Perceived Competence Among Occupational Therapists in Mental Health

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This pilot study examined the level of perceived competence among 95 occupational therapists practicing in mental health in New York and New Jersey. Most respondents (80%) rated their ability to perform 15 professional tasks listed on the study questionnaire as good or excellent. The remaining six tasks listed on the questionnaire received lower perceived competence scores.

The findings suggest that basic, continuing, and postprofessional education programs along with a personal commitment to continued professional learning may provide therapists with the knowledge, skills, and attitudes needed to perceive themselves as competent mental health practitioners.

Because the percentage of occupational therapists practicing in mental health is declining, it is vital that we develop and support the perceived competence of our mental health practitioners.

T he issue of perceived competence for clinical practice is important for the occupational therapy specialty of mental health, because the proportion of therapists practicing in this specialty area is declining steadily (American Occupational Therapy Association [AOTA], 1985; Silvergleit, 1987). If therapists do not perceive themselves as competent mental health practitioners, how long will they remain in this practice area?

I conducted this pilot study to identify the level of perceived competence among New York and New Jersey occupational therapists practicing in mental health. The results can be used to identify the educational needs of the therapist in mental health and, eventually, to design basic, continuing, and postprofessional education programs that support areas of perceived competence and strengthen areas of perceived incompetence (Prietz, 1987).

Literature Review

Although no published studies have directly investigated occupational therapists' perceptions of competence for practice, many studies have related perceived competence to issues of professionalism and specialization.

Professionalism

Perceived competence has been identified as essential to professional survival in the health care system (Ethridge, 1986; Fidler, 1981; Jameton, 1984) and to professional socialization (Bucher & Stelling, 1977). Bucher and Stelling emphasized that a feeling of competence is a prerequisite to the development of a professional identity and commitment to a field. Fidler (1981) supported this assertion by stating that the failure to develop a sense of competence and mastery for occupational therapy practice will produce a therapist whose professional identity, efficacy, and commitment are tenuous. Kielhofner (1983) was concerned that occupational therapists lacked unity and confidence in their professional identity, whereas Rogers (1982) identified the acquisition of a subjective image of competence as facilitory to professional development.

Self-image, professional identity, and confidence for practice were also discussed by Breines (1986), who said that self-image is an important component of professional competence and that the ability to perceive oneself as competent can increase one's professional efficacy.

Lack of confidence and decreased feelings of competence in practice were also cited in Allen and Cruickshank's (1977) study of the perceived problems of beginning therapists. Entry level therapists in all practice areas identified "feeling competent when
1 treat certain kinds of patients” and “being self-confident professionally” as frequent problems (p. 559).

The importance of perceived competence to entry level professionals was also discussed by Kramer (1974) and Kramer and Schmalenberg (1977) in their studies on the professional socialization of neophyte nurses. They identified a lack of confidence and diminished sense of competence as resulting from the “reality shock” (Kramer, 1974, p. VII) that a neophyte professional undergoes when faced with work situations that conflict with professional ideals and values. The authors proposed that these factors have contributed to the increased number of practitioners who are leaving clinical practice.

Specialization

Perceived competence has also been linked to specialty selection: Several studies have identified perceived competence factors as related to the decline in mental health as a practice preference.

Burnett-Beaulieu (1982) explored the reasons for short clinical careers and proposed that occupational therapists leave mental health clinical practice in response to the repeated experience of not being able to cure a chronically ill patient. This experience may result in therapists feeling helpless, frustrated, depressed, angry, or impotent. Sturgess and Poulsen (1983), in discussing Burnett-Beaulieu’s work, questioned if there was a relationship between the chronicity of psychiatric patients and the increased level of burnout they discovered among therapists practicing in mental health. Their results showed that therapists practicing in mental health had significantly greater feelings of burnout and decreased feelings of personal accomplishment than did those employed in other specialties.

Burnett-Beaulieu (1982) and Sturgess and Poulsen (1983) cautioned that idealization of practice may result in therapists who feel unprepared to face the realities and chronicity of current clinical practice in mental health. A lack of perceived competence in this area may foster increased attrition among mental health practitioners.

