sort of working relationship as well.

Nadja: How do you think an OT could contribute in that setting, like when you're working as a clinical psychologist rather than the neuro psych? Can you think of any benefits that an OT could ...

Dee: Yeah, I think definitely thinking about what supports that person needs when they go home, and how their mental health might impact on what they're gonna use or not use. And particularly thinking about them getting out in the community and doing stuff when they've got conditions like anxiety, which can be a huge barrier to that. Yeah, I definitely think that would have been valuable. Yeah.

Nadja: How would you describe your experience of working with occupational therapists?

Dee: Good. I've worked with quite a few since I've been in my role now. Yeah, good. I think sometimes, because there's so much overlap in terms of the cognitive assessments, sometimes I think we probably should talk more about those things. Because sometimes I get the sense ... and just with some OTs, certainly not with all ... but that they're kind of like, "Ah, yeah, you know, it's actually like the functional stuff that counts. Like, the [inaudible 00:07:54] assessments don't matter." And I'm gonna think, "You're right, in a sense. There's a time and a place for them."

And certainly if you're taking somebody out and you're really not seeing anything that I might have seen on testing, that's weird and it needs to be looked into further, and [inaudible 00:08:13] But I guess it probably comes from maybe sometimes each other not really understanding. Like, "Okay, what is this actually based on?" pretty much. Like groups of participants and what they've found is actually pretty soft. There's obviously exceptions to that and people aren't putting in effort or can't see the point of it, you're not gonna get a true result, but they're actually pretty stable, what we find, and what you find across groups in general. And sometimes people can cover up stuff pretty well, and you can not think that they have [inaudible 00:08:46].

a: Do you feel like ... I've sort of heard that sometimes ... do you feel that OTs don't really quite value the formal assessment part?

I think, to be fair, that's only happened to me once. But yeah, I just got the sense it was like I don't think they necessarily understand but then maybe I'm standing here, maybe I didn't understand what they were doing.

a: On that note, what is your perception of occupational therapy? How would you describe occupational therapy?

Oh, my gosh, that is such a hard question.

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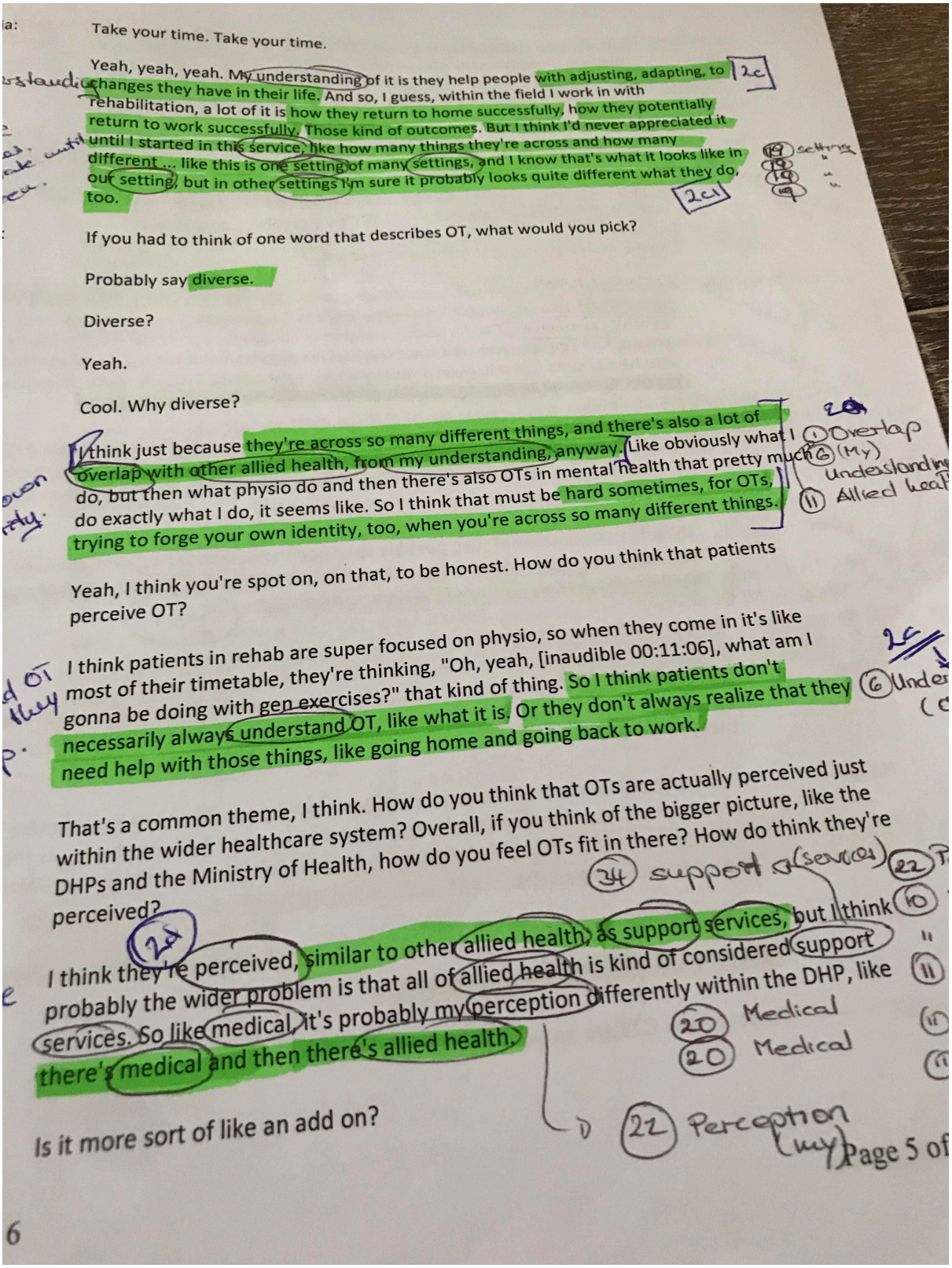


