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Abstract

This qualitative study explored the experience of professional transition from student to practitioner among six Canadian occupational therapists in the first year of their career, with a focus on how beginning practitioners learn about doing practice. A sociocultural theory of learning provided the framework to understand the role of context and activity in learning. Data collection consisted of two semi-structured interviews and a series of journal entries. An initial interview was conducted with each participant beginning in their third to fifth month of practice to discover their perception of transition, their learning needs, and the role of collaborative interactions in supporting their learning. Each participant then maintained a journal of their experience of transition and their learning experiences for one month. A second interview was held with the participants in their eighth to tenth month of practice, which focussed on their change in knowledge and skills.

The transitional experiences of the research participants revealed that the support of colleagues and peers was critical to their learning and eased their adjustment to practice. They preferred to learn from an experienced occupational therapist, and the availability of this support influenced the new practitioners' choice of their first job. In their initial months of practice they struggled with their lack of practical experience, responsibilities of client care, challenges to client-centred practice and competing work demands. Their relationship with clients was particularly valuable to the participants' learning and professional identity.

Mentoring and implementing practical learning experiences in the university curriculum were suggested as strategies for easing the transition from student to therapist. The role of client interaction as a valuable source of learning was also recognized.

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This thesis is dedicated in honour of my mother, Anne Toal, who taught me about the importance of caring about others, which to me, is the essence of teaching and mentoring.

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Chapter 1: Introduction

This study explored the phenomenon of professional transition from student to practitioner among six Canadian occupational therapists in the first year of their career. The majority of the research on transition from student occupational therapist to practitioner has originated from the United Kingdom and the United States. The health care work environment in Canada may present unique stressors and challenges to the beginning practitioner. Issues such as time pressures, financial and organizational restraints, lack of supervision and support, may influence how professionals learn in the workplace (Leonard & Corr, 1998). The education of occupational therapists in Canada is also changing; by 2010 a Master's degree will be the minimum entry requirement to the profession (Canadian Association of Occupational Therapists, 2002). While educational programs must prepare students to function in the practical setting, it is unclear how new therapists achieve the connection between theoretical knowledge and practical skills. A Canadian perspective on how occupational therapists develop their competence in practice is required to develop strategies to support lifelong learning.

Research on the transition from student to occupational therapist identifies it as a difficult process and discusses the need for support and supervision to assist this stressful period (Hummell & Koelmeyer, 1999; Parker, 1991; Rugg, 1996; Sutton & Griffin, 2000, Tryssenaar & Perkins, 2001). At the same time, little information exists about the type, availability, and extent of support and supervision mechanisms (Leonard & Corr, 1998; Hummell & Koelmeyer, 1999; Tryssenaar, 1999). Studies that have explored the challenges

faced by new occupational therapists in acquiring skills and knowledge in the first year of practice have been primarily quantitative in nature (Atkinson & Steward, 1997; Leonard & Corr, 1998; Parker, 1991; Hummell & Koelmeyer, 1999; Rugg 1996). This approach does not allow an understanding of how occupational therapists make meaning of their world and how they “interact with the whole process of socialization” (Howkins & Ewens, 1999, p. 42). In addition, developmental and skill acquisition theories have been used as a conceptual basis for many of the studies (Missiuna, Polatajko & Ernest-Conibear, 1992; Spalding, 2000; Tryssenaar & Perkins, 2001). A chronological process assumes that socialization is learning the skills and behaviour of a profession and does not acknowledge that it also includes the experiences, values and behaviours of the individual. Developmental theories view knowledge as a passive process and assume that there is an endpoint to the process of learning (Darwin, 2000). If learning is viewed as a “dynamic, reciprocal and participatory process” (Darwin, p. 202) then developmental theories are limited in their ability to help us understand the complex process of learning to practice occupational therapy. Therefore, an alternative conceptual model was required.

Sociocultural theory provides the perspective to understand the role of context and activity in learning. Vygotsky (1978) believed that learning and knowing is constructed through collaboration with others during problem-solving or shared activity with others. In his view, language and other signs or tools such as writing and works of art, were essential to making meaning within the context of family and communities. In this socially mediated view of cognition learning “is a matter of acculturation, of joining a community of practice, rather than the application of skills or principles which operate independently of social

context” (Cope, Cuthbertson & Stoddart, 2000, p. 851). Learning in practice is described as a cognitive apprenticeship in which individuals acquire and develop the tools and skills of their culture through social interaction (Brown, Collins & Duguid, 1989). A sociocultural theory of learning emphasizes the participatory, active construction of knowledge between learners and their environment (Lave, 1997; Lave & Wenger, 1991; Samaras & Gismondi, 1998; Vygotsky, 1978). The specific values, knowledge and skills of the community are mastered by participation in context-specific activities. These activities are potential opportunities for development and change, requiring participants to jointly construct understandings that enhance their past experiences (Wells, 2000).

The profession of occupational therapy can be viewed as a culture with its own knowledge, behaviours, beliefs and language. From this perspective, learning can be viewed as a process of enculturation where students develop the specific tools of the discipline and adopt the culture of the profession by participating in the work context. Therefore, this study adopted a socio-cultural perspective to understand the challenges faced by occupational therapists, the development of knowledge, skills and professional identity, and the role of mentoring in supporting learning within the practice context.

Chapter 2: Review of the Literature

Professional socialization is generally divided into two stages; formal academic education and clinical fieldwork training. Sabari (1985) proposed that there is a third stage which is integral to the socialization process; the “situational demands of the individual’s early work setting” (p. 96). There is, however, little research about new therapists’ initial entry into practice and their perception of the transition from student to practitioner. Research on socialization and mentoring as a strategy to assist in the socialization process will be discussed. The role of culture and social context in learning will then be reviewed.

Transition as Socialization

The question of how students are socialized into healthcare, teaching and other human service professions, is of critical importance to the education process and has implications for how these professions can maximize the learning experiences of students and new graduates. Professional socialization can be defined as “the acquisition of knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession”(Clark, 1997, p. 442). Socialization involves a continual interaction between the person, and the environment which includes institutions, systems and individuals. It is a complex process in which practitioners are inducted, trained and credentialed into the culture of their profession, and the values and norms of the group are incorporated into the self-concept (Cahill, 1996; Howkins & Ewens, 1999; Sabari, 1985). In the health care disciplines, professional identity is constructed through interaction with fellow students, faculty, and patients (Clark, 1997). Beyond the school setting the socialization process

continues with new work environments, colleagues, and the day-to-day situations of practice. Students have an active role in this dynamic process of socialization, as they strive to make meaning of their world and the connection or disjuncture between their expectations of practice and their actual experience (Clark, 1997; Howkins & Ewens, 1999). The transition from student to professional involves looking at the process of change; letting go of an old situation and identity and adjusting to a new situation and identity (Bridges, 1989). This change in roles from student to worker requires provision of support and creation of a learning environment that facilitates growth and exploration of oneself and the world (Super, 1984). Transition challenges the new practitioner to make “meaning and coherence in what can seem fragmented and senseless” (Daloz, 1986, p. 193). It is important for educators to understand transition and how the patterns of learning evolve or change throughout a person’s life, to promote lifelong learning (Caffarella & O’Donnell, 1987).

Research on socialization in occupational therapy has focussed on the value of fieldwork or apprenticeship in enabling students to acquire and develop the tools and skills of their culture of practice. Fieldwork is recognized as an integral part of the education and preparation of occupational therapists. Through the fieldwork process students are socialized into the profession by observing theory in action and developing practical skills, a sense of professional identity and ability (Missiuna, Polatajko & Ernest-Conibear, 1992; Thompson & Ryan, 1996). Fieldwork allows students to develop skills in an authentic context which the classroom cannot provide (Lave & Wenger, 1991).

Tompson and Ryan (1996a) examined the role of fieldwork in the professional socialization of occupational therapy students through interviews with students and journal entries. The researchers found that the experience of fieldwork helped to concretize what it meant to work as an occupational therapist. Fieldwork supervisors discussed the reasoning process and underlying assumptions behind their actions. This form of socialization provided a valuable educational experience, making the thought behind the action explicit. A second theme from their research concerned the development of a concept of professionalism through fieldwork experience. Students learned the boundaries that defined their role including showing empathy and concern for patients and learning how to deal with patients' right to privacy and physical space. They developed an understanding of their place as therapists within the health system through observations of how other team members worked together. During fieldwork, theoretical knowledge from the academic setting is mixed with practical experience to create a sense of professional identity and ability-it is a "link between the academic world and the world of the practising professional" (Tompson & Ryan, 1996a, p. 65).

Tryssenaar and Perkins (1999) found that fieldwork may shelter students from the real world of practice with its "professional strains, demands and imperfect solutions" (Tryssenaar & Perkins, 1999). Workplace factors such as lack of recognition of occupational therapy services, staff conflict, lack of resources, and organizational politics may hinder the transition from student to graduate (Hummell & Koelmeyer, 1999; Tryssenaar, 1999). In addition, the emphasis on clinical skills in fieldwork may protect students from the organizational and professional problems and stresses they will encounter

during the critical first year (Tryssenaar & Perkins, 1999).

Tompson and Ryan (1996b) found that fieldwork allowed students to apply theory to practice, learn and practice assessment skills and treatment methods, and experience the real-world of occupational therapy through interaction with clients and team members. In their study, students did not comment about the differences in content between what they were taught in the academic setting and what they observed in the clinical setting, however found a different learning process between the two settings. In an academic setting, learning was pre-planned and structured compared to a fieldwork setting where learning was unstructured and a “process of trial and error; of learning through interactions with others” (Tompson & Ryan, 1996b, p. 100). The different learning processes were viewed as a contributing factor to students’ difficulty applying theory to practice and lack of integration of knowledge and skills between course work and fieldwork.

The occupational therapy literature has explored the role of the fieldwork supervisor in supporting the student in acquiring the knowledge and skills of practice. However, we do not know about what supportive relationships are available to occupational therapists in their first year of practice and the functions they serve. There are few studies that have examined professional socialization beyond the student level, and in particular, the phenomenon of transition from occupational therapy student to practitioner (Atkinson & Steward, 1997; Hummell & Koelmeyer, 1999; Parker, 1991; Rugg, 1999; Sutton & Griffin, 2000). Supervision has been equated with mentoring thereby contributing to the confusion of how these relationships contribute to occupational therapists’ learning (Crowe & Mackenzie, 2002; Steward, 1996; Tryssenaar & Perkins, 2001).