The negative effects of perceived competence on specialty choice was discussed by Ethridge (1986), who said that “many new graduates express concern about their readiness” to enter the current mental health care system (p. 2). Ethridge identified the abstractness and lack of structure in mental health practice as a reason therapists may not practice in this specialty—Many therapists may feel more comfortable in a more structured clinical setting.

Barris and Kielhofner (1986) proposed that the declining percentage of therapists practicing in mental health may be due to feelings that this practice area “is nebulous and not clearly differentiated from other mental health professions” (p. 535). This lack of professional clarity may result from the eclectic teaching practices of the occupational therapy educators who responded to Barris and Kielhofner’s (1986) study and may lead to a diminished sense of competence in practice.

Diminished perceptions of competence resulting from the nebulous role of occupational therapy practice in mental health has also been cited by entry level occupational therapists as a deterrent from mental health practice. Christie, Joyce, and Moeller (1985), in their study of specialty choices, found that “inadequate theoretical preparation in specific clinical areas made some respondents decide against practicing in these areas because of feelings of insecurity and inadequacy” (p. 673). In the academic stage of professional preparedness, psychiatry was identified as a negative influence more frequently than any other specialty area, and mental health fieldwork was viewed three times more negatively than physical disability fieldwork, thereby diminishing mental health as a practice preference.

Exersky, Havazelet, Scott, & Zenler (1989) studied factors affecting specialty selection among occupational therapists practicing in physical disabilities, mental health, pediatrics, and geriatrics. They found that “not feeling effective was a strong deterrent in all four specialties” (p. 230). A limited sense of effectiveness may result in decreased perceived competence for practice.

The literature shows that the relationship between perceived competence and professional development, identity, efficacy, self-confidence, self-image, specialty selection, career commitment, and attrition may affect the number of therapists entering and remaining in mental health practice. Although the literature reviewed above did not directly investigate perceptions of competence in practice, the authors cited have raised numerous issues and concerns that substantiate a need for further study in this area.

Method

Subjects. Two hundred fifty subjects were drawn randomly from the population of 544 occupational therapists who were members of AOTA’s Mental Health Special Interest Section and were New York or New Jersey residents as of September 1987. The sample was geographically limited because this was a pilot study with financial and time constraints.

Instrument. Because no published instrument was available, a questionnaire was constructed specifically for this study. The questionnaire comprised three sections: (a) seven questions on professional demographics and employment characteristics, (b) a list of 21 professional tasks, to which respondents
rated their performance ability on a 4-point Likert-type scale (poor [1], fair [2], good [3], excellent [4]); and (c) an open-ended question requesting comments on perceived competence for occupational therapy practice in mental health.

The instrument's content validity was established through a review of the occupational therapy literature, which was assumed to provide a representative sample of items relevant to professional competence in mental health (AOTA, 1981, 1983b; Barris, Kielhofner, & Watts, 1983; Evans, 1985; Fine, 1983; LaDuca, Madigan, Risley, & Engel, 1980; Mosey, 1986). A panel of occupational therapy educators and clinicians, all with at least 5 years' experience in mental health, reviewed the instrument and validated its content.

To establish the instrument’s reliability, a pilot test was conducted with 12 occupational therapists in mental health practice. A 7-day test–retest reliability coefficient of .80 was obtained.

Procedure. Questionnaires were mailed to the subjects along with a cover letter explaining the study's purpose and requesting a response within 4 weeks. Of the 250 questionnaires sent, 134 were returned (a response rate of 53.6%). Two of these questionnaires were not included in the data analysis because they were incomplete.

Data analysis. The data were processed with the SPSS-X statistical package (Statistical Package for the Social Sciences, 1988). With descriptive statistics, frequency data were obtained for all questions and means were determined for the ratings of the 21 professional tasks. Parametric statistics were applied to the data to measure the relationship between the response categories of two or more items to professional demographics with the multivariate analysis of variance statistical program.