Take your time. Take your time.

Yeah, yeah, yeah. My understanding of it is they help people with adjusting, adapting, to changes they have in their life. And so, I guess, within the field I work in with rehabilitation, a lot of it is how they return to home successfully, how they potentially return to work successfully. Those kind of outcomes. But I think I'd never appreciated it until I started in this service, like how many things they're across and how many different ... like this is one setting of many settings, and I know that's what it looks like in our setting, but in other settings I'm sure it probably looks quite different what they do, too.

If you had to think of one word that describes OT, what would you pick?

Probably say diverse.

Diverse?

Yeah.

Cool. Why diverse?

I think just because they're across so many different things, and there's also a lot of overlap with other allied health, from my understanding, anyway. Like obviously what I do, but then what physio do and then there's also OTs in mental health that pretty much do exactly what I do, it seems like. So I think that must be hard sometimes, for OTs, trying to forge your own identity, too, when you're across so many different things.

Yeah, I think you're spot on, on that, to be honest. How do you think that patients perceive OT?

I think patients in rehab are super focused on physio, so when they come in it's like most of their timetable, they're thinking, "Oh, yeah, [inaudible 00:11:06], what am I gonna be doing with gen exercises?" that kind of thing. So I think patients don't necessarily always understand OT, like what it is. Or they don't always realize that they need help with those things, like going home and going back to work.

That's a common theme, I think. How do you think that OTs are actually perceived just within the wider healthcare system? Overall, if you think of the bigger picture, like the DHPs and the Ministry of Health, how do you feel OTs fit in there? How do think they're perceived?

I think they're perceived, similar to other allied health, as support services, but I think probably the wider problem is that all of allied health is kind of considered support services. So like medical, it's probably my perception differently within the DHP, like there's medical and then there's allied health.

Is it more sort of like an add on?

Dee: It does feel a bit like an add on, yeah. Like you come to hospital wanting to be healed, and then there's other people pop in that can ... they don't do that, but they kind of help with that.

Nadja: Fair enough. How would you describe what the value of OT is?

Dee: [inaudible 00:12:38] thinks that if you thought about not having it and people just going home, you'd see a lot more people coming back in or a lot more people struggling in silence. I think in terms of people being able to return to work without having that kind of service, some people would be really screwed. I think the value's actually probably really quite underestimated.

Why do you think that it is underestimated?

I think there's probably not ... I could be wrong ... but not very much information about it out there. Like it's, people know what physios do, and probably because most people haven't experienced, they're seeing a physio or someone, they know they're seeing a physio. And I guess psych, if it's not themselves, they've got a vague idea of somebody else having seen a psych, even if it's like a really stereotyped idea from TV or something. But then they might not have necessarily seen an OT before they came in.

Why do you think people do know a lot more about physio or psych, rather than OT? What do you think is the difference between those professions? How do they promote themselves more, or better or .... What's the difference? Why do people know about physio and clin psych, but they don't know about OT?

