RESEARCH ARTICLE

Professional and Organizational Commitment in Paediatric Occupational Therapists: The Influence of Practice Setting

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Abstract

The professional and organizational commitment of paediatric occupational therapists working in two distinct practice settings, schools and medically based settings, was investigated. A web-based survey program was used to administer a questionnaire to occupational therapists employed in New York, New Jersey and Connecticut. The study employed social identity theory as a guiding perspective in understanding therapists' professional and organizational commitment. One hundred and fifty-seven paediatric therapists responded to the Professional Commitment Questionnaire and the Organizational Commitment Questionnaire to gauge their commitment to both the profession and their employing organizations. Results indicated that paediatric therapists, regardless of employment setting, have high professional commitment. Paediatric occupational therapists employed in medically based settings indicated statistically significant higher organizational commitment than their school-based counterparts. For therapists that work in school settings, the presence of a professional cohort did not influence professional commitment scores. As the study employed a web-based survey methodology, only individuals who were members of associations and had access to a computer and the Internet were able to participate. Further study might include widening the participant pool as well as adding additional instruments to explore both professional and organizational commitment on a more national scale.

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Keywords

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Introduction

A person's professional commitment is characterized by the sharing of beliefs, goals and values of the profession (Lachman and Aranya, 1986; Hall et al., 2005; Lemmens et al., 2009). In addition, the organizational setting in which the professional chooses to work influences his or her professional commitment to the profession. When the mission of an organization, or its set of goals and values, harmonizes with the profession's goals and values, positive professional commitment can flourish (Wallace, 1995; Lui et al., 2001; Johnson et al., 2006).

A person's organizational commitment is in part determined by the extent to which he or she shares in and identifies with the goals and values of the organization (Porter et al., 1974; Mowday et al., 1982; Mathieu and Zajac, 1990). Job satisfaction and job performance

are factors that have been positively correlated with organizational commitment (Mathieu and Zajac, 1990). Social identity theory (Tajfel and Turner, 1986; Turner, 1987; Hogg, 2006) proposes that as a person identifies with various groups in his or her environment, he or she begins to internalize the values of those groups. The more salient a group is to a person's identity, the more likely the person is to modify his or her behaviour to align with group norms (Stets and Burke, 2000; Hogg, 2006). Therefore, if a professional works in an organization that has goals and values that align with his or her professional goals and values, he or she is more likely to modify his or her behaviours to be consistent with the organization's norms and develop positive professional and organizational commitment (Ashforth and Mael, 1989).

If an organization employs people from the same profession, social identity theory posits that there will be a salient group for the professional to identify with and, therefore, an avenue to support professional commitment (Sorensen and Sorensen, 1974; Chattopadhyay and George, 2001; Johnson et al., 2006). If, however, a professional from a particular field is in a minority, or works in isolation from others in the same profession, this may prohibit the development of commitment to the profession and encourage the professional to identify with others in their organization (Chattopadhyay and George, 2001; Johnson et al., 2006).

Within the field of occupational therapy, the specialty area of paediatrics offers an exemplar through which to examine how practice settings may influence professional and organizational commitment. Occupational therapists who work in paediatrics primarily work in practice settings with two distinct foci: medical or educational. The medical setting aligns with most of the medically oriented, pre-service, professional education that therapists receive (Brandenburger-Shasby, 2005; Mendoza, 2005). Muhlenhaupt (2010) proposes that paediatric occupational therapists who work in medical settings are more likely to be part of an established occupational therapy department because of the structure of medical establishments. Therefore, in medically based settings, these therapists have the opportunity to interact with and be part of an established group of professionals that share similar pre-service, educational backgrounds and professional socialization experiences to their own profession.

In contrast, occupational therapists who work in schools are often professional isolates (Wills and Case-Smith, 1996; Pape and Ryba, 2004; Mendoza, 2005). These therapists frequently provide services only to a small set of children within the larger school population or are itinerant personnel who provide services to children in multiple schools and therefore may not have the opportunity to interact with other occupational therapists (Holtzinger and Hight, 2005). Contractual and itinerant arrangements further complicate the development of professional relationships because of the transient nature of contractual employment relationships (Mendoza, 2005). Furthermore, therapists who work in schools indicate that they are confused about their roles in schools (Barnes et al., 2003) and are not comfortable in school settings (Prigg, 2002).