Results

The 132 completed questionnaires were divided into 2 groups, according to the respondents' indications that they were or were not currently practicing occupational therapy in mental health. Ninety-five respondents (72%) were current practitioners, and 37 respondents (28%) were not (see Table 1 for the respondents' demographics).

The questions regarding characteristics of the work setting and perceived competence in the performance of professional tasks were analyzed only for the 95 respondents currently in mental health practice. The analysis of work-setting characteristics produced no significant findings. The analysis of perceived competence indicated an overall high level for performance of professional tasks (M = 3.3 on a 4-point scale). Sixty-eight percent of the 95 respondents rated their ability to perform all 21 professional tasks as good or excellent; 80% of the respondents rated their ability to perform 15 of the 21 tasks as good or excellent (see Table 2).

Because minimal variance within the data occurred for 15 of the 21 tasks, analysis of variance was limited to those 6 tasks that more than 18% of the respondents rated negatively. Analysis focused on the relationships between the variance of perceived competence mean scores according to educational level, years in practice, work setting, and patient population characteristics. Only 5 of the 24 relationships analyzed produced a variance in mean scores. Most respondents rated their skills equally regardless of professional demographics or employment characteristics.

Relationships were found between educational level and ability to use frames of reference in practice and to provide input regarding the functional effects of medications. Occupational therapists with postprofessional master's degrees had higher mean scores...
Table 2
Perceived Competence in Performance of Professional Tasks by Occupational Therapists Practicing in Mental Health (n = 95)

| Professional Task                                                                 | Poor (1) | Fair (2) | Good (3) | Excellent (4) | M*  
|-----------------------------------------------------------------------------------|----------|----------|-----------|---------------|------
| Describe OT's role in psychiatry to multidisciplinary staff                       | 1        | 2        | 41        | 56            | 3.5  
| Set goals relevant to client's current and expected environments                   | 1        | 1        | 40        | 57            | 3.6  
| Design and lead activity groups                                                   | 0        | 2        | 30        | 67            | 3.7  
| Implement a new, relevant OT program based on an assessment of patient population's needs | 1        | 3        | 35        | 61            | 3.6  
| Evaluate patient's assets and limitations                                          | 0        | 3        | 39        | 57            | 3.6  
| Set behavioral objectives realistic for client's functional level                  | 1        | 5        | 42        | 55            | 3.5  
| Manage problem behavior and psychotic symptoms                                     | 0        | 5        | 52        | 42            | 3.4  
| Communicate and document the efficacy of OT intervention                          | 1        | 4        | 46        | 48            | 3.4  
| Select and use OT modalities according to needs and goals                          | 1        | 5        | 47        | 45            | 3.4  
| Revise goals and program as needed                                                | 1        | 7        | 40        | 50            | 3.4  
| Adapt OT role as practice setting and mental health system change                  | 1        | 7        | 53        | 37            | 3.3  
| Supervise OT and/or non-OT staff                                                  | 2        | 7        | 48        | 41            | 3.5  
| Supervise OT students                                                             | 1        | 7        | 41        | 47            | 3.4  
| Prepare client for discharge                                                      | 1        | 11       | 46        | 40            | 3.3  
| Initiate and obtain referrals                                                     | 4        | 10       | 37        | 46            | 3.4  
| Provide OT input on patient's level of functioning according to Axis 5 of DSM-III-R | 5        | 14       | 40        | 39            | 3.2  
| Conduct a quality review of the program                                           | 4        | 21       | 47        | 27            | 3.0  
| Use community resources                                                            | 1        | 23       | 41        | 52            | 3.1  
| Provide OT input regarding the functional effects of psychotropic medications     | 3        | 25       | 47        | 23            | 2.9  
| Use OT frames of reference in practice                                            | 5        | 25       | 47        | 21            | 2.9  
| Use in practice current research findings relevant to the nature of mental illness and to mental health interventions | 1        | 31       | 46        | 22            | 2.9  

Note: Percentages have been rounded. Some questions received no response from 1 or 2 subjects. OT = occupational therapy. DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised) (American Psychiatric Association, 1987).