I think that same thing of they possibly have had more experiences with them before. You see it more, like in the media, social media, TV. To be fair, I don't watch that much TV, so maybe there are OTs in TV shows, but I do-

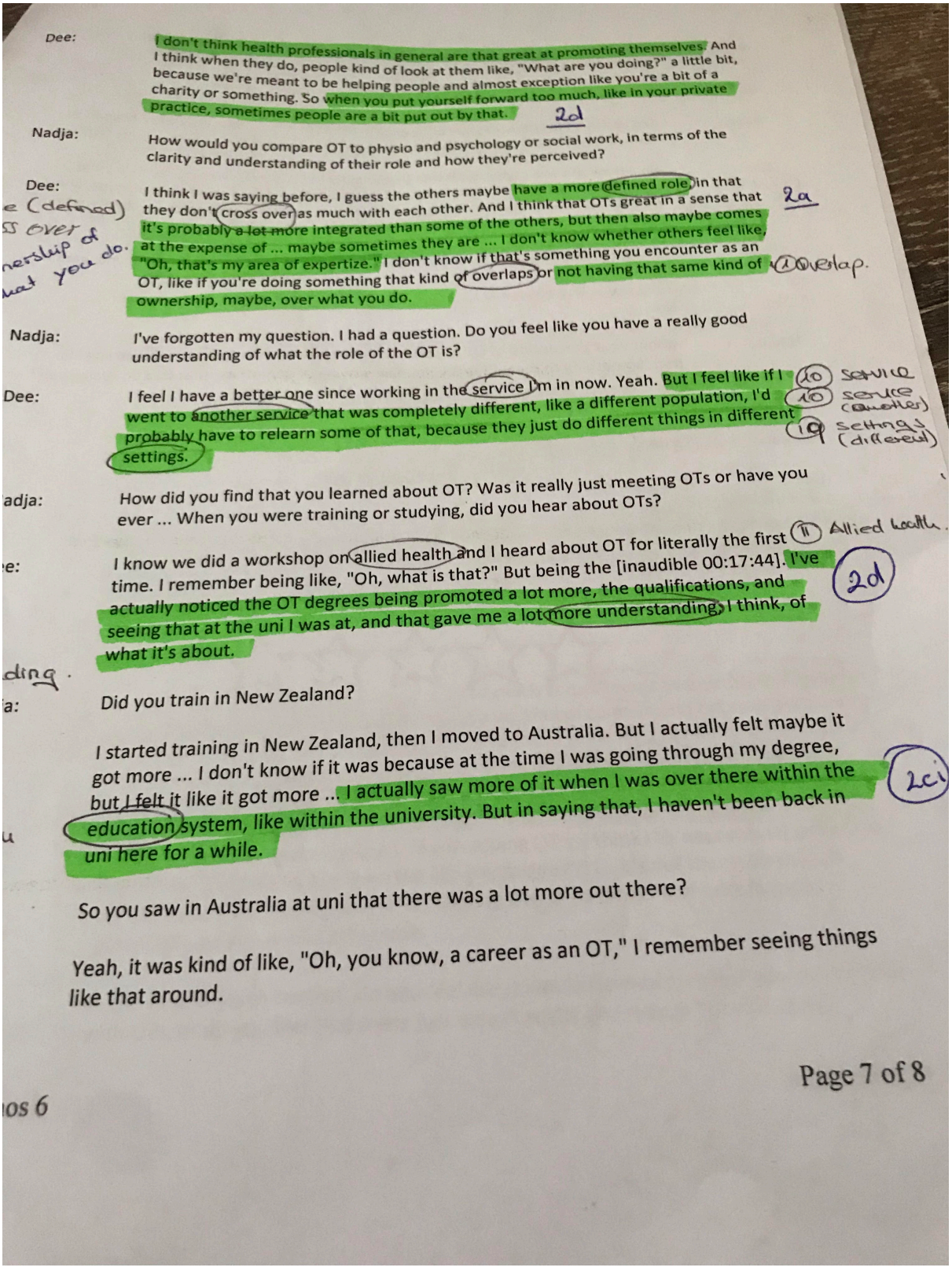
I haven't encountered one.

But I mean in classic [inaudible 00:14:32] Street and all those kind of medical dramas and things like that. And I guess they work a lot within the private sphere as well, but then, so do OTs.

How do you think that OTs sort of contribute to this, contribute to how they're perceived and also like that they're not very well known? How do think ... is there anything that OTs ... that you can identify that OTs do, that you think like, "Well, you're kind of contributing to that?"

I don't know that there is. I think it's probably more that wider system that they work in, rather than what they're doing, per se.