A prominent problem in occupational therapy education and training has been difficulty in connecting theory, which is the focus of educational programs, and practice, which occurs in clinical areas (Atkinson & Steward, 1997; Steward, 1996). Professional educators have identified a gap between the school's "conception of professional knowledge and the actual competencies required of practitioners in the field" (Schon, 1987, p. 10). Mezirow's (1998) theory of adult learning is relevant to our understanding of the learning process in socialization. According to this theory, individuals have a construction of reality that is reinforced by their socio-cultural milieu (Jarvis, 1995; Mezirow). These constructions are transformed when individuals' perceptions of reality are not in harmony with their experiences. In this way, learning can be understood as "as a series of transformations in our ways of making meaning of our experiences" (Dalo, 1986, p. 137).

The challenge for educators is to prepare practitioners to function in complex and unpredictable practice environments, characterized by considerable uncertainty (Higgs & Titchen, 2001). Knight (2002) describes the complex system as non-linear; there are many contingencies such as resources, individuals and contexts, which influence outcomes. The indeterminate zones of practice involve messy situations, value conflicts or ethical dilemmas, and cannot be approached with technical problem-solving, however, it is these zones of practice, that are "central to professional practice" (Schon, 1987, p. 7). New practitioners have the theoretical foundation, clinical experience, and clinical reasoning skills to enable them to work in diverse health and social contexts. However, they are not prepared for dealing with difficult ethical conflicts and clinical problems, which requires professional artistry. According to Schon, professional artistry involves knowing how to make practice

judgments that are optimal for the client and the context, despite the uncertainty of the situation. This advanced level of clinical competence is developed through critical reflection and grappling with the “gray areas of practice” which allow practitioners to create meaning from their experiences (Higgs & Titchen; Schon).

Mentoring has been proposed as a strategy to support socialization of occupational therapists (Greensmith & Blumfield, 1989; Hanft & Anzalone, 2001; Ilott & Allen, 1995; Steward, 1996; Tryssenaar, 1999; Tryssenaar & Perkins, 2001). In the Canadian occupational therapy literature there is little research about the transition from student to therapist, mentoring relationships in occupational therapy, and the role of mentoring in supporting learning in a practice context. The majority of research has focussed on the role of fieldwork and clinical supervision as methods of supporting professional growth of the student or beginning therapist (Nolinske, 1995; Thompson & Ryan, 1996a, 1996b).

Socialization and Mentoring

Mentoring research comes primarily from three contexts; business, education and nursing. The business literature explores mentoring from the perspective of career development and the psychosocial and job-related skills obtained through the mentoring experience. The education and nursing literature describe how mentoring “bridges the gap between the classroom and the reality of the workplace” (Donovan, 1990, p. 298).

Mentoring has been defined in many different ways, leading to confusion about this complex process (Donovan, 1990; Newby & Corner, 1997; Woodd, 1997; Yoder, 1990). Mentoring has most commonly been described as an interpersonal relationship between two

individuals who are at different stages in their professional development. The mentor, the knowledgeable, more experienced of the two, teaches and trains the protégé (Collins, 1994; Newby & Corner; Yoder). Mentoring provides protégés with an opportunity to develop skills, learn about the organization and its culture, and advance their career (Eby, 1997; Newby & Corner). Although the language of mentoring is ambiguous the “presence of an adult learner and a teacher clearly locates it in an ideology of adult education” (Darwin, 2000, p. 198).

There are a wide range of relationships that can support and meet learning and development needs. Peutz (1987 as cited in Donovan, 1990) described a continuum of learning relationships and functions, with mentoring and role modelling located at opposite ends of the continuum. Preceptorship and sponsorship, which involve teaching and nominating the protégé for opportunities, are less influential relationships and are located in the middle of the continuum. Mentoring is viewed as the most intense of the relationships, where a mentor “assumes the role of both teacher and advocate” (Shapiro, Hazeltine & Rowe as cited in Woodd, 1997, p. 334). It is the emotional intensity between mentor and protégé that “sets the relationship apart from role modelling, counseling, coaching, or sponsorship” (Nolinske, 1995, p. 40). The protégé progresses through stages of professional growth “beginning with dependence and moving toward independence and individualization” (Schemm & Bross, 1995, p. 33).

Mentoring relationships are dynamic and change over time. Developmental models have been proposed to describe the purpose and function of the mentoring relationship at different stages of learning (Ballantyne, Hansford, & Packer, 1995; Kram, 1983; Moir &

Stobbe, 1995). Burlew's Multiple Mentor Model (1991 as cited in Woodd, 1997) described the mentor's activities related to the protégé's learning and support needs. The training mentor assists the protégé in settling into an organization and developing the necessary skills and knowledge to achieve a proficient level of job performance. The education mentor helps the protégé progress in their occupation and prepare for a new or different position within the organization. Finally, the development mentor helps the protégé anticipate the future and the changing needs of the organization, through activities directed at personal and professional growth. Despite differences in the literature regarding the characteristics and length of the stages of mentoring, there is general agreement that mentoring has a beginning and an end, and the objectives of the relationship will depend on the individuals involved (Scott, 1992). As well, the mentoring relationship is characterized by "substantial emotional commitment by both parties" (Bowen, 1985, p. 31).

Mentoring in Business.

The majority of the research on mentoring is from the business literature and consists of both conceptual articles and empirical studies. Mentoring has typically been explored as a hierarchical relationship involving a senior person in terms of age and experience and a junior person or protégé (Bowen, 1985; Kram, 1985; Woodd, 1997; Yoder, 1990). The goals of the mentoring relationship have commonly been categorized into career development and psychosocial support functions (Kram, 1985). Career functions are those aspects of the relationship that help a younger person establish a role in the organization and enter into professional networks. This type of support includes coaching, sponsoring,

protecting, promoting advancement within the organization, and providing challenging assignments to the protégé (Eby, 1997; Kram, 1985; Sosik & Godshalk, 2000; Walsh & Borkowski, 1999). Psychosocial functions of mentoring primarily promote a sense of professional identity and competence and include role modelling, counselling, friendship and acceptance. Career functions focus on the organization and the development of the protégé's career, whereas psychosocial functions focus on the development of the protégé's personal development (Ragins & Cotton, 1999). Age, gender, race, ethnicity, career stage, and power status of the mentor and protégé will influence the intensity and scope of mentoring activities (Yoder, 1990). In addition, the functions and outcomes of the mentoring relationship depend on the needs and expectations of the mentor and protégé, and the formal or informal characteristics of the relationship. Informal mentoring develops spontaneously where two interested persons establish a mentoring relationship, and formal mentoring develops with the assistance of the employees' organization (Darwin, 2000, Ragins & Cotton, 1999).

Ragins and Cotton investigated the functions and career outcomes of formal and informal mentoring relationships using Kram's (1985) conceptualization, among a sample of men and women in the engineering, journalism and social work professions. Their findings suggested that protégés in informal mentoring relationships experienced more career development and psychosocial functions than protégés in formal mentoring relationships. Protégés with informal mentors reported more satisfaction with their mentors and earned significantly more than protégés with formal mentors. The researchers proposed that the initiation, structure and processes in formal and informal relationships may account for these

differences. Formal mentors may be less motivated to participate in a mentoring relationship than informal mentors, due to the assigned nature of the relationship and therefore less likely to provide career and psychosocial functions. Informal relationships which are based on perceptions of mutual interests, respect, competence and friendship, are more likely to enhance psychosocial outcomes. The goals of formal mentoring may be more short-term related to the protégé's current position, therefore limiting the time required to realize career outcomes. In contrast, the goals of informal mentoring are more long-term in nature, allowing for the career needs of the protégé that extend beyond one organization.

Technological advances and diversity in the workplace have challenged informal mentoring structures within organizations (Darwin, 2000). Formal mentoring programs are more common (Walsh & Borkowski, 1999) and are implemented with specific goals and practices "that serve developmental purposes for both individuals involved" (Burke & McKeen, 1989, p. 76). These programs are characterized by management support, careful matching of mentors and protégés, and clearly stated responsibilities and expectations for those involved (Noe, 1988). The trend towards formal mentoring programs is due in part to the change in today's workforce where women comprise half of the workforce and racial minorities one-third (Darwin, 2000; Van Collie, 1998). Women face greater obstacles to developing informal mentoring relationships than men and may be "more likely to seek formal relationships as a substitute for informal mentoring relationships (Ragins & Cotton, 1999, p. 530). Formal mentoring programs may be a solution to allow a match between "women and minorities with experienced, upper-level managers to accelerate their performance and assimilation of the organizational culture" (Van Collie, 1998, p. 38).

Studies have shown that being mentored is as important to men as it is to women, however women may be less likely to have mentors because of barriers such as a lower status in organizations, lack of recognition, and discriminatory access to experiences that are central to advancement (Koberg, Boss, & Goodman, 1998; Yedidia & Bickel, 2001). Women's culture differs from men's culture within each society as "women do not participate in the rituals or foster the values dominant in the men's culture and vice versa" (Hofstede 1991 as cited in Woodd, 1997, p. 339). Women also face identity and discrimination issues throughout their careers which influences learning within relationships (Darwin, 2000). In a study exploring the perspectives on the scarcity of women in leadership positions in academic medicine, thirty-six clinical chairs indicated that it would be difficult for men mentors to understand or identify with the unique pressures and barriers facing women faculty members (Yedidia & Bickel, 2001). The barriers identified by the respondents included traditional gender roles, sexism and bias, and few leadership role models. Strategies directed at an individual and an institutional level were proposed to eliminate these barriers and included mentoring, appointing women to prominent faculty positions, changing faculty schedules and on-call arrangements to accommodate family responsibilities, promoting part-time appointments, and modifying tenure policies.

The words used to describe mentoring and the functions of mentoring relationships may be influenced by the characteristics of the mentor and protégé. In a study using a self-report questionnaire among 387 hospital employees, Koberg, Boss and Goodman (1998) found that the characteristics of the mentoring dyad (gender and race) and the characteristics of the protégé (education and ethnicity) influenced the level of psychosocial mentoring in

the relationship. A relationship of the same gender provided more psychosocial support to the protégé than diversified dyads. Ragins (1997) proposed that mentors and protégés of the same gender share a common identity and have a greater amount of interpersonal comfort than those in diversified relationships. This shared identity leads to more psychosocial support and role mentoring functions. Psychosocial mentoring which provides friendship, support, and acceptance may be more available to women at all levels of the organization, whereas career-related mentoring which depend on a person's experience, position and influence in the organization, may be less attainable (Koberg et al.). Mentors' power in an organization influences their ability to provide protégés with career functions such as sponsoring them to high profile positions, providing them with visibility, and acquiring increased compensation for them. Ragins and Cotton (1999) proposed that male mentors may be able to provide more career development functions than female mentors because males "generally have more power in organizations" (p. 533).