Table 3
Condensed Analysis of Variance for Six Professional Tasks (n = 95)

<table>
<thead>
<tr>
<th>Professional Task</th>
<th>OT Degree</th>
<th>Years of Practice</th>
<th>Work Setting</th>
<th>Patient Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide OT input on patient's level of functioning according to Axis 5 of DSM-III-R</td>
<td>2.22</td>
<td>.122</td>
<td>1.88</td>
<td>.167</td>
</tr>
<tr>
<td>Use OT frames of reference in practice</td>
<td>4.49</td>
<td>&lt;.050</td>
<td>2.43</td>
<td>.101</td>
</tr>
<tr>
<td>Provide OT input regarding the functional effects of psychotropic medications</td>
<td>2.76</td>
<td>.076</td>
<td>3.46</td>
<td>&lt;.050</td>
</tr>
<tr>
<td>Use community resources</td>
<td>0.67</td>
<td>.516</td>
<td>1.48</td>
<td>.239</td>
</tr>
<tr>
<td>Conduct a quality review of the program</td>
<td>1.07</td>
<td>.352</td>
<td>0.54</td>
<td>.587</td>
</tr>
<tr>
<td>Use in practice current research findings relevant to the nature of mental illness and to mental health interventions</td>
<td>1.66</td>
<td>.202</td>
<td>1.83</td>
<td>.173</td>
</tr>
</tbody>
</table>

were often several paragraphs long and expressed much concern and interest regarding perceived competence in occupational therapy practice in mental health.

Study Limitations

This study had several limitations, including the lack of a standardized valid instrument with which to measure perceived competence. Although reliability and content validity were established for the study instrument, the identification of areas of competence may be considered somewhat arbitrary and may not represent all practice areas (Berner & Bender, 1978; Hinojosa, 1985). The study was also limited by the sample size, the geographic concentration, and the voluntary nature of membership in AOTA and the Mental Health Special Interest Section. The study sample, therefore, does not represent all occupational therapists practicing in mental health.

The study's overall response rate (53.6%) and net response rate of current mental health practitioners (38%) are considered adequate (Babbie, 1979). The degree of data bias due to nonresponse, however, is unknown and thus limits the ability to make generalizations. In addition, a direct interaction may have existed between the survey's topic and the response rate. Some respondents may have participated in order to project a particular image of competence, whereas others may not have responded due to the questionnaire's sensitive nature (Dillman, 1978). The self-evaluation of one's competence is not routine and therefore may be resisted (Berner & Bender, 1978).

Discussion

The finding of a high level of perceived competence for the performance of professional tasks (see Table 1) was somewhat surprising given the concerns identified in the literature. For example, several authors expressed concern over the lack of a clear role definition for occupational therapy in mental health (Allen & Cruickshank, 1977; Barris & Kielhofner, 1986; Breines, 1986; Fidler, 1981; Kielhofner, 1983). In the present study, however, 97% of the study's 95 respondents currently practicing in mental health perceived their ability to describe occupational therapy's role in mental health as good or excellent. Other authors have questioned occupational therapy's ability to adapt to a changing mental health care system (Barris & Kielhofner, 1986; Burnett-Beaulieu, 1982; Ethridge, 1986; Johnson, 1978). In the present study, however, 90% of the 95 respondents perceived their ability to adapt their role to a changing practice setting and mental health system as good or excellent.

Twelve additional tasks received over 85% of good or excellent competence ratings. Although six professional tasks did receive negative ratings by over 20% of the 95 respondents, most respondents rated their ability to perform these tasks as fair, with only 1% to 5% rating their skill level as poor (see Table 2). These overall high ratings may show that these tasks are firmly rooted in occupational therapy education and are widely accepted as part of occupational therapy's practice in mental health.

Education

The study's results indicate that basic, continuing, and postprofessional education programs are providing many therapists in mental health with the necessary knowledge, skills, and attitudes needed to perceive themselves as competent. In addition, if perceived competence is related to professional identity, self-image, self-confidence, practice preference, and career commitment, as identified in the literature review, this study has identified a number of therapists whose high level of perceived competence may contribute strongly to such areas in mental health. We should focus, therefore, on supporting perceived competence for practice in mental health. AOTA's continuing education programs specific to mental health practice (Robertson, 1986, 1988) and the growth of postprofessional degrees in occupational therapy appear to be positive steps in this direction.