Do you think OTs are very good in promoting themselves?



Dee: I don't think health professionals in general are that great at promoting themselves. And I think when they do, people kind of look at them like, "What are you doing?" a little bit, because we're meant to be helping people and almost exception like you're a bit of a charity or something. So when you put yourself forward too much, like in your private practice, sometimes people are a bit put out by that. 2d

Nadja: How would you compare OT to physio and psychology or social work, in terms of the clarity and understanding of their role and how they're perceived?

Dee: I think I was saying before, I guess the others maybe have a more defined role, in that they don't cross over as much with each other. And I think that OTs great in a sense that it's probably a lot more integrated than some of the others, but then also maybe comes at the expense of ... maybe sometimes they are ... I don't know whether others feel like, "Oh, that's my area of expertize." I don't know if that's something you encounter as an OT, like if you're doing something that kind of overlaps or not having that same kind of ownership, maybe, over what you do. 2a

Nadja: I've forgotten my question. I had a question. Do you feel like you have a really good understanding of what the role of the OT is?

Dee: I feel I have a better one since working in the service I'm in now. Yeah. But I feel like if I went to another service that was completely different, like a different population, I'd probably have to relearn some of that, because they just do different things in different settings.

adja: How did you find that you learned about OT? Was it really just meeting OTs or have you ever ... When you were training or studying, did you hear about OTs?

e: I know we did a workshop on allied health and I heard about OT for literally the first time. I remember being like, "Oh, what is that?" But being the [inaudible 00:17:44]. I've actually noticed the OT degrees being promoted a lot more, the qualifications, and seeing that at the uni I was at, and that gave me a lot more understanding, I think, of what it's about. 2d

a: Did you train in New Zealand?

I started training in New Zealand, then I moved to Australia. But I actually felt maybe it got more ... I don't know if it was because at the time I was going through my degree, but I felt it like it got more ... I actually saw more of it when I was over there within the education system, like within the university. But in saying that, I haven't been back in uni here for a while. 2ci

So you saw in Australia at uni that there was a lot more out there?

Yeah, it was kind of like, "Oh, you know, a career as an OT," I remember seeing things like that around.

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Appendix 5: Example of narrative report

Narrative Interview Report

What are the essential characteristics of the interviewee's story that may contribute to a better insight into the research question: Does Occupational Therapy in New Zealand have an image problem?

The interviewee described that she feels that working together with OT in her current role as a Neuro Psychologist is beneficial as OTs are completing functional assessments which complement the paper-based assessments that Neuro Psychologists complete within the service. However, the interviewee mentioned that at times there seems to be a lack of understanding of each other's roles. The interviewee stated that she did not work closely with OTs in previous roles as a Clinical Psychologist which she partly led back to confidentiality issues but mostly to how the particular service was set up and processes not promoting interdisciplinary work. However, the interviewee also commented that working alongside OTs as a Clinical Psychologist would be valuable for the patients.

The interviewee described OT as a profession that helps people to adjust, adapt to changes in their life. In the interviewee's current setting this involves focusing on outcomes such as returning home or to work. The interviewee commented that even though she feels she has a good understanding of the work OTs do in her current setting but that the work would look different in another setting. The word the interviewee used to describe OT was diverse and commented that she did not appreciate how many different things OTs are across. She further commented that there is a lot of overlap between the OT and other allied health profession and that together with the diversity aspect the interviewee thinks this might cause difficulties for OTs in forging their own identities.

The interviewee thinks that patients do not always understand what Occupational Therapy is and that they don't always realise that they would benefit from OT input such as support with returning home or back to work.

The interviewee said that Occupational Therapy seems to be perceived as a support service provided additional to the medical treatment. She expands by explaining that this is not specific to OT but applies to all allied health professions. The interviewee described OT as being really quite underestimated. She felt that this might be caused by the lack of information being provided about the profession, particularly in media such as social media and TV. She did not feel

that OTs contributed in any way to this, but it is more due to the setup of the system they work in. She further commented that all health professionals are not very good in promoting themselves as people are put out by health professionals who put themselves forward too much. The interviewee pointed out that other health professionals have more clearly defined roles and that due to the diversity of OTs and the overlap with these professionals, OTs cross over professional role boundaries and therefore lose ownership of what they do.

The interviewee stated that she did not hear about OT until she completed an allied health workshop and that the OT degrees seem to be more promoted as a career option at Australian universities than New Zealand universities at the time of her studies.