The marked differences in the social milieu of these two practice settings provide a contextual backdrop for the exploration of how these settings support or work against professional and organizational commitment. Belonging to social groups provides a person with a sense of self within society (Tajfel and Turner, 1986; Hogg, 2006). Applying this concept to the schools, there may not be a salient group in which occupational therapists can belong (Pape and Ryba, 2004; Mendoza, 2005). Therapists in a school may not have the same opportunities to develop strong professional commitment as those practising in a medical setting. Furthermore, if the goals and values of the school do not align with the goals and values of the professionals who work there, social identity theory suggests that this may negatively affect organizational commitment, and professionals may change their allegiance to another professional orientation that supports the organization's goals and values (Johnson et al., 2006).

Johnson et al. (2006) used social identity theory to explore the professional and organizational commitment of veterinarians working in medically related veterinary settings with those in non-veterinary settings. This study found that veterinarians employed in non-veterinary settings had higher commitment to their profession and decreased commitment to their employing organizations. Johnson et al. (2006) argue that this finding supports social identity theory. Social identity theory states that people are attracted to groups that provide them with higher status (Tajfel and Turner, 1986). They contend that the identification that veterinarians who worked in non-veterinary settings had with their profession was indicative of the higher status that their profession provided to them in the non-veterinary organizational setting.

The purpose of this study was to explore the influence of practice setting on professional and organizational commitment for paediatric occupational therapists. Examining professional and organizational commitment of therapists is important to the profession. If occupational therapists have low levels of organizational and professional commitment, they may not be satisfied with their work situations and, ultimately, with their choice of profession. This in turn may lead to occupational therapists leaving the setting or the profession altogether.

Method

Procedures

This survey study used a quasi-experimental, non-equivalent group design (Trochim, 2001). Using a snowballing recruitment technique, Survey Monkey (http://www.surveymonkey.com/), a web-based survey program, was used to administer the questionnaire. An introductory letter outlined the purpose of the research project, briefly summarized the types of questions in the survey and asked potential participants to forward it to other potential participants as well as completing the survey themselves. A link to the questionnaire was included in this email. As recommended by Dillman et al. (2009), a follow-up final thank you/reminder email was sent 1 week later.

Recruitment of participants involved five methods. First, recruitment began with a mailing to 36 paediatric sites from a university fieldwork list. Second, an announcement was posted on a university listserve. Third, the New York, New Jersey and Connecticut state occupational therapy associations either sent out email invitations to their membership or posted an announcement on their web sites providing the Web link to the survey web site. Fourth, postcards were sent to 520 addresses of members of the American Occupational Therapy Association (AOTA). Finally, therapists from medical facilities were located from an Internet search of paediatric rehabilitation centres that resulted in an additional 39 respondents. The New York University Human Subjects Review Board reviewed and approved the study procedures.

Participants

As most studies using the Organizational Commitment Questionnaire (OCQ) and the Professional Commitment Questionnaire (PCQ) do not indicate power or effect size, it was difficult to base analysis on prior work. Therefore, to decrease the possibility of type II error, a conservative beta of 0.85 (Portney and Watkins, 2000) and a moderate effect size of 0.5 was chosen. Power analysis indicated that a total sample size of 118 respondents was needed, 59 in each group.

A total of 206 surveys were completed. Twenty-six surveys were eliminated because participants had not fully completed the survey instrument. An additional 23 surveys were eliminated because of inclusion criteria: 8 respondents were not from New York, New Jersey or Connecticut; 4 respondents did not work with children; and finally, 11 respondents had less than 1 year of experience. The final sample consisted of 157 participants, 59 therapists in medically based settings and 98 therapists in school-based settings.