Burke, McKeen and McKenna (1993) examined the mentor relationship from the perspective of the mentor. Data were obtained by questionnaire from ninety-four managerial employees who were mentors in high technology companies. Findings indicated that similarity between the mentor and protégé's background, work style and interests were significantly related to provision of specific mentoring functions. It appeared that more psychosocial functions were present when women were involved. Other research has failed to find an association between gender and mentoring outcomes (Dreher & Ash, 1990; Ensher & Murphy, 1997). Burke, McKeen and McKenna cautioned that the results of the study were tentative and suggested the need for further research into the characteristics of

mentor and protégé in the mentorship process, as well as the importance of gender.

A different conceptualization of the mentoring relationship was proposed by Eby (1997) which recognized lateral mentoring, or mentoring provided by peers, as well as hierarchical mentoring. Peer mentoring involves individuals at a similar level in terms of their status and responsibilities within an organization, who provide support for each others' learning. Peer learning provides a structured process to gain "knowledge, through study, experience, observation or teaching of an equal" (Lincoln & McAllister, 1993, p. 17). Peers can share information, discuss problems and provide emotional support and feedback during periods of transition and stress. This mutuality is viewed as a critical aspect in helping a young adult develop a sense of competency and professional identity (Kram & Isabella, 1985). Peer relationships "enable both individuals to experience being the giver as well as receiver" of career-enhancing and psychosocial functions" (Kram & Isabella, 1985, p. 118). In today's workplace, peer relationships may be more available to individuals than traditional mentoring relationships involving a junior person, and a supervisor or senior person (Kram & Isabella, 1985).

Studies have acknowledged the complexity of individual, interpersonal and organizational factors involved in mentoring relationships and outcomes (Dreher & Ash, 1990; Ragins & Cotton, 1999). Although further research is required into the structure and function of mentoring relationships, mentoring has been associated with positive career outcomes for the protégé (Kram, 1985) and positive results for the organization. Mentoring benefits the participants and the organization; it builds on the employee's capacity to learn, and enhances their performance goals and the organization's objectives (Van Collie, 1998;

Van Slyke & Van Slyke, 1998). Organizations also benefit through the continued development of human resources and the strength to respond to a rapidly changing work environment. Those who have been mentored “receive substantial benefits such as higher promotion rates, greater career satisfaction and higher overall compensation” (Allen, McManus & Russell, 1998, p. 453).

The wide variation of findings in the business literature can be explained in part by the complexity of issues involved in the mentoring process and the lack of a common definition of mentoring among studies (Merriam, 1983; Scott, 1992). Further research on mentoring as a “colearning, interdependent activity...across cultures, genders and hierarchical levels” is required (Darwin, 2000, p. 208). Mentoring cannot be viewed as an informal, patriarchal process between older and younger males within an organization because this conceptualization does not address the needs of today’s diverse workplace culture (Darwin, 2000). As well, further research is needed to examine the various types of mentoring relationships and the organizational conditions that support mentoring (Eby, 1997; Koberg, Boss & Goodman, 1998).

Mentoring in Education.

In the field of education, mentoring is more clearly defined as an intervention to support the continuing development of adult learners. A mentor may be critical to the learning process providing developmental opportunities, guidance and building confidence (Eby, 1997). Levinson (as cited in Bova & Phillips, 1984) stated that the “mentor relationship is one of the most developmentally important relationships a person can have in

early adulthood” (p. 97). The mentor system provides a special form of entry for the protégé into the social network and provides an opportunity for modelling (Dreher & Ash, 1990). Polson (1999) described this aspect as occupational socialization, which facilitates the development of a student’s occupational identity. In a study examining graduate students’ socialization into adult education, Polson found that the student’s relationship with their faculty advisor was the single most important element determining the quality of their graduate experience. Similarly, Spouse (1996) identified that the quality of the mentoring relationship was fundamental to students’ development of professional knowledge during clinical fieldwork experience.

In their analysis of the professional growth of new teachers, Moir and Stobbe (1995) identified four phases of development that occur throughout the school year. The initial phase is devoted to survival in learning the “day-to-day details of running a classroom” (p. 86). The disillusionment phase occurs approximately six to eight weeks later, when the teacher questions if they have chosen the right career, as they face a number of stressful demands such as parent conferences, report cards, and their own performance evaluation. In January of the school year, teachers enter a rejuvenation phase as they begin to develop their own teaching strategies and take responsibility for their own professional development. Finally, a period for self-evaluation and reflection occurs at the end of the school year.

Ballantyne, Hansford, & Packer (1995) explored how mentoring facilitated the professional development of novice teachers with their changing needs, concerns and expectations. The study used a qualitative approach to describe the development of mentoring relationships, and the functions, benefits and limitations of mentoring

programmes. Sixteen teachers beginning their first teaching assignment at a primary school in Australia, participated in the study. Twelve of the teachers had a mentor assigned to them who was an experienced teacher of the same grade at their school. Four teachers developed their own mentoring relationships informally within the first week of the school term. The participants identified an initial mentoring role of personal and emotional support in the first few weeks of teaching, progressing to a role of critical reflection and feedback during the second term of teaching. Involvement of the mentor was most intense during the first term of teaching. The second term, marked a change in the mentor-teacher relationship, as the beginner teacher tried to establish their independence and maintain a friendship with their mentor. Throughout the phases of the relationship, mentors offered valuable support, practical assistance and benefits of experience to beginning teachers, assisting in induction into the teaching profession.

The studies of mentoring and teaching have viewed mentoring as a hierarchical and individualistic process. However, some of the benefits of mentoring for new teachers which include learning skills, receiving emotional support and helping new entrants fit into the existing culture of the school, may be applicable to new occupational therapists (Hargreaves & Fullan, 2000).

Mentoring in Nursing.

The nursing literature on mentoring is most similar to the occupational therapy literature, discussing the role of mentoring in the socialization of students into their profession. Oermann and Garvin (2002) explored the challenges and stresses experienced by forty-six nurses in beginning clinical practice, using the Clinical Stress Questionnaire. The stresses that were reported most frequently by the new graduates were “1) not feeling confident and competent, 2) making mistakes because of increased workload and responsibilities, and 3) encountering new situations, surroundings and procedures” (p. 228). Applying knowledge to the practice setting was identified as a significant challenge by the new graduates. The study recommended that nurses should have opportunities to practice skills and receive feedback from an experienced clinician to facilitate learning. A mentor could assist new graduates in coping with stresses encountered in beginning practice and create an environment that supports learning and the development of self-confidence.

A peer mentoring program for student nurses was developed as a strategy to enhance learning in the clinical setting and develop students’ confidence in working in a clinical environment (Yates, Cunningham, Moyle & Wollin, 1997). Second year nursing students acted as mentors to first year nursing students. The mentor facilitated a group of 4-7 students who met for five sessions throughout a semester. The sessions focused on students’ experiences in the clinical setting, reflective learning, and methods to achieve the learning objectives for the particular setting. Results of the program indicated that peer mentorship increased students’ confidence in their practice skills. This benefit was attributed to greater personal control gained from sharing experiences and strategies for handling

stressful situations. The program provided students with a sense of support, as well as an opportunity to integrate theory and practice through linking course material and practicum learning. The role of peer mentorship in personal and professional growth among female nursing students was also explored by Glass and Walter (2000). A peer mentoring group involving seven participants, met weekly for one hour on twelve occasions in which nurses discussed personal or professional issues. The focus of mentoring in this study was on providing support to nurses about emotional issues, not professional issues such as nursing knowledge. The researchers concluded that nursing education should include exploring how nurses care for themselves, each other and their clients. Validation and acknowledgment “was essential and a necessary precursor to open discussions of professionalism” (p. 159).

The challenge of making connections between theory and practice in nursing education was explored by Cope, Cuthbertson and Stoddart (2000). Learning in a practice context allowed experienced nurses to guide new practitioners through the “complexities of practice” (p. 851). Similarly, Spouse (1996) identified the importance of the mentor’s dialogue with the protégé to challenge their perspective, assist in meaning-making, and to consider actions in relation to theory. A collaborative dialogue was seen as crucial to the students’ learning. The need to support students as they enter the practice setting was articulated and includes acceptance of not only the technical or professional knowledge of practice but also social inclusion. Campbell-Heider (1986 as cited in Donovan, 1990) suggested that a female dominated profession such as nursing required a range of mentorship models to reflect the nature of nursing work and female socialization. Nurses have “different needs than aspiring executives, scholars and administrators” (p. 297). New

practitioners need access to persons who “provide informal information about the hospital system which can appear overwhelming for the neophyte” (p. 297).

The mentor relationship in nursing has been described as intense and transitional, promoting students’ self-efficacy (Hayes, 1998; Yoder, 1990). The nursing research has proposed diverse definitions of mentoring, with associated processes and roles. Recently, peer mentorship has been proposed as a means for supporting, learning and caring among nurses (Glass & Walter, 2000; Yates, Cunningham, Moyle & Wollin, 1997). Personal and professional growth appear to be integral to the mentoring process however further research is required to identify the benefits of mentoring, types of mentoring and persons most likely to benefit from mentoring programs.

Transition and Mentoring in Occupational Therapy

Students and new practitioners “perceive a gap between theory and practice” that occurs between course work and fieldwork, academics and clinicians, schools and departments (Steward, 1996, p. 264). This disjuncture tends to arise from beliefs that knowledge which has been formalized in the classroom, can be readily transferred to clinical practice (Spouse, 1998). Evidence suggests that new graduates of occupational therapy have particular problems making the transition from student to therapist (Allen & Cruickshank, 1977; Hummell & Koelmeyer, 1999). These difficulties concern issues of self-confidence, relationships with others, and uncertainty about their professional identity and role. New practitioners feel inadequately prepared and suggest that not enough emphasis is placed on the practical aspects of occupational therapy in university such as learning about

equipment, applying theory, and planning treatment (Parker, 1991).

Among new graduates, Atkinson and Steward (1997) found that “theory was not adequately supported by practice” highlighting a discrepancy between academic skills and implementing the occupational therapy process (p. 341). Proposed strategies to minimize the difficulties encountered in the first year of practice include supervision or mentoring, discussions and readings on professional practice, continuing education courses and resources for dealing with stress and burnout (Tryssenaar & Perkins, 1999). Mentoring can facilitate professional learning, socialization and adaptation of protégés into the health care profession (Kalbfleisch & Bach, 1998).

Ilott and Allen (1995) discussed a formal mentorship program designed for students enrolled in a part-time occupational therapy program in the United Kingdom. Students were required to have a mentor throughout their four year educational program. A series of workshops were held every six months for the mentors and protégés and revolved around themes such as fieldwork placements, incorporating knowledge into work roles, and coping with transition between student and worker. Both mentors and protégés identified that support, either practical or emotional, was the most important role of mentorship. Lack of commitment from mentors and time constraints from both mentors and protégés were identified as negative aspects of mentorship. A formal or informal mentorship relationship “has the potential to facilitate the transition for new entrants” and promote lifelong learning (p. 295). The authors recommended further research into the properties of mentorship.