Appendix 6: Example of conceptual interview scheme

Conceptual Interview Scheme

What does this mean for the image of Occupational Therapy in New Zealand?

Overlap, identity & Collaboration

- OT complements NP
- Lack of understanding of each other's roles
- Working together depends on setting/role (CP vs NP)
- Working with OTs in CP role would be valuable for patients
- Service set up and environmental set up can function and enabler or barrier for collaboration
- Depends on patient
- Compare findings of assessments to get each other's perspectives and check validity of findings.
- Set up of service determine interdisciplinary work
- Overlap between other allied health and OT
- Cross over with other professions/crossing into others expertise = loss of ownership
- Overlap and diversity might cause difficulty for OT forging identity.
- Other allied health professionals have a more defined role

Perception of OT

- Helping people to adjust/adapt to changes
- Help people return home/to work successfully
- Across many things
- Work of OTs different in different settings
- Beneficial
- valuable
- Functional (assessments)
- Good in determining support that person needs, impact of mental health, community access and doing stuff.
- OTs at times do not understand benefit and purpose of NP assessments
- Without OT people might struggle in silence or return to hospital
- Value of profession underestimated

Awareness & Lack of understanding

- Difficulty understanding what OTs role is in different settings
- Lack of understanding of OT by professionals and patients

- Lack of understanding of benefit of OT
- OT perceived as support service as many other allied health professions
- Additional to medical treatment
- Lack of appreciation of range of tasks OT do
- Lack of information on profession
- Lack of information in media
- Understanding of OT through exposure.
- Understanding of OT in one setting does not mean understanding of OT role in another setting.
- Patients do not always realise they need help with daily tasks or returning back to work.
- System contributes towards low awareness of profession
- Health professionals generally not good in promoting themselves
- Self promotion not well perceived in the health care system
- OT not well promoted in the education system

Memo notes:

- Difficult not to use literature review headings to organise themes.
- Difficulty finding titles for categories/themes for information gathered in this interview as the key points seem to relate to each other and it took time to see connections/themes that were not guided by Literature review.
- Change of "working together" to collaboration to align concept names among concept schedules.
- Changing description of OT to perception to align concept names among concept schedules.
- Moved points from Institutional set up into collaboration as the environmental/service set up was identified to function as a barrier or enabler for collaboration, so does not need to be a separate point. Further I added identity to the concept but not 100% sure how this links in or if it needs to be a sperate point. How does it relate to role confusion? Should there be a separate concept called role confusion and identity and leave overlap and collaboration as a separate concept when transferring these concepts to the general concept theme?
- Is it too easy to just label a category "perception of OT'? Might need further thought.
- There is a link between lack of understanding and awareness and perception
- Difference between concept of perception and lack of understanding is perception = interviewee's perception while lack of understanding general aspect.

Appendix 7: ***General concept scheme***

Overlap, role confusion/identity & collaboration

- Unsure of how to collaborate with OT as New Grad
- Joint session with OT helpful
- Good to have another person/professions perspective that links with own focus.
- Level of collaboration depends on environment and service set up. Some setups promote collaboration others are a barrier.
- Confidence in own role determines ability to collaborate (New Graduate vs Experienced Practitioner)
- Patients quite receptive as OT related to daily tasks
- OT overlaps with other professions/disciplines causes confusion
- Changing role boundaries between settings is confusing
- Changing role boundaries make collaboration difficult
- Role confusion causes management to perceive OT as replaceable.
- Confusion over OT role definition and boundaries
- Flexibility strength but also cause confusion
- OT complements NP
- Lack of understanding of each other's roles
- Working together depends on setting/role (CP vs NP)
- Working with OTs in CP role would be valuable for patients
- Service set up and environmental set up can function and enabler or barrier for collaboration
- Depends on patient
- Compare findings of assessments to get each other's perspective and check validity of findings.
- Set up of service determine interdisciplinary work
- Overlap between other allied health and OT
- Cross over with other professions/crossing into others expertise = loss of ownership
- Overlap and diversity might cause difficulty for OT forging identity.
- Other allied health professionals have a more defined role
- Working together means access to broader knowledge and learning from each other
- Working together is getting a second opinion of a discipline similar to PT.
- Working together brings better outcomes for patients.
- Boundaries cross over between OT/PT
- Doing assessments together
- Joint sessions
- Sort of like physio
- Profession you chose when you didn't get into PT