Table I presents the characteristics of the respondents. Most (95%, $n = 149$) were women and worked in schools ($n = 98$, 63%). The sample is consistent with the national figures for gender within the profession (AOTA, 2006). While respondents had had a wide range of experience, the range of the initial year of certification was from 1957 to 2006 with a mean of 16

Table I. Demographics of sample participants

Participant characteristics	%	n
Gender		
Female	95	149
Male	5	8
State of practice		
New York	57	89
New Jersey	31	48
Connecticut	13	20
Practice setting		
School	63	98
Medical	37	59
Employment relationship		
Directly employed	74	116
Contracted by organization	8	13
Contracted by agency	7	12
Work with other therapists		
Yes	88	138
No	12	18
Belong to national association		
Yes	72	114
No	27	43
Belong to state association		
Yes	43	67
No	57	90

Note: Frequency data are provided as percentages of $n = 157$. Percentages have been rounded and may not add to 100%.

years of practice. It should be noted that, while there was a significant spread in the range, the highest frequencies were in 8 years ($n = 10$) and 9 years of experience ($n = 11$). Of the 157 surveys, a majority of the sample came from New York (57%, $n = 89$), followed by New Jersey (31%, $n = 48$) and, finally, Connecticut (13%, $n = 20$).

Respondents reported information about their employment relationship with the organizations they worked for, including the number of hours they worked per week, whether they worked with other therapists and the amount of contact they had with therapists in their employment settings. Seventy-four percent ($n = 116$) of respondents indicated that they were directly employed by the organization. Eight percent ($n = 13$) indicated that they were contractual workers hired by the employing organization, and the remaining 8% ($n = 12$) were employed by contracting agencies themselves. The number of hours worked per week had a wide range, with the low end at 3 hours weekly and the high end at 80 hours per week. The majority of respondents indicated that they worked 30 hours (6%, $n = 10$), 35 hours (17%, $n = 26$) and 40 hours per week (20%, $n = 32$). In a review of the data, it appeared that respondents with extremely high numbers of hours per week worked in more than one setting. For example, some respondents both worked in a rehabilitation centre and also provided early intervention services. Eighty-eight percent ($n = 138$) of respondents indicated that they worked with other therapists.

Table I also includes respondents' reported involvement in both the profession and their employing organizations. Forty-three percent ($n = 67$) reported belonging to their state association, and 72% ($n = 114$) reported belonging to the national occupational therapy association. Fifty-eight percent ($n = 91$) indicated that they had been involved in an orientation programme provided by their employer. Participation in continuing education and inclusion in organizational social activities were the items that had the highest participation from respondents, while attendance at professional conferences had the lowest level of participation. Table II provides a breakdown with respect to the school and medical settings.

Table II. Breakdown of practice settings

Type of setting	%	n
Public school	37	58
Children's hospital	17	26
Private practice	13	20
Special population school	11	17
Private school	9	14
Other medical facility	8	13
Other school setting	6	9

Note: Frequency data are provided as percentages of $n = 157$. Percentages have been rounded and may not add to 100%.

Instrumentation

This study used the OCQ (Porter et al., 1974) and the PCQ (Aranya and Ferris, 1984). In addition, demographic, professional and organizational questions were added to the survey. The OCQ (Porter et al., 1974) assessed the therapist's commitment to the organization in which he or she is employed using a 15-item, 7-point Likert scale questionnaire. Responses were scaled from 1, indicating strongly disagree, to 7, indicating strongly agree. The OCQ has consistently demonstrated high internal reliability with a median Cronbach's alpha of 0.90 (Barge and Schlueter, 1988; Bline et al., 1991; Way, et al., 2005). The PCQ (Aranya and Ferris, 1984) was created by substituting the word 'profession' for 'organization' in the OCQ to assess professional commitment. Examples of questions in the surveys are as follows: I am willing to put in a great deal of effort beyond that normally expected in order to help the profession be successful; I find that my values and the profession's values are very similar; and This profession really inspires the very best in me in the way of job performance. The examination of the PCQ by Bline and his colleagues (1991) reported high internal reliability with a Cronbach's alpha range from 0.89 to 0.92. Further, they conclude that the OCQ and PCQ had high internal reliability, and had convergent and divergent validity.