Literature from the United Kingdom has focussed on new graduates' perceptions of their initial occupational therapy position, their professional development, and factors that influence job satisfaction (Hummell & Koelmeyer, 1999; Rugg, 1996; Spalding, 2000). Retention of occupational therapists and attrition has been a concern for the profession, educators and employers (Bailey, 1990; Freda, 1992; Parker, 1991; Rugg, 1996; Sutton & Griffin, 2000). Occupational therapists at the basic grade level (new practitioners), are most at risk of leaving the profession (Greensmith & Blumfield, 1989; Rugg, 1996). In the United States, Freda (1992) found that those with less than one year's experience cited occupational therapy peer relationships, professional growth opportunities, and salary as the most important considerations in deciding to leave or remain in their current job. Other studies have also identified the need to provide support and supervision from experienced colleagues to assist new practitioners in the socialization process (Hummell & Koelmeyer, 1999; Parker, 1991). Davis (as cited in Tryssenaar, 1999) proposed that mentoring was crucial to the professional development of therapists in their first year of practice and recommended that occupational therapists ensure that mentoring was available in their first job.

Rugg (1996) explored areas of difficulty for occupational therapists in their first year of practice and the variables that influenced their withdrawal from practice. This longitudinal study followed 177 graduates from one British occupational therapy program for one year after graduation. A questionnaire describing perceived problems of occupational therapy practice was administered just prior to graduation and again after one year of practice. The study indicated that knowing the occupational therapy role in a given setting and obtaining

adequate supervision were concerns for participants. The study also revealed a mismatch between the participants' early expectations and their actual experience of practice and suggested further research to understand the experience of new therapists.

The early work experiences, availability of mentors, and congruence between academic and clinical learning are important factors contributing to one's identity as an occupational therapist and decision to remain in the profession (Greensmith & Blumfield, 1989; Tryssenaar, 1999). Hummell and Koelmeyer (1999) described new graduates' perception of their first occupational therapy position. Seventy-four occupational therapists were surveyed 6 months after graduation, using a self-administered questionnaire. The study found that support and supervision from senior colleagues assisted the new therapists in making a successful transition from student to graduate. Interestingly, the respondents also "perceived lack of support/supervision as the major difficulty in this transition" (p. 356).

The phenomenon of transition from student to therapist was explored by Tryssenaar and Perkins (2001). Three occupational therapists and three physical therapists maintained reflective journals during their final fieldwork placement and their first year of practice. Four consecutive stages described the participants' experience in becoming a therapist: transition, euphoria and angst, reality of practice, and adaptation. Participants expected that clinical practice would be less stressful than university and were surprised by the pace and demands of work, and were fearful of experiencing burnout. They were challenged by the politics of the health care system and the organization, paperwork, and the hierarchy among team members. The findings revealed a need for mentors to assist novice professionals through the transition process and for educators to teach students how to find mentors. The

mentor's role would include assisting new therapists in building self-confidence, developing clinical reasoning skills, and integrating theory and practice (Tryssenaar & Perkins, 2001).

A need for senior occupational therapists or peers to provide support and supervision was clearly identified by new graduates in Parker's (1991) study. Fifty-one therapists who had been working for 6 months participated in the study. A questionnaire consisting of rating scales and open-ended questions was used to identify the aspects of their employment that created apprehension for new therapists and the aspects which impeded job satisfaction. The participants were also asked to describe the support and supervision they would have liked to receive when beginning their new job. A number of recommendations were proposed with the recurrent theme of providing support to assist new therapists entering the profession. One of the recommendations which involved a peer support group was implemented by an educational program in occupational therapy, The Robert Gordon Institute of Technology in the United Kingdom. Students in the final year of their university program meet with recent graduates to share "experiences, solutions to problems, positive and negative aspects of working and personal and professional difficulties" (p. 166).

Many of the studies in occupational therapy recommend mentoring as a means to support beginning practitioners, although there is no research on the role of mentoring in the socialization of occupational therapists or in the development of professional identity and knowledge. The challenge of bridging the academic and clinical setting has been identified, along with the need for therapists to "connect the gaps between what the theory explains and what the world presents" (Kielhofner, 1997, p. 310). However, the situatedness, contextuality, and cultural implications of how occupational therapists learn, has been largely

overlooked in the research.

As part of a course on qualitative research design, I conducted a pilot study with one occupational therapist in November 2000 to help inform the content of the interview questions for this research study. Four primary themes of experience in becoming an occupational therapist were identified: practical experience, expectations, transition, and professional identity. The participant's fieldwork experience in pediatrics influenced her decision to work as a school therapist. There was a sense of comfort in a job position in which she had prior clinical experience, easing the transition into the workplace. The value of clinical fieldwork in the development of knowledge and skills is supported by Atkinson & Steward (1997) and Parker (1991). However, although the fieldwork placements allowed the participant to assume responsibility for her own caseload, she was not prepared for the larger ramifications of her treatment decisions and the corresponding responsibility. At times she experienced conflict between her perception of her role as an occupational therapist and the reality of practice; she could not provide the care she thought was required. Issues concerning role clarity, value and recognition by other professionals were raised by the participant. Hummell & Koelmeyer (1999) found that a weak sense of identity as an occupational therapist and the lack of recognition of the role of occupational therapy by other professionals in the workplace, are key issues that make the transition from student to graduate a difficult process. The participant sought her own mentor in a senior staff therapist and used peer colleagues for support and supervision. The findings provided direction for this research study and confirmed that the experience of occupational therapists' first year of practice warranted further exploration.

Socialization and Learning in Context

Vygotsky's (1978) sociocultural theory of learning and development provides a useful framework for exploring the professional development and the socialization of occupational therapists. Vygotsky believed that learning occurred during situated activity and in authentic settings of practice. Knowledge therefore, is a "product of the activity, context, and culture in which it is developed and used" (Brown, Collins & Duguid, 1989, p. 32). Theories of learning associated with classroom activities are not appropriate to the workplace setting because of the situated context for learning (Brown et al.; Spouse, 1998). In the work environment knowledge is applied to situations that are different to what is taught in school (Steward, 1996).

Vygotskian theory states that learning, thinking and knowing are socially mediated and occur through collaboration with others. A person's knowledge and skills depend on the activity or social systems in which they participate and the support they receive from others in the community (Wells, 2000). Language plays a central role in making meaning and has been defined as "the process by which experience becomes knowledge" (Wells, 2000, p. 57). To understand how language and other semiotic systems are instrumental in learning, it is important to explain the developmental process in the relationship between thought and word. Vygotsky (1978) distinguished between the vocal and semantic aspects of speech to explain how words come to represent thoughts. As children grow older, they progress from using single words, to simple and then complex sentences to express their thoughts. Vygotsky distinguished between speech for oneself, inner speech, and speech for others, external speech. Inner speech involves the ability to "think words" rather than pronouncing

them; “thinking begins on an interpersonal level before it is internalized as intrapersonal knowledge” (Samaras & Gismondi, 1998, p. 717). This is evident when a student is learning the language of their profession and practising the appropriate use of words or phrases to understand their meaning (Spouse, 1998). External speech requires “learners to make explicit their understanding of practice” and is the dialogue or tool to understand the meaning of actions in the learners’ environment (Cope, Cuthbertson & Stoddart, 2000, p. 851). Understanding is constructed in the process of people working together to solve the problems that arise in the course of shared activity (Wells, 2000).

Conceptual knowledge is developed through language. Concepts are not abstract, self-contained entities but rather a set of tools that reflect the culture and the activities in which the concepts have been developed (Brown, Collins & Duguid, 1989). Concepts expand in practice, and with experience, change and evolve. In this process, “knowledge is created and re-created between people as they bring their personal experiences and information” to solve a problem (Brown, Collins & Duguid, 1989, p. 67). The meaning that individuals assign to a situation is socially constructed and is based on the previous experience and knowledge of the individual and the context of the event. In occupational therapy new practitioners are faced with emerging conceptual thinking as they enter the cultural professional world of practice. This demands clinical knowledge and an ability to consider the context and content of an event and act accordingly (Thornquist, 1994).

Another fundamental feature of Vygotsky’s (1978) theory is the relationship between individuals and their environment. Learning depends on the relationship “between personal stock of knowledge and the socio-cultural milieu within which the experience occurs”

emphasizing the importance of the environment in an individual's development (Jarvis, 1987, p. 171-172). A person acquires values, knowledge and skills through participation in the sociocultural practices of a community. Lave and Wenger (1991) describe learning as a process of legitimate peripheral participation, "by which newcomers become part of a community of practice" (p. 29). Knight (2002) argues that a community of practice is the most important site of learning, in which knowing is "created by doing, and distributed throughout the community" (p. 232). Learning occurs in the interactions between people; individuals are sponsored by an experienced practitioner and participate in the activities of the culture. Initially, modelling and guidance are provided to assist the newcomer in carrying out an activity. Scaffolding is a term used to describe this process of providing support for the initial performance of a task that later will be performed without assistance (Lave & Wenger). As the individual gains more control and self-confidence they progress to collaborative learning in which the social network helps the person develop the culture's "language and belief systems and promotes the process of enculturation" (Brown, Collins & Duguid, 1989, p. 39). One of the features of learning in a practice context is that experts are able to guide novices through the complexities of practice. Mentors can serve as mediators between the therapist's existing knowledge and the demands of the environment scaffolding their learning in unfamiliar tasks and situations (Spouse, 1998).

Mentoring conceptualized within a Vygotskian (1978) theory of learning emphasizes the participatory, active construction of knowledge between learners and their environment. Mentoring creates the zone of proximal development defined as "the distance between the actual developmental level as determined by independent problem solving and the level of

potential development as determined through problem solving under adult guidance or in collaboration with more capable peers” (Vygotsky, 1978, p. 86). Mentoring can be defined as an interactive, collaborative approach to learning among individuals with different capabilities and experiences in a community of practice. The specific values, knowledge, and skills of the community are mastered by participation in context-specific activities. These activities are potential opportunities for development and change, requiring participants to jointly construct understandings that enhance their past experiences (Wells, 2000). Within the Vygotskian framework, mentors learn along with their protégés. In this process, the role of language, tools and artifacts in mediating learning is essential. Mentoring from the perspective of the zone of proximal development requires a “learning culture rather than a hierarchical or paternalistic culture” found in traditional definitions of mentoring (Woodd, 1997, p. 336).