- OT assisting PT
- OT specific domains
- Upper limb
- Wheelchairs
- Type and level of Collaboration depends on service setting & environment
- OTs more key worker role
- Depends on setting (Working alongside in a team vs working close with them but spending less time with OT, liaise)
- Managing referrals to other services
- Confused with therapy assistance or nursing staff in inpatient setting
- A good introduction might reduce role confusion/increase understanding of OT among patients/clients.
- Working with OT good experience
- Appreciating bouncing ideas of each other
- Shortfalls with system are blamed on AH professionals.
- Joint assessments
- Initial assessments
- Home visit
- Service and environmental set up influence level and type of collaboration

Awareness & Lack of understanding

- Patients confused by name
- Understand what OT is/does after exposure as it relates to their day to day life
- Lack of understanding of OT knowledge, skills and expertise
- Lack of understanding of skills means people don't think of OTs for referring for certain assessments
- OT not well known outside of health care
- OT not often talked about as career choice
- OTs pragmatic and do not enjoy promoting themselves
- No knowledge until first exposure at placement
- Good understanding developed through working with OTs
- Lack of understanding means OTs are underutilised.
- Difficulty understanding what OTs role is in different settings
- Lack of understanding of OT by professionals and patients
- Lack of understanding of benefit of OT
- OT perceived as support service as many other allied health professions
- Additional to medical treatment
- Lack of appreciation of range of tasks OT do

- Lack of information on profession
- Lack of information in media
- Understanding of OT through exposure.
- Understanding of OT in one setting does not mean understanding of OT role in another setting.
- Patients do not always realise they need help with daily tasks or returning to work.
- System contributes towards low awareness of profession
- Health professionals generally not good in promoting themselves
- Self promotion not well perceived in the health care system
- OT not well promoted in the education system
- Lack of experience in own profession influencing work with OT
- Lack of understanding of OT as a new grad
- Understanding of OT improved with exposure
- Experience of working with OT generally good.
- Patients understand tasks that OTs do rather than job title
- Not working in hospitals, you don't get exposure to OT = lack of understanding/awareness
- Name is misleading
- Name is suitable for return to work programme
- Unknown profession
- Random profession
- Not well marketed
- Less known as PT, less referred to by doctors
- Not publicly advertised
- Change of perception/understanding through exposure
- Only understanding of OT through exposure
- Patients/clients unsure of what OT is.
- Patients/clients do not perceive OT as therapy
- Seen as an organisational person in community setting
- Perception of what therapy is
- Occupations seen as menial or basic by patients
- Practicing occupations not of high importance to patients
- Increase understanding through exposure
- No in depth understanding of what OT does even with exposure
- Understanding of OT muddy until exposure
- People understand OT through exposure
- People have good understanding of PT
- Medical team has lack of understanding of allied health roles/reasoning at times
- Lack of understanding of allied health professions by the medical staff cause of issues

- Lack of promotion due to OTs pragmatic mentality
- Patients perception of rehab as physical based contributes to reduced awareness and understanding of OT
- Allied health professions that are not based within the medical model are losing their identities by being absorbed/suffocated by the health care system
- Current system can make role vague and difficult to navigate
- Current hierarchical system leaves AH professionals often overruled
- Medical staff seen to know more than AH
- Being overruled by medical model can feel undermining and disrespectful

Interviewee's Perception of OT

- Helpful with goal setting which improves outcomes
- OT focuses on person's function, tasks and what is important to them as well as how this can be achieved.
- Practical
- Overall (big picture, drawing from other professions and bring it all together)
- Combination of functional and cognitive focus
- Practical and functional approach
- Identifying what is important to people
- Working with OTs positive
- OT perspective helpful
- First perception that OT domain lies in vocational area
- Perception of OT depends on experience of the person with individual practitioners
- OT young profession (just like SLT) compared to PT
- Equipment clear OT domain
- Helping people to adjust/adapt to changes
- Help people return home/to work successfully
- Across many things
- Work of OTs different in different settings
- Beneficial
- valuable
- Functional (assessments)
- Good in determining support that person needs, impact of mental health, community access and doing stuff.
- OTs at times do not understand benefit and purpose of NP assessments
- Without OT people might struggle in silence or return to hospital