Participants were also asked to report if they believed that, in their work setting, they have a professional cohort and to identify who they believed that cohort to be based on answers to the following two questions: 'Do you believe that you have a professional group that you belong to in your work setting?' and 'If so, please indicate the professional group within your work setting with which you most identify yourself.' The second question was open ended to allow the therapist to name the group they felt is most salient within the employment setting. There were also questions relating to participation in professional development activities such

as: membership in national and local organizations, time spent reading professional journals, attendance at professional conferences, participation in continuing education and participation in peer groups, in-services and mentoring programmes.

Analysis

Completed surveys were automatically stored in the Survey Monkey database. Once the necessary number of respondents was obtained, the data were downloaded to SPSS 17 (2008) for analysis. An analysis to examine the internal consistency resulted in Cronbach's $\alpha = 0.77$ for the PCQ and $\alpha = 0.88$ for the OCQ. These findings are consistent with other research in which these surveys have been used (Aranya and Ferris, 1984; Aranya et al., 1986; Lachman and Aranya, 1986; El-Rajabi, 2007). Additionally, two Mann–Whitney *U*-tests were run to determine if there were differences in organizational and professional commitment based on practice setting as well as based on the presence of professional cohorts in the practice setting.

Results

Analysis of the data using a one-tailed, independent samples Mann–Whitney *U*-test ($p < 0.05$) indicated that there was no significant difference between therapists who worked in schools and therapists who worked in medical settings regarding professional commitment. On the PCQ, therapists who worked in medical settings had a mean score of 5.74 for professional commitment and the therapists who worked in schools had a mean score of 5.81. Hence, the scores reported by these therapists were indicative of a fairly high level of commitment. This finding indicates that paediatric occupational therapists are able to maintain high professional identity regardless of the practice setting in which they are employed.

Therapists who worked in medical settings, however, had a significantly higher level of organizational commitment than did their school-based counterparts ($p = 0.05$) based on an independent samples Mann–Whitney *U* analysis. On the OCQ, therapists who worked in medical settings had a mean score of 5.37 for organizational commitment and the therapists who worked in schools had a mean score of 5.07.

Next, data were analysed examining school-based respondents who worked with other therapists and those that did not. Of the 98 respondents who worked in schools, 76 reported that they had a cohort group, 16 did not and 6 did not answer the question. An independent samples Mann–Whitney *U* was run ($p < 0.05$) on the scores of the PCQ for the cohort (M = 5.8, standard deviation [SD] = 0.61) and no cohort (M = 5.8, SD = 0.58). Results indicate that the presence or absence of a professional cohort did not influence the professional commitment of therapists who worked in schools.

Discussion

The results obtained from the PCQ supported that paediatric occupational therapists have a strong professional self-concept and commitment to the profession. This commitment was maintained even when therapists worked in settings that have organizational goals and values that differed from therapists' professional goals and values, and where therapists did not have professional cohorts. These therapists' strong sense of professional commitment may in fact be an indication that they chose the profession because it had similar goals and values to their personal goals and values. Study results indicated that for most of these therapists, neither the employment setting nor the presence of a professional cohort in the work setting influenced professional commitment in a significant way.

According to social identity theory (Tajfel and Turner, 1986), people compare themselves with others, form identities and then in turn classify themselves as belonging to a particular social group or category. These categories are also used to make comparisons between the social group to which they belong and other social groups. If an employment setting, such as a school, does not offer a salient group for paediatric occupational therapists to identify with, these therapists may then increase their commitment to occupational therapy in order to maintain a sense of identity in a setting where they have no other salient social group. Therefore, the school-based therapists' comparison between themselves and other school personnel may in fact reinforce their commitment to occupational therapy rather than lead to a migration to a more numerous and powerful group within the school.