The profession of occupational therapy can be viewed as a culture with its own knowledge, behaviours, beliefs and language. From this perspective, learning is viewed as a process of enculturation where students develop the specific tools of the discipline and adopt the culture of the profession by participating in the work context. Vygotsky’s theory of learning is appropriate to the study of how occupational therapists acquire the knowledge, culture and practices of the work setting, and the meaning of transition from academia into practice.

Chapter 3: Method

The purpose of this qualitative study was to understand the experience of professional transition in occupational therapy with a focus on how beginning occupational therapists learn about doing practice. This study sought to answer the following questions:

- 1) What is the experience of transition from student to practicing occupational therapist?
- 2) What are the challenges faced by occupational therapists in their entry to practice?
- 3) How do occupational therapists learn in a practice context?
- 4) What is the role of mentoring in supporting new therapists' learning?

Occupational therapists are a cultural and social group with a common professional language, knowledge and belief system, and tools of practice. This qualitative study used a phenomenological approach to understand the voices of occupational therapists in the context of transition from student to new practitioner. The meaning of this transition to the participants' and their experience of doing occupational therapy at the beginning of their career, were studied. Phenomenology attempts to understand the meaning of an aspect of human experience, in this study, the phenomenon of transition within the larger "context of the whole of human experience" (van Manen, 1990, p. 62). Phenomenology considers that the individual's experience may also be shared by others; descriptions of lived experience seek to establish a universal meaning (Creswell, 1998; Tryssenaar, 1999). Individuals who recently entered the profession of occupational therapy provided a comprehensive description of their everyday experiences and how they learn in a practice context through semi-structured interviews and journal entries.

The following assumptions shaped the research question: a) the transition from student to professional is a demanding and difficult process, b) early work experiences are critical to the development of a professional identity and are influential in decisions related to job or career changes, c) mentoring is helpful in consolidating a professional identity in the first year of practice and d) mentoring can promote the professional development of occupational therapists beyond the first year of practice.

Participants

A random selection of six of the 28 occupational therapists who graduated in June 2001 from the University of Ottawa, received an invitation through email to participate in this study. The selection process was repeated until six affirmative responses were obtained. Eighteen invitations were sent to receive six affirmative responses. I chose this program because it was through my involvement in teaching at the University of Ottawa that my interest in the transition from student to occupational therapist developed. Of the twelve universities in Canada that offer occupational therapy education, the University of Ottawa is the only remaining four year program in occupational therapy. The other programs offer a three year program following one year of general studies, or a Masters degree in occupational therapy or rehabilitation science. The University of Ottawa program consists of general study courses, discipline courses, and a minimum of 1000 hours of clinical training obtained through fieldwork experience. The program subscribes to the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists, 1997), a model of client-centred practice used in occupational therapy in Canada which is part of the

professional culture of occupational therapy. This model illustrates the dynamic relationship between the person, the environment and occupation, and is reinforced throughout the educational preparation of therapists. Client-centred concepts which recognize client autonomy, client choice in treatment, the benefits of collaboration between client and therapist and the importance of the environment in the occupational therapy process, are at the core of the curriculum. The University of Ottawa program also promotes a multi-disciplinary approach to learning; occupational therapy students take courses with students from nursing, psychology, human kinetics and physiotherapy. A broad perspective of health is emphasized; students develop abilities in assessment, treatment, prevention, administration and research.

The six participants in this research study were female, bilingual in English and French, and between the ages of 22 and 28 years of age. The area of practice (mental health, physical medicine), client population (pediatric, adult, geriatrics) and the practice setting varied among the participants. Three worked in hospitals in urban areas and one in a hospital in an isolated northern community. One occupational therapist worked for a private clinic, and one worked for both an agency that provided home care and for a private rehabilitation company that provided school-based care. The therapist that worked full-time at a psychiatric hospital also worked occasional hours in the evenings at a general hospital. Table 1 provides details about the characteristics of the participants and their work settings. All of the occupational therapists in this study engaged in full time employment. Three of the six participants were sole charge or independent practitioners who did not have access to other occupational therapists in their work setting. This was the case for the two therapists that

Table 1: Research Participants

Participant	Practice Setting	Caseload	Position	Support Available
Nancy	Acute hospital setting (500 beds)	Adult trauma unit	Staff therapist	Occupational therapists, occupational therapy assistants, physiotherapists, physicians, nurses, social workers
Marie	Private rehabilitation clinic	Adults with motor vehicle or work-related injuries	Sole charge therapist	Physiotherapists, and physiotherapy assistants
Jane	Small general hospital setting (76 beds), 8 bed rehabilitation unit	Adults with various medical diagnoses (orthopedic and neurological conditions)	Sole charge therapist	Occupational therapy assistant, physiotherapists, physicians, nurses, social workers
Carole	1) Private rehabilitation company 2) Home care program	1) Children with developmental disabilities (school system) 2) Adults, children with physical disabilities	Independent practitioner	-Teachers, teaching assistants -Case manager
Amy	Acute care hospital	Adults with various medical diagnoses (orthopedic, cardiac, respiratory and neurological conditions)	Staff therapist	Occupational therapists, occupational therapy assistant, physiotherapists, physicians, nurses, social workers
Estelle	1) Large psychiatric hospital 2) General hospital	1) Adults with depression, dementia 2) Adults post-surgery	Staff therapist	Occupational therapists, recreation therapist, psychologists, social workers, psychiatrists, nurses

worked for private companies, and the therapist that worked in the northern community hospital.

Design

This research study obtained participants' perceptions of transition and the learning process in a practice context, through interviews and journals. The data collection period followed the therapists for a 5 month period, beginning in their third to fifth month of practice, and ending in their eighth to tenth month of practice (see Table 2). Data consisted of two semi-structured interviews and a series of journal entries. An initial interview was conducted early in their practice, with each of the six participants for approximately one hour. Each participant maintained a journal for one month following the initial interview. A second interview, approximately one hour in duration, was held with the participants at the end of the study.

Table 2

Data Collection Phases

Participant	Months of Practice		
	Initial Interview	Journal	Second Interview
Jane	3 rd month	4 th month	8 th month
Estelle	4 th month	5 th month	9 th month
Marie	4 th month	5 th month	8 th month
Amy	5 th month	6 th month	10 th month
Nancy	4 th month	5 th month	9 th month
Carole	5 th month	6 th month	10 th month

The timing of the interviews was selected so that the initial interview followed a “settling in” period identified in the literature as the “3-month stress peak” (Maben & Macleod Clark, 1998, p. 147). The second interview was conducted approximately 5 months later to allow a sufficient length of time to capture differences in the participants’ transition experiences. Four of the interviews were held face-to-face and two of the interviews were conducted by telephone due to the distance in location between the researcher and the participant. The initial semi-structured interview consisted primarily of open-ended questions to explore the participants’ perceptions of transition from student to practitioner (see Appendix B). Specifically, the interest was in their learning needs, the discrepancies between theory and practice, the development of knowledge and skills, and the role of collaborative interactions in supporting their learning. The interview questions evolved from multiple sources. They were developed out of the work of previous researchers (Parker, 1991; Rugg, 1996; Tryssenaar, 1999), and were further refined by the results of a pilot study conducted by this researcher in 2000, with one occupational therapist in her third month of practice. Finally, professional feedback was obtained from three occupational therapy professors at the University of Ottawa who reviewed the interview questions. Revisions were made to the initial questions based on their feedback.

The questions for the second interview were developed from the content of the transcripts from the initial interview and the journal entries (see Appendix C). Participants were asked about the challenges and rewards experienced at work, change in knowledge and skills, and memorable learning experiences that they had identified in the journal and the initial interview. They were also asked about their recommendations to ease the transition

process for new practitioners.

Journal keeping was an important data source as it provided a personal view of the meaning of the participants' experience of transition. The journals allowed the participants to note the day-to-day experience of practice including the highs and lows, their response to, and feelings about, practice. It was felt that journals would allow the researcher to gain an understanding of the lived experience of becoming an occupational therapist, through the participants' writing. The journals were a tool for "examining practical knowledge" and was relevant to this study because it provided therapists with an opportunity to reflect on various occurrences related to their practice (Black & Halliwell, 2000, p. 105). The journals also provided a written record to help participants identify their progress in learning (Tompson & Ryan, 1996). The journals were maintained for one month and participants were asked to write in the journal on a daily basis. The amount that they recorded was an individual decision. Participants were asked to write about their everyday work experiences and the role of peers or colleagues in their learning.

Data Analysis

All interview sessions were tape recorded and transcribed. Immediately following the interview, notes were made on the impressions, ideas, and concepts expressed during the interview to try to capture the meaning of the participants' responses (Stake, 1995). The journal entries were also transcribed. The theme of the participants' experience was noted at the end of each entry. Data analysis involved searching and arranging the information gathered from listening to the tapes and reviewing the transcribed interviews and journal

entries, to try to establish an understanding of the participants' experience. Judgement and interpretation of the data was based on the researcher's professional experience as a practicing occupational therapist (Creswell, 1998).

Themes and sub-themes were identified from the literature that described transition, discrepancies between theory and practice, challenges, rewards, change in knowledge and skills, and support for learning; these themes and sub-themes were grouped into categories. Additional categories were developed from examination of the verbal interview data and journals. Significant statements of the participants' experiences were grouped into these categories and maintained in a data summary file for each participant. An initial twelve categories were created based on the summary files: transition, gap between theory and practice, workplace challenges, rewarding aspects of work, dissatisfying aspects of work, ways of learning, change in knowledge and skill, remaining challenges, professional identify, fieldwork experience, recommendations for beginning practitioners, and curriculum strengths. Each category was defined by key themes and sub-themes derived from interpretation and the research literature (Stake, 1995).

The occurrences of the themes and sub-themes were coded for each participant at the three phases of the data collection; initial interview, journal and second interview. A comparison among the participants was made to determine what changes in themes occurred over time and to identify patterns among the participants' experience within the larger context of transition. Areas in which themes were present across time and participants were examined. Themes and sub-themes were organized into six groupings based on common, significant, experiences of the participants in order to better capture the participants'

experience of transition from student to occupational therapist. The change in knowledge and skills grouping was further analyzed to identify common meanings of the participants' experiences. Participants' statements described learning how to work within an organization or system and the development of professional and technical skills. The occupational therapists identified discrepancies between their academic learning and the competencies required in the field that appeared to reflect occupational therapy knowledge and skills, and expectations of practice. As a result of this analysis, four grouping categories were finally produced; occupational therapy knowledge and skills, professional identity, expectations of practice, and learning in clinical practice. The themes and sub-themes were then summarized within these four grouping categories by an examination and interpretation of the transcripts and review of the literature. References to support the grouping categories and themes were identified with corresponding text. Themes that evolved from the participants' stories and were not found in the literature were noted and identified as emergent. Appendix A provides a summary of the research evidence on transition from student to occupational therapist with related themes, sub-themes and examples.