Personal commitment to continued professional learning is important. Therapists who perceive their ability to perform a professional task as negative have a professional responsibility to upgrade their task performance (Boissoneau, 1980; Breines, 1988; Jones & Kirkland, 1984; Parham, 1987; Pelouquin, 1987). Lower levels of perceived competence are a cause for concern, because several of the tasks rated negatively were tasks identified as essential to occupational therapy education (AOTA, 1983a) and as standards of practice for occupational therapy services in mental health (AOTA, 1983b) (e.g., the task of providing input regarding the patient's functional level). Active, competent members of the mental health treatment team should be able to provide their professional expertise and knowledge relevant to current diagnostic criteria, practice standards, frames of reference, and research findings.

I was encouraged that the majority of respondents perceived their competence level as good or excellent. Many respondents commented that literature reviews, self-study, supervision, and continuing and postprofessional education facilitated the development and maintenance of their competence. Further research should be conducted to identify the factors that influence the development and maintenance of perceived competence.
The most important finding from the analysis of variance was the overall lack of relationship between professional demographics and perceived competence for the performance of professional tasks (see Table 3).

Educational level did influence two tasks, with the most significant differences occurring between occupational therapists with postprofessional degrees and occupational therapists with entry level bachelor’s or master’s degrees. The benefits of postprofessional education on perceived competence were strongly supported by 23% of those respondents who provided additional comments.

Work Setting
Several studies have expressed concern about the effect of the work setting on a practitioner’s perceived competence (Deane & Campbell, 1985; Jameton, 1984; Kramer, 1974); the present study’s findings were inconclusive. Further research is needed to determine the work setting characteristics that may influence perceived competence.

Experience
Of the 95 respondents currently practicing in mental health, 67% had more than 5 years of experience in mental health practice, whereas only 4% had less than 1 year of experience: this may account for the lack of variance according to years of practice. Many respondents commented that their work experience enabled them to develop competence in the performance of professional tasks. This response is supported in the literature, which describes competence increasing through a professional’s life as one gains assurance and expertise in the use of professional skills (Deane & Campbell, 1985).

Differences were also noted in the professional demographics of the 132 respondents. Therapists not presently engaged in clinical practice had attained more non-occupational therapy degrees than had practicing therapists (68% versus 40%). Nonpracticing therapists also had more overall professional experience than did practicing therapists (79% versus 61%, with 5 years or more of occupational therapy experience). This study shows that more educated and experienced therapists leave mental health clinical practice while sustaining their interest in the specialty area of mental health.

The acquisition of an additional non-occupational therapy degree and the accumulation of years of experience as an occupational therapist may result in therapists being employed as administrators, consultants, educators, and researchers. Although these roles are not direct practitioner roles, they are still valuable to occupational therapy practice in mental health and may reflect one’s natural professional career development. These findings indicate a need for further study in the area of postprofessional education and career development.

Summary
This study showed that a high percentage of the surveyed occupational therapists currently practicing in mental health perceive their ability to perform professional tasks as good or excellent. This finding is important in light of recent concerns regarding occupational therapy practice in mental health. Equally important is the finding that most of the respondents are strongly committed to the development and maintenance of professional competence. This study also identified six practice areas in which many respondents perceived their skills negatively.

These findings, although geographically limited, may serve several uses for the support and enhancement of perceived competence for practice in mental health:

- Entry level education programs can be reviewed and strengthened to ensure adequate, relevant course content in mental health.
- Continuing and postprofessional education programs can be developed to focus on areas of professional need.
- Self-evaluation of skill level can help one to identify individual learning needs.
- Personal commitment to continued professional learning can strengthen one’s perceived competence.

Considering the declining percentage of therapists practicing in mental health, it is vital that perceived competence be developed, maintained, and supported through a concerted effort of individual therapists, professional education programs, and professional organizations.

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References