Meyer et al. (2006) hypothesized that social identities can either be situated or deep structure identities. Situated identities are more superficial and heavily reliant on situational cues of the environment. In contrast, deep-seated identities include an altering of the

self-concept to include the values of the group. Deep-seated identities are more enduring than situational identities. As occupational therapists participate in educational programmes that are approximately 2.5 years in length, followed by a minimum of 6 months of fieldwork experience, one could argue that they have a rigorous professional socialization process and that this process results in the formation of deep-seated identities as occupational therapists. For example, Sabari (1985) discusses the vigorous socialization process that occupational therapy students undergo as part of their pre-service training. Using socialization theory (Sherlock and Morris, 1967; Wentworth, 1980), Sabari argues that through educational programmes, where students receive a consistent message regarding the goals and values of the profession, strong professional socialization occurs. Thus, it is plausible that the professional socialization of occupational therapists is so strong that even when employed in settings with other professional groups, they retain and maintain their professional identity and commitment via deep-seated identity with occupational therapy.

In this study, paediatric occupational therapists who work in schools, and who also reported that they did not have a professional cohort in their employment setting, did not have decreased professional commitment. This result seems to indicate that paediatric therapists who work in schools are able to maintain high levels of professional commitment regardless of their ability to belong to a specific group within the school. This finding also supports the notion that the strong professional socialization process at the beginning of occupational therapists' careers creates deep-seated identities within members of the profession as discussed above. As Meyer et al. (2006) theorize, deep-seated identities are more enduring and are not easily affected by situational cues. Thus, occupational therapists' deep-seated identities will not be affected by the lack of occupational therapists in their environment, nor will the presence of other different professionals impinge upon their occupational therapy identities and commitment to their profession. Consistent with social identity theory, therapists' continued involvement with professional activities outside their employment settings would reinforce and maintain their professional identity and professional commitment.

It is perhaps notable that studies (Weintraub and Kovshi, 2004; Spencer et al., 2006) have found that therapists who work in schools continue to employ medical model treatment strategies. As people make comparisons between groups, social identity theory posits that people will identify with the group perceived to have the highest status. Consistent with this, paediatric occupational therapists may view their alignment with the medical field as having higher status than other professions in the school. Such a perception of higher status is what Johnson and his colleagues (2006) determined to be important in their study of veterinarians employed in non-veterinary settings who had higher commitment to their profession and decreased commitment to their employing organizations. They concluded that people are attracted to groups that provide them with higher status. Perhaps paediatric occupational therapists are thus able to maintain their professional commitment in school settings as they continue to implement medical model paradigms within schools.

Respondents reported that they continue to remain involved in the profession's activities outside their employment setting. They also indicated involvement in both state and national associations. Respondents indicated that they exerted themselves to be active members in their profession. From a social identity perspective, participation in professional activities may be a result of identification with and, therefore, commitment to the profession. According to social identity theory (Tajfel and Turner, 1986), when people identify with a particular group, they also align their behaviour to follow the norms and actions of that group. Consequently, participation in professional activities may allow these therapists to foster and maintain their professional identity and commitment to occupational therapy.

Alternatively, it may be that the school setting, as an organization, does not, in fact, have significantly different goals and values than the professional goals and values of occupational therapists. For example, goals of the American educational system include the development of productive members of society and the transmission of knowledge (Achieve Report, 2008). As paediatric occupational therapy and schools share the mission to work with and help children, these two settings may share some similar goals and values.

Furthermore, the work groups that paediatric therapists associate with in a school may be different from the larger school organization. As therapists who work in schools provide services to special education programmes, and are designated as 'related services', the therapists are often associated with special educators

and other special education specialists. Respondents indicated that they belonged to professional cohorts that included teachers, psychologists, speech therapists and school psychologists. These specialists may indeed share similar professional education and training to that of occupational therapists and may therefore be a salient group for therapists who work in schools with which to align themselves.

Finally, occupational therapists who work in schools may have high levels of professional commitment because of the autonomous nature of work in schools. Therapists who work in schools often are able to make their own schedules and decide what specific goals they will pursue with their students. If the therapists in this study positively viewed the autonomy that working in schools offers, this too may have positively influenced their professional commitment.

It may also be the case that professional commitment scores were not influenced by belonging to professional cohorts because occupational therapists who work in schools take pleasure in the actual work that they do. Their high professional commitment scores, regardless of the presence of a professional cohort with which they identify, may simply be indicative of their satisfaction with their profession. Therapists in this study, regardless of practice setting, indicated that their personal goals and values were similar to their professional goals and values. This supports the view that therapists in this study have similar personal and professional goals and values.