- Value of profession underestimated
- Assessment and provision of equipment & support services perceived as main OT domain during first years of practice.
- In more specialist area OT at times have additional domains but not consistently.
- Helpful for both patients and collaboration
- Profession that makes people do stuff
- OTs encourage independence (making them do stuff)
- OT good ability to listen to what patients need and how to make it work.
- Good communicators
- Good advocates/mediators
- See different point of views
- OT not a well understood profession
- OT a respected profession
- Ability to be assertive impacted by dealing with complex issues that don't have easy answers
- Need to balance rapport building/empathy and encouraging independence
- OTs are respected when they are experienced, advocate for their patients & connect them with services
- Requires more medical training in order to communicate their reasoning more clearly
- Helpful
- Interesting/unique approach to treatment
- Make tasks work better
- Working together is very beneficial by providing broader knowledge and unique perspective using functional approach.
- Undervalued
- Challenge the level of independence of patients in a hospital setting
- Get patience to value independence
- Reducing burden on hospitals and care facilities
- Functional approach
- Treatment approach
- Broader range of knowledge
- Unique perspective
- Functional (point of view, focus, approach, tasks, restoring)
- Holistic
- Big picture that is missed by other health professionals
- Enable people to live their life (as independently as possible).
- Finding alternatives
- Leading into therapy/Happening before therapy

- therapy added to OT to assist/therapy based on functional goal
- Education system not on par
- Education more practical
- Education lacking emphasis on illness and injury
- Education shapes perception
- What you study if you did not get into PT
- Restricted to certain settings.
- Important part of rehab
- Unclear OT domains
- Wheelchairs & Return to Work OT domain
- Undervalued
- Needs clearer role distinction between nursing staff and OT
- Improve discharge planning
- Perception of OT changed over time through exposure
- First perception: equipment
- Later perception: therapeutic focus but not sure 100% of understanding of OT
- OT has non-physical focus that does not align with people's perspective of rehabilitation
- Physiotherapists are regarded higher than other allied health professions
- Approachable
- Comfortable to work with
- Hands on
- Practical
- Meeting practical needs
- Getting people to do things
- Invaluable
- Bigger picture - focusing on daily tasks
- OT's wider perspective of patient needs is helpful
- Prevent risk
- Offer slightly different view on things
- PT regarded higher that OT
- Different view
- OT less aligned with medical model
- System causes difficulty for OT.

Memo notes:

- Overlap between professions makes collaboration with other disciplines beneficial as OT can draw from knowledge of other disciplines (and vice versa) and draw it all together in a holistic picture. On the other side the overlap causes role confusion, unclear role boundaries, etc..
- Further I added identity to the concept but not 100% sure how this links in or if it needs to be a sperate point. How does it relate to role confusion? Should there be a separate concept called role confusion and identity and leave overlap and collaboration as a separate concept when transferring these concepts to the general concept theme?
- Is it too easy to just label a category "perception of OT'? Might need further thought.
- There is a link between lack of understanding and awareness and perception
- Difference between concept of perception and lack of understanding is perception = interviewee's perception while lack of understanding general aspect.
- ?Adding subthemes during reviewing interview 1 & Lynn-
    - Perception: OT has value, strength of OT in its approach, OT not perceived as therapy, education, Characteristics of Occupational Therapists
    - Understanding: creating through exposure, confusion of OT domain, professional name
    - Collaboration: Working with Occupational Therapy, Difficulty with system based in medical model:
- Difficulty separating content into concepts as they seem to interrelate/overlap.
- Aligning OT with medical model - ? Easier communicating vs losing OT identity.