A summary of the initial interview and journal entries was reviewed with each participant in order to determine if it was an accurate reflection of their perspective. This is a form of verification to strengthen the trustworthiness of the study (Creswell, 1998). Triangulation of data sources (initial interview, journal and final interview), establishment of trust with the participants, and the professional knowledge of the researcher in the area of study contributed to the credibility of the data (Lincoln & Guba, 1985).

Chapter 4: Results and Initial Discussion

The results of this study will be presented and discussed within each of the four main grouping categories of the analysis: occupational therapy knowledge and skills, professional identity, expectations of practice, and learning in clinical practice (see Table 3). Each grouping category presentation will include quoted material from the participants in order to have access to their own voices as they expressed themselves.

Occupational therapy knowledge and skills

This category included the themes of the gap between theory and practice, clinical reasoning, and client-centred practice.

The gap between theory and practice. The bridging of theory and practice is complex and was challenging for the new practitioners. They felt adequately prepared in their theoretical knowledge and research skills, and reported finding information related to clinical conditions or treatment approaches from books and journals. The contextualization of this knowledge, however, was difficult. The meaning of the condition for the client required the participants to identify problems and generate solutions to them, with limited practical experience of tackling problems in the clinic or hospital setting:

I find that I have a theory. I understood -- okay, you know, whiplash, lumbar strain, tendonitis, everything. You know what that is and I know my goal is to go back to work. I knew where to find my information, everything. But when it actually gets to it, oh, what is this exercise going to do for tendonitis, I had no idea whatsoever.

(Marie, initial interview).

Table 3: Grouping Categories with Themes and Sub-themes

Grouping Category	Themes Identified from the Research	Emergent Themes	Sub-themes
Occupational therapy knowledge and skills	Gap between theory and practice		-incongruence between academic learning and competencies required in the field -practical knowledge and skills, treatment activities, specific procedures such as splinting and wheelchair prescription -gaining competence and confidence in occupational therapy skills
		Clinical reasoning	-dealing with messy or “indeterminate zones of practice” -what to do with the client to address clinical problems
		Implementing client-centred practice	-global aspects of the person -comfort level with clients -communication skills -observation skills
Professional Identity	Role definition		-role clarity -receipt of recognition and feedback by team members -client interaction and progress
	Fieldwork experience and professional socialization		-prepares student for practice -influences career choice -shelters from organizational issues, reality of practice

Grouping Category	Themes Identified from the Research	Emergent Themes	Sub-themes
Expectations of Practice	Challenges encountered in practice		-increased responsibility and accountability, decisions about client care -time management (juggling multiple demands, determining priorities) -caseload management
	Learning the system		-knowledge of policies and procedures -working with a team, staff conflict -financial restraints -limited resources -paperwork, learning the charting language
Learning in Clinical Practice	Mentoring		-learning from team members, physiotherapist -need for support of an occupational therapist
		Collaboration with clients	-building on experience -trial and error
	Professional development		-professional development opportunities (books, journals, in-services) lack practical component

The therapists identified the need to know how to relate knowledge gained from texts and lectures to the situation-at-hand. In practice, they needed to know “what to do” with a client including determining treatment priorities and therapeutic activities to address presenting problems:

I guess sometimes not knowing what to do with the patient. You know the diagnosis but you don’t always know where you’re going, what you should start off with, and sometimes I felt I was just going in circles, or what am I supposed to do next. (Amy, initial interview).

They also described not feeling prepared for complex areas of practice such as wheelchair prescription, splinting and hand therapy, cognitive remediation, and home safety equipment. These areas, although common to the scope of practice of occupational therapy, require specialized skills, tools and materials, and knowledge of procedures and problem-solving strategies. Opportunities to practice these skills commonly occur in fieldwork placements, rather than in the curriculum:

I know that with my brain injury patients I have to do sensory stimulation. That was it and they never give you examples and I find that that’s hard. You know what you have to do but you don’t have enough experience to know how to get to it. (Jane, initial interview).

I went to a school for kids with special needs. I saw a few students and couldn't figure out what to do with them. They have high needs, but they are being met at school and I don't know what to add. I wish I could help, but I think they (the teachers) could teach me a thing or two about interventions. I know this knowledge will come with experience, but what do you do before then? (Carole, journal).

These examples also illustrate the participants' expectation that their knowledge and skills would develop through participation in the day-to-day activities of practicing occupational therapy. This expectation was realized; over the duration of the study the occupational therapists experienced a change in their evaluation and treatment skills that varied with their practice setting and client population. Through interactions with colleagues and clients, they developed specific therapeutic procedures such as wheelchair seating and muscle strengthening techniques, and more general abilities such as learning how to "let people do as much as they can" for themselves in therapy:

Things are going well with my in-pt. I'm for sure gaining confidence. I'm feeling more confident & comfortable c my transfers. I think I just needed to do a few to feel comfortable-I guess it's like everything else. (Jane, journal).

With the MS [multiple sclerosis] patients. . . I was sort of zigzagging and I didn't know what to do, and I wasn't structured, I found, in my interventions and now it's organized and I sort of know more now what to do and where to go with those patients. (Amy, second interview).

They began to feel competent in their clinical role, by the second interview. With experience they gained skills in clinical treatment and expressed an increased confidence in their abilities:

Like I was looking back on when I was a student and I'd do my assessment and it would always take me forever to try and figure out what to do for the treatment. And now I can... you know, I go in to the patient and I do the evaluation and then after I know exactly where I'm going and what I'm doing. And I think that I've noticed that lately, that I'm getting better at that. You know, really focussing on what the issues are and what are the problems, and going from there for the treatment plan. So I think I've come a long way in that aspect of things. (Jane, second interview).

Participants also identified improved communication and observation skills, and more comfort in their interactions with clients over time. One participant discussed how she learned to develop a rapport with people and an ability to "ask the right questions" during her assessments. This may reflect an understanding of how a clinical condition is presented in a practice context and the meaning of this problem for a client's function.

Therapists also talked about significant learning experiences since beginning their career in occupational therapy and this included the need to project confidence even when they did not feel confident, trial and error as a way of learning, and knowing when to consult others for advice or assistance:

I've had one case where at night I went home and I didn't sleep all night because I was so worried and I felt bad about something. So I guess my biggest learning tool is. . . when you do an intervention and it doesn't feel right or something that, you know, get the opinion of somebody else. Like, it's good to be independent, but you know [when to ask for help]. (Nancy, second interview).

I believe that I found the secret: Even if you feel incompetent, pretend you don't. Think positive and have confidence in what you do. I tried this today-and I felt a lot better. I really need to keep a positive look on things, and not focus on so much the negative. (Jane, journal).

Four of the participants discussed the challenges of working with clients that were non-compliant in therapy or who were aggressive because of cognitive impairments. Initially they attributed this behaviour to their own lack of experience:

It's like failing when I can't get the pt to participate in the activity, especially when the doctor, social worker, are waiting for the assessment. (Amy, journal).

With experience, they learned ways to deal with difficult clients which included accepting that this was part of practice, negotiating with or distancing themselves from clients, or requesting a change in caseload. The transition from student to occupational therapist reflected an acknowledgement that there were limitations in what they could accomplish in their work.

Clinical reasoning. The thought processes in which occupational therapists use theory to understand and act on a problem in practice is defined as clinical reasoning (Neistadt, 1996). The theme of clinical reasoning evolved from the occupational therapists' stories about grappling with the grey or indeterminate areas of practice. Clinical reasoning was challenging for these participants as they tried to apply the principles learned in school to a different context which was complex, unpredictable, and characterized by considerable uncertainty. Clinical reasoning requires the ability to contextualize knowledge, understand the situation and act accordingly (Thornquist, 1994). They were required to use their theoretical knowledge to understand and act on problems encountered in practice and make decisions regarding therapy. The support of experienced practitioners assisted the new practitioners in developing clinical reasoning skills:

I took a lot of time to work with my stroke pt. I do like to take the time. I find I can try different techniques, see what works and what doesn't. It was a good learning experience. I followed some exercises that the physio gave me...she was also there to guide me which was nice. I find I learn the best when it's hands on. I also find that I learn a lot when me and the physio go & do a session together at the same time...I learned a lot, going through (an assessment) together. (Jane, journal).

Their progress in clinical reasoning was illustrated in comments about their ability to act on problems, set priorities for treatment and modify treatment from client cues:

A lot of the times I am faced with this situation and I've not necessarily learned this in school, but with the knowledge and the reasoning that you have, you can come to a conclusion as to, okay well I'll try this with the treatment. It's not something you learned, but just with I guess a little bit of experience and the knowledge and I always say, well it's common sense, but it is for me but not for other people. (Jane, second interview)

I am taking educational guesses, with more confidence in the outcome. Problem-solving is easier than it was at first. I find that I'm able to come up with quicker answers for clients, sometimes on the spot-even for more complicated issues. This makes me gain confidence in myself as an OT. Slowly but surely it's coming. (Carole, journal).

The occupational therapists identified that strategies need to be developed in the university curriculum to help students integrate theory and practice. They highlighted two final year courses in their education that incorporated case studies, small group learning and problem-solving. The teaching model adopted in these courses was experiential and based largely on problems encountered in professional practice. Students were encouraged to reflect on their own clinical experience and discuss client problems, occupational therapy intervention, and rationale. They reported that these courses provided them with an understanding of the clinical reasoning process and knowledge of concrete treatment modalities that they could use in practice. This teaching approach is consistent with

Vygotsky's concept of mediation in which the learner is placed in a "situational context in which problems need to be solved or experiences understood" (Goodman & Goodman, 1990, p. 236). The teacher acts as a mediator supporting the learner and their zone of proximal development, not controlling it. In addition, students also mediate their own learning through discussion, experimentation of ideas, and reflection. The participants recommended that more authentic learning situations linking classroom and clinical practice, should be implemented in the curriculum. This emphasis on learning through participation in real-world activities would provide students with opportunities to construct the knowledge, and adopt the language, of their profession and culture.

Implementing client-centred practice. Client-centredness is an approach to providing occupational therapy services in which the client is an active participant in treatment working in partnership with the therapist. The client's knowledge and experience are recognized and their goals are central to the treatment process. Enabling clients to solve problems in their daily occupations is the focus of the therapist-client relationship. Although there have been many developments in client-centred theory, the integration of client-centred concepts into practice remains difficult (Wilkins, Pollock, Rochon & Law, 2001).