While social identity theory is frequently employed as a way to explore and understand organizational commitment, there is little discussion on the implications of social identity for professional commitment. It is unclear if this is because of other theoretical assumptions that are more often employed to explain professional commitment. One such example is socialization theory (Sabari, 1985). Self-categorization, however, is the part of social identity theory that explains how taking on an identity helps us to understand who we are and who we are in relation to others. It would seem, then, that self-categorization could be used to further understand how professional commitment develops. The results of this study, however, indicated that the presence of a professional cohort did not create a significant difference in professional commitment scores. This would seem contrary to the postulates of social identity theory and the ideas of self-categorization because, according to social identity theory, the absence of a professional cohort would likely lead to a decreased sense of self as there would not be a salient social group with which to identify oneself. This was not the case in this study. Perhaps proponents of the social identity theory need to explore how self-categorization and social identity are important in the development of professional identities. In addition, further study to explore how multiple identities impact on overall professional commitment might be useful in understanding how commitment to a profession can be developed and supported in various work settings.

Further understanding of the differences between these concepts may provide additional understanding of how people fit in and work towards organizational and professional goals and values. For example, in this study, therapists who worked in schools indicated that they had high levels of professional commitment. From personal experience, therapists who work in schools often indicate that they are confused about their roles in schools and they do not feel adequately prepared to work in schools. For occupational therapists who work in schools, there may be a disconnection between the concepts inherent in commitment and identification (such as the desire to work towards professional goals and values as well as professional satisfaction), and their day-to-day experiences or how therapists actually feel.

Based on the analysis of the survey data, occupational therapists employed in medical settings reported significantly higher organizational commitment on the OCQ than did therapists employed in schools. This finding is consistent with postulates of social identity theory because paediatric occupational therapists working in medical settings work with other occupational therapists and other medically based specialists such as doctors and physical therapists. Therefore, medical settings provide a group of similar professionals with which therapists can easily identify. However, therapists who work in schools often work with few or no other occupational therapists. As they indicated in the survey, therapists that worked in schools included classroom teachers and specialists from other disciplines such as school psychologists and social workers as their professional colleagues.

An additional factor that may have influenced the organizational commitment of therapists who work in schools is itinerant employment situations. Although the data indicated that most therapists were directly hired by their school districts, respondents were not asked if they were employed in one school or many

schools within their school districts. Working in one school versus several schools could have had a major influence on the ability of therapists to develop commitment to the organization, as therapists would have limited time in each of their various school settings.

This study has several limitations. First, the sample was difficult to obtain, requiring the use of several recruitment strategies. Only therapists who were members of the associations or knew people who had received an email invitation had a chance to participate in the study. As a web-based survey, only therapists who had access to the Internet were able to respond. The study also relied on self-reporting by participants. Finally, because respondents self-selected to respond, it may be the case that only those who were disproportionately committed paediatric occupational therapists responded. Even with these limitations, the present study provides evidence that paediatric occupational therapists employed in medically based facilities demonstrated significantly higher organizational commitment than did paediatric occupational therapists employed in schools. Furthermore, the study also revealed that for respondents who work in schools, the presence or absence of a professional cohort in the employment setting did not influence their high levels of professional commitment.

Further research in the area of professional and organizational commitment of paediatric occupational therapists might include widening the participant pool. A national random sample would provide data that are more comprehensive. Furthermore, the effects of interaction with others in the employment setting and the presence of a group of professional peers within the work setting warrant further investigation.

Future research might also include the use of a measure of professional and organizational identification. As previously discussed, there is a debate within the community of those who study organizational commitment regarding the differences between commitment and identification. While it is generally accepted that these are two distinct constructs, exploring the correlation between identification and commitment as well as how identification and commitment influence a person's relationship with his or her profession, and also investigating employee relationships with organizations, would add to the existing body of knowledge in this area. Exploring how social identity theory mediates both identification and commitment would be another area for future research.

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