Appendix 8: Data Analysis Stage 9

Interview 1	Interview 2	Interview 3	Interview 4	Interview 5	
Overlap/Cross over	Overlap/Cross over	Overlap/Cross over	*Overlap/Cross over*	*Overlap/Cross over*	2
Boundaries	*Boundaries*	*Boundaries*	*Boundaries*	*Boundaries*	1
Confusion	Confusion	*Confusion*	*Confusion*	*Confusion*	1
Joint (session/work)	Joint (session/work)	*Joint (session/work)*	*Joint (session/work)*	Joint (session/work)	3
Assessment	Assessment	Assessment	Assessment	Assessment	5
Perspective	Perspective	*Perspective*	Perspective	Perspective	3
Understanding	Understanding	Understanding	Understanding	*Understanding*	4
Working with/together	Working with/together	Working with/together	Working with/together	Working with/together	5
Environment	Environment	*Environment*	Environment	*Environment*	2
Service/*system*	*Service/system set up.*	Service/system	Service/system	Service/system	3
Allied Health	*Allied Health*	Allied Health	Allied Health	Allied Health	4
OT Domain	OT Domain	*OT Domain*	OT Domain	*OT Domain*	2
Role	Role	Role	Role	Role	5
knowledge	knowledge	*knowledge*	knowledge	knowledge	4
Interdisciplinary	*Interdisciplinary*	*Interdisciplinary* tea m	*Interdisciplinary* Tea m	Interdisciplinary	2
Separate	*Separate*	Separate	Separate	*Separate*	3
Skills	*Skills*	*Skills*	*Skills*	*Skills*	0
Pragmatic	*Pragmatic*	*Pragmatic*	*Pragmatic*	*Pragmatic*	0
Settings	*Settings*	Settings	Settings	Settings	4
Medical	*Medical*	Medical	Medical	Medical	4
Promotion	*Promotion*/promote	*Promotion*	*Promotion*	*Promotion*	0
Perceive/Perception	Perceive/Perception	Perceive/Perception	Perceive/Perception	*Perceive*/Perception	4
Exposure	Exposure	*Exposure*	*Exposure*	*Exposure*	2
Name	Name	*Name*	Name	*Name*	2
Helpful	Helpful	*Helpful*	Helpful	Helpful	4
benefit/beneficial	benefit/beneficial	*benefit/beneficial*	benefit/beneficial	*benefit/beneficial*	3
Practical	Practical	*Practical*	Practical	Practical	3
Functional	Functional	Functional	Functional	*Functional*	4
Value	*Value*	Value	Value	*Value*	3
Equipment	Equipment	*Equipment*	Equipment	Equipment	5
Education	*Education*	Education	*Education*	*Education*	2
View	View	*View*	View	View	4
Approach	Approach	*Approach*	Approach	*Approach*	2

Support	*Support*	Support	Support	Support	3
Holistic	Holistic	*Holistic*	Holistic	*Holistic*	2
Placement	Placement	*Placement*	Placement	Placement	3
Vocational	Vocational	*Vocational*	*Vocational*	*Vocational*	1
Positive	Positive	*Positive*	*Positive*	*Positive*	1
Experience	Experience	Experience	*Experience*	Experience	4
Different area	Different area	*Different area*	*Different area*	*Different area*	1
Underestimated	*Underestimated*	Underestimated	*Underestimated*	*Underestimated*	2
Together	Together	Together	Together	Together	5
Advocate	*Advocate*	*Advocate*	*Advocate*	*Advocate*	1
ADL	*ADL*	*ADL*	ADL	*ADL*	2
Showering	Showering	*Showering*	Showering	*Showering*	3
Dressing	Dressing	*Dressing*	Dressing	*Dressing*	1
Disciplin	*Discipline*	*Discipline*	*Discipline*	Discipline	1

Appendix 9: Data analysis Stage 10

The value of Occupational Therapy

- Invaluable
- Important
- most useful thing
- practical
- undervalued
- underestimated
- ability to increase a person's independence by restoring function after illness or injury reduce support services costs
- see the bigger picture/holistic picture
- independence versus need for support services
- Collaborating validate clinical reasoning.
- flexibility
- functional approach
- role and boundary confusion and uncertainty

Professional Identity

- confusion
- association with tasks that performed rather than the profession: providing equipment, assisting in the shower.
- confused with other health care professions
- non-therapeutic profession/key working role/lead into therapy/add therapy in to.
- name a cause of the confusion
- therapy tasks perceived as basic/unable to identify any benefit
- no specific domains
- role varies between different settings and therapists within the same setting.
- appearance of being easily replaceable.

Marginalisation of the profession

- New Zealand health care system operates under medical model/historical hierarchy
- The lack of understanding of the role of Occupational Therapy a clear theme
- Most participants still not fully clear on what the role of Occupational Therapy.
- broader range of knowledge to allow for a holistic approach
- level of uncertainty around fully understanding the role and tasks Occupational therapists. Occupational Therapy specific tasks seem to be able to be performed by other disciplines.
- understanding of Occupational Therapy only results with exposure to the profession.
- At best, some basic understanding of Occupational Therapy after completing their training,

Promoting Awareness of Occupational Therapy

- Not very effective in promoting own profession, lack of assertiveness, lack of confidence, not confident in their clinical reasoning skills, struggle answering questions by medical professionals.
- complex nature of the issues was also identified as a cause of the lack of assertiveness
- occupational therapists assertive when advocating for their patients or clients.
- Need to be compassionate to build rapport but also assertive to encourage people to complete tasks themselves.
- health professionals who promote themselves often been met hostility.
- perception that promoting their profession lies with the individual professional

Environment & System constructs

- elements of the physical and institutional environment that impacted on how they perceived the role of Occupational Therapy.
- The policies and systems of health services either enabled or limits the opportunities for collaboration

- separate offices and or workspaces as contributing factors.