Occupational therapists' perception of barriers to client-centred practice most commonly involve goal-setting; therapists and clients often have different goals (Sumsion & Smyth, 2000). In a medical model the therapist traditionally has the power because of authority and knowledge. This imbalance of power prevents a collaborative partnership as required by client-centred practice (Sumsion & Smyth, 2000).

The ability to be client-centered was a challenge for the new practitioners in this study and provided additional evidence of the gap between theory and practice. This theme evolved from the study and was not in the research literature that was reviewed. Participants talked about the difficulty of adopting a holistic approach to client care. They were challenged by system barriers such as high caseloads or team members that did not espouse a client-centred philosophy. Time constraints were a significant challenge to implementing client-centred practice, rendering it difficult to conduct thorough assessments. The new practitioners were unsure of the importance of different pieces of information obtained from the client and how this directed the goals of the intervention and the desired outcomes. The curriculum differs from what practitioners do; they do not “divide what they know into more or less basic components” (Becker as cited in Steward, 1996, p. 92). One of the participants felt that because she had learned sections of the assessment process in school, it was difficult to obtain a holistic view of the client in practice:

One thing that I found was lacking was when you come to the room [client’s room] the first time, initial interview, like what you have to go over and how you put every thing together. So we’ve done it all in little sections like when you look at mobility, when you look at ADLs, [activities of daily living] but I found it was hard to put everything together and when you go in, what do you look for right away? (Nancy, initial interview).

Rather than addressing the relationship between the person, the environment and occupation (which is the basis for the client-centred model of practice in Canada), participants often focussed on one aspect such as a person's physical function or bathroom safety. This seemed to be an unexpected occurrence in practice which was accompanied by an uneasiness about this compromised approach. They offered some reasons why they could not apply the client-centred model to their practice including lack of time due to long waiting lists and high caseloads; limited funding that allowed intervention in critical areas only such as equipment for mobility; and at a more profound level, a difference in philosophy of practice between the therapist and their work setting. The conflict between what they had learned in school and what was occurring in the real world was more evident in the private practice setting:

I just thought it would be more like -- like more the global aspects of everyone and I find it's very much we're concentrating on the physical right now and when we have time, we'll concentrate on more. . . . The spiritual is not being touched at all where I'm working. (Marie, initial interview).

And the thing that I find the hardest is at Ottawa U [University], we learned like client-centredness. I always talk of the people I see as clients. But over there, it's always patients. And it's such a stupid little thing, it's a word thing. But I find it makes a big difference in everybody's approach. . . . We're there to work on the physical, that's it, that's all. (Marie, initial interview).

Because of the waiting list and because of the crunch in time, you can't do everything that you learned you could do in occupational therapy. Because there [in school] you learned client centred, ask them what they like to do, what's important for them, significant activities, it's really nice and it's a great approach and it's wonderful if you could actually do it. (Carole, initial interview).

One of the challenges to implementing client-centred practice for two of the therapists that worked in a hospital setting was lack of support from nurses. This concerned nurses not following directions for occupational therapy treatment such as monitoring the length of time a client wore a splint or the providing the necessary degree of assistance for dressing a client. This situation was attributed to time constraints and a different philosophy of treatment:

I find nurses don't have the time to encourage indep. [independence] and will perform ADL [activities of daily living] tasks that pt's can do. That is why I am so important-to break things down for pt's and staff to ↑ [increase] functional indep. & safety. (Estelle, journal).

Participants expressed a positive experience when they were able to adopt a client-centred approach, because this was congruent with what they had been taught in school:

I worked with a pleasant Pt [patient] this morning, showed her how to get up from the bottom of the tub, this was hard for her so we opted to shower on a bathseat. This made her realize that she didn't have the strength presently to go in the bottom of the tub. I felt good, that I had given the Pt the opportunity to realize what her capabilities /limits were-I think it's part of my role as "facilitator", giving the choice to the client, helping in creating opportunity to try, learn on one's self. (Amy, journal).

Professional Identity

Professional identity is defined by new practitioners' participation in work activities and interaction with others in the practice setting (Lave & Wenger, 1991; Trysennaar & Perkins, 2001). The occupational therapists' professional identity included the themes of role definition and the experience of fieldwork in professional socialization.

Role definition. The occupational therapists in this study described beginning their professional practice with feelings of uncertainty and apprehension; they struggled with understanding the boundaries that defined their role in the practice context, which included learning about clinical skills and how to work with the team in their work setting. An orientation program within the workplace assisted in their transition from student to therapist, providing them with some knowledge about the policies and procedures of the organization and the role of the occupational therapist. Four of the six participants had an opportunity to meet with an experienced therapist and were eased into the job by starting with a low caseload, and taking time with the clients and to familiarize themselves with the

medical charts, equipment and resources. This orientation period was one to two weeks in duration. The other two therapists had a half day orientation which consisted primarily of review of facility procedures. They did not have time to acquaint themselves with the clients or the work setting and this appeared to hinder their transition. Participants that had chosen their area of practice based on previous fieldwork experience felt more comfortable with the client population and the work environment. They were less concerned about their competence than the therapists who were in private practice. Fieldwork assisted them in gaining knowledge about occupational therapy intervention and what it meant to work as a therapist.

For the two participants in private practice, the initial few months of practice were characterized by feeling overwhelmed, frustrated and anxious. One of these therapists described the transition from student to new practitioner as one of “culture shock.”

You know, the first few months was discouraging, like I thought about quitting almost every day. Which is funny because I know, okay, the first year is the highest drop out rate, I have to pass one year. The only thing that’s keeping me going is like some of the contact with the clients. . . . But just the all around pressure and everything else, it makes you want to quit. And the only thing that keeps you going is knowing that it has to get better, and it does get better. And everybody else says that, so okay. And this is normal for somebody starting out. But if it wasn’t for that, if I didn’t know it was normal or I didn’t know it was going to get better, I would quit. Because there is no way that I would do this for, I don’t know how many years. (Carole, initial interview).

In the initial interviews, these two participants had considered quitting their jobs because of stress and dissatisfaction with the work situation. They decided at that time to remain in their job to honour the commitment they had made to their employer. For one of the therapists, the goals of the organization and the values of the other health professionals were incongruent with her own values about occupational therapy and her role. In the following example, she did not agree with the physician's decision to discharge someone from treatment because the client was frustrated and aggressive. She felt that the client was co-operative and making gains in his treatment. Her opinion that the client should remain in therapy was ignored:

I don't think I want to work here anymore. I'm still very upset about yesterday and am having a hard time accepting it. It goes against what I learned as an OT and who I am as a person. I talked to a few friends about it and they feel the same. It's not worth getting so upset for a job and I seem to get upset a lot at this job. (Marie, journal).

The other therapist in private practice described feeling exhausted and distressed. She worked in isolation without support of any health professionals:

I feel like I'm turning around in circles, the more I try to do. there is to do. . . . I felt like this almost every day when I first started (the first two months). I would get so stressed-I thought my heart would explode from beating so fast. . . . It's amazing the effect this job has had in every part of my life: body, spirit and mind). I don't know there are more positive then negative effects. Last night I cried at the thought of another week at work. (Carole, journal).

By the second interview both of these therapists had elected to change jobs. They stated that their health and personal lives were being compromised by their work and they would not allow this to continue. At the end of the study, one of the therapists remained unemployed and was considering not returning to practice occupational therapy. The other therapist changed employers and client populations, working with children instead of working with adults. This was her original career goal; she had wanted to work in pediatrics because she had previous fieldwork experience in this area, but upon graduation was unable to find work in pediatrics.

The team's knowledge and perception of occupational therapy was important to the participants' professional identity. For the therapists that worked in hospital settings, the role of the occupational therapist was more clear because of established occupational therapy departments. For the therapists in private practice the role of occupational therapy was confused with other disciplines such as physiotherapy or teaching. An effort was made by one of the therapists to change a negative impression of occupational therapy in the work setting. She described that other professionals talked about occupational therapy as "playing cards with the clients." This perception was replaced with an understanding of her role in helping clients return to work. Physicians were less aware of the functions and roles of occupational therapists despite her efforts to meet with the physicians and explain her position.

In all cases, the participants' perception of their role as an occupational therapist was influenced by colleagues. They described feeling like an occupational therapist when approached by another health professional for their opinion. There was a sense of

satisfaction when they were able to provide a response to their colleagues in which they felt confident. They felt respected as an occupational therapist when the health care team valued their input or followed through with their recommendations, particularly those that involved critical decisions such as a client's readiness for discharge from hospital. When they viewed the team as supporting them, this interaction facilitated their development of self-confidence. In some of the examples cited by the participants, the occupational therapist had a valued role in determining the safety of the client's home environment, prescribing needed equipment, and arranging community support such as home care services. Engaging in team decision-making contributed to the participant's identity as an occupational therapist as well as to their self-esteem:

One of the doctors approached me today to discuss what assessments we use in O.T. . . . The doctor wanted to know about my profession & valued my opinion. That's a first for me! I got a call from someone in management today. They wanted to use my stats as an example to show another depart. I took that as a compliment. So as you can see-today was a pretty good day. (for my self-esteem anyways). (Jane, journal).

Just when people come up and ask me questions, so the team will come up and say what do you think about this? Do you think she's ready, it's like "Wow they're asking my opinion", so that for me is the biggest part, people asking me for advice. . . . That was the first part of you know making me feel like an OT. (Nancy, initial interview).

One of the participants talked about the need to earn the team's respect:

I find also that the team kind of built up. They didn't know me at the beginning so obviously they always questioned what I was doing, and now they know how I work and they know what I stand for. So I find that it's not as hard anymore because if I give a recommendation, most of the time they won't question it and they'll know my rationale behind it. So I find it's easier in both those ways. (Nancy, second interview).

Three of the participants stated that it was a challenge for them to communicate at team meetings with the physician. They were sensitive to being a new therapist and felt insecure in their role, particularly if they did not agree with a physician's perspective:

I was in a case conference for a pt. c TBI. [patient with traumatic brain injury]. The doctor said it was ok for the pt. to have a lot of visitors and there should not be a limit. I feel that this pt. is getting overstimulated and level of stim. ## [sic] of visitors should be limited-I did not speak up & express my pt. [sic] of view. I don't want to go against the doctor's word; not when I feel like this-not confident. (But I know I should speak up). (Jane, journal).

Therapists felt particularly threatened when they were unable to respond to a question about a client from another health professional or from a member of the client's family:

I had a discussion with a physiotherapist today about a Pt and she was asking what I was planning to do for Tx [treatment] I was put on the spot, I had done the initial interview and hadn't thought at all about this-I'm not yet very comfortable with ALS [amyotrophic lateral sclerosis] pts and was planning on looking in my notes to think what to do-This was a moment I felt I was missing the knowledge and experience...I didn't want to look stupid. (Amy, journal).

A critical component of the transitional experience for all of these therapists was the satisfaction they received from client interaction. This sub-theme evolved from the participants' stories about the rewards of helping clients and observing their progress, and was present for all of the participants at each phase of the data collection. Situations such as a client remembering the therapist's name, or visiting them after discharge from hospital, were memorable for the participants. They were passionate in talking about their clients and reinforced for them the reason why they became an occupational therapist. The ability to make a difference to someone was highly valued:

It's nice to know that you've done something and the time an [sic] the effort was worth it. Because it did help, it did improve the patient. I know you can't always get the results that you want, but it's a good feeling and that they're happy and you say, okay, well I am doing something right. I am doing okay. (Amy, second interview).

I love working on the trauma unit because I love seeing people you know that come in with multiple injuries and then they go home. That! I love seeing that! (Nancy, initial interview).

Fieldwork experience. The role of clinical fieldwork training in facilitating the transition from student to therapist was a theme in the therapists' experience. Whereas job location and monetary factors influenced the job choice for two of the participants, previous fieldwork experience was the factor in deciding to enter an area of practice for four of the participants. They perceived themselves to be capable of undertaking the position based on skills that they had acquired with a client population experienced in their fieldwork. Their knowledge of the specific work environment and available support also influenced their decision as highlighted by the following comments:

For me it was a criteria when I was looking for work that to make sure that I'd be working with other occupational therapists, that I wouldn't be left right away on my own. (Amy, initial interview).

Well, my last few placements were in pediatrics, and I really enjoyed them. I had a lot of fun. And it was, well I had the most experience basically, where I knew the most, and I felt more comfortable starting there. (Carole, initial interview).

In fieldwork, students develop the skills of their profession in an authentic context, guided by an expert who teaches them the complexities of practice (Lave & Wenger, 1991). This can be described as apprenticeship in which the student learns how to do occupational therapy. Learning is a process that takes place through participation in the community of occupational therapy. For the study participants, fieldwork provided them with an opportunity to gain clinical skills, develop confidence, and acquire experience in using the tools of practice such as assessments and charting. It helped them learn how to interact with teams and how to communicate with clients. However, in fieldwork their participation in client care and their responsibility for clients were limited; the supervising therapist assumed the ultimate responsibility for the client's therapy. In beginning practice, the participants acknowledged the depth of their new responsibilities for client care; they missed the support and feedback that a clinical supervisor provided during fieldwork. In addition, there was an awareness that fieldwork placements sheltered them from the organizational responsibilities of practice such as paperwork, issues of health care funding and conflict among employees:

You had a little more time to write your notes, to think things through. Now the client's there, there's a medical book there you have to write right away, and...

Everything has to be done faster. (Amy, initial interview).

It's still it's still not the same as being a therapist yourself in the way that just doing a transition between theory and practical, that's the biggest change. . . . like all the administrative stuff behind it that you have to deal with, and being polite and being in difficult situations and how to get information from different people, and how to. . . just like conflict management and situational management I should say. (Carole, initial interview).

The type of fieldwork placement appeared to be an important factor in fostering growth and developing competence. Participants felt that a broad base of experience working with different client populations and in different practice settings was necessary for developing their knowledge and skills, as well as determining their practice preferences. They found that during their academic education, their learning opportunities were restricted by limited availability and location of fieldwork sites. They described an imbalance in fieldwork with a heavy concentration of certain populations, such as geriatrics, and little or no exposure to others, such as mental health. They were, therefore, unable to see the diverse areas of occupational therapy practice. Placements that were less than two weeks in duration only allowed for an orientation to the work setting and observation of the work process. One participant stated "You don't see much in eight days." They recommended that longer placements would allow students to interact with a client from the initial evaluation stage to discharge and obtain a complete picture of the occupational therapy process.

Expectations of Practice

Expectations of practice emerged as a category of transitional experience and was described by the challenges encountered in practice, and learning about the responsibilities of their role and the system in which they worked. There was a conflict between the therapists' perception of their role on the one hand, and the reality of practice on the other, similar to the findings discussed. In their accounts of their day-to-day work experiences they revealed that they were not prepared for the larger ramifications of treatment decisions and the corresponding responsibility. This was often discussed in relation to a client's capacity such as readiness for discharge from hospital or safety in the home:

You sort of take your own decisions now. It's more... I think it's the responsibility issue that's a little scary. (Amy, initial interview).

I have a hard time saying, you know, no, you can't go home. I really have a hard time with that. . . . Because I don't -- I don't think it should just be my decision that somebody can't go home. I think it's, you know, it depends on the family, if they want them to stay where they are, do they want to give them the support? (Estelle, initial interview).

You do have to be responsible for your choices. If somebody says, I want to get into the bottom of the bathtub, and you're not really sure if it's safe or not, you have to decide. . . . You realize there's nobody else there like your supervisor. You have nobody to ask. Like in this situation, is it okay? Because you have to make a decision on the spot and you're responsible for it. (Carole, initial interview).

Learning is a process of taking part in, and being a part of, a greater whole (Sfard, 1998). In this view, their participation in the practice context required learning about organizational issues such as supervising support workers, requesting hospital supplies and coping with staff shortages due to budget cuts.

I learned today that c budget cuts, my assistant no longer has a job. . . This is very frustrating. I am having a hard time understanding why her position is getting cut. . . I will find it hard not having the support from my assist-It's just a shame! And a big shock! I'm a little innocent; I didn't think these cuts would ever affect our hospital. (Jane, journal).

The system also required the participants to juggle multiple client demands and determine priorities not only with individual clients but also among clients; activities of practice in which they did not feel prepared. In their course work, assignments were structured and focussed on individual case studies. The emphasis was on assessment and treatment techniques and did not incorporate the organizational aspects of practice, including managing caseloads, allocating resources, and doing paperwork. There was a

feeling of being overwhelmed with their schedules with insufficient time to accomplish all work-related responsibilities. The participants struggled with the time they needed for learning and expressed concern about the amount of overtime required in the first months of practice to prepare and plan for treatment. They felt that they should be able to keep up with their more experienced peers in their skills and the number of clients they could manage. Four of the participants talked about difficulties determining a realistic caseload. They assumed responsibility for increasing number of clients despite feeling overwhelmed:

I didn't know how many people you're supposed to see a day. So I just kept taking them on, taking them on. (Marie, initial interview).

I need a lesson on time management and prioritising-Today I was like a tornado spinning [sic] out of control-that's how I felt. I tryed [sic] sitting at one point in the day to organise but I couldn't sit still to think and even felt panicked [sic] at one point-like I won't make every thing on time this week. . . . They definitely don't teach you this at school and even doing it on paper doesn't prepare you for how you feel when it happens. I'm wondering if I miss managed my time, gotta be more time efficient...my supervisor said to not worry-this sometimes happens everything has to be done at once. (Amy, journal).

With experience, they developed strategies to deliver care more efficiently such as preparing treatment materials in advance and developing assessment forms specific to their population and setting. They discussed the need for treatment protocols which would help them determine priorities and types of intervention. In this example, a therapist described how she devised a list of treatment activities for clients with brain injury to help her focus treatment:

It's not anything taken from a book or anything, just with my... I think it's reasoning and judgement, I came up with a list of activities and I also got the speech language pathologist to look it over. So we developed a program together. And so she has a lot of experience under her, and so I brought my ideas and then she brought hers and... you know, modified some and gave me some suggestions. (Jane, initial interview).

Comments such as setting priorities, “trying to do everything with one person rather than seeing a number of people and doing less” indicated that with experience participants learned how to organize their time and manage their caseload. The participants in hospital settings appeared to gain some sense of control over their work responsibilities and learned strategies to deal with the policies and procedures of their organization. The therapists in private practice however, found themselves in work situations in which they had little control and that were not amenable to change.

Charting or maintaining client records and statistics were difficult areas of practice noted by the participants. Charting is used in health care to record the actions of the professional and the client. The written report is a legal document necessitating correct and accurate wording. New practitioners recognized the importance of report writing, citing how they would write the notes in a rough format before transferring them to the medical record. However, report writing was difficult and time consuming and as one participant admitted, was placed after client treatment and other clinical responsibilities in terms of priorities. Paperwork was perceived as stressful because higher caseloads necessitated more paperwork:

I figure I got to find ways to cut down on the darn paper work that I don't really have to do-to cut down on the lengths of my notes, one OT said to me if its too long they don't read it-gotta learn to synthesis-I'm really trying especially that the part I dislike about the job is the paper stuff and the infamous stats! (Amy, journal).

The new practitioners learned the tools of charting and the medical language through interaction with team members, reading client files, and writing assessment reports and progress notes on the medical record. It was noted that they used medical terminology and the language of occupational therapy in their journals, evidenced by acronyms, abbreviations and signs and symbols to denote symptoms, diagnoses and treatment.

The therapists in private practice experienced more conflict with team members, than those in hospital settings, perhaps because they worked more in isolation with fewer opportunities for collaboration with others. Lack of communication presented unique challenges as evidenced by the following comment:

Today paperwork/procedures frustrate me! I went to see a client today only to find out she died over the weekend. I told the case manager, she knew already-the paperwork was being passed on to me. Because of rules and procedures I wasted more time today. I could have seen someone else that was waiting too long to see an OT. (Carole, journal).

Good team work was viewed as a positive factor in the structure of the workplace, conversely team conflict was viewed as a challenge.

Learning in Clinical Practice

Mentoring: Learning from colleagues and peers. For all of the participants learning occurred through trial and error, and through interactions with team members who modelled aspects of practice for the new practitioners, coached them by providing feedback on their performance, or scaffolded them in completing tasks that they were unable to do independently (Vygotsky, 1978). The following description of how learning took place illustrates the Vygotskian perspective of learning:

Yes and the physio even at the beginning, she would say "Well, you know, I'm seeing this person, it's for this, and you know, you should really get involved with them and see, you know, how they are managing with their ADL." So she, initially, gave me a lot of, well you know, try this position and try that and see what you find. She was great. Like she gave me a lot of support on the unit and . . . when I had questions, she was able to answer them, we were able to work things out, troubleshooting. (Estelle, initial interview).

Mentoring occurred through informal interaction with colleagues in the everyday activities of the workplace. Interaction with more experienced co-workers including physiotherapists, nurses, physicians, and social workers, was critical to learning technical skills and “acquire the rules and culture of the community” in which the participants practiced (Schlager, Poirier & Means, 1996, p. 244). The less knowledgeable occupational therapist sought out a more knowledgeable person for learning skills such as splinting and for learning theory such as medications used in dementia treatment. They were comfortable in asking questions related to procedures such as completing medical forms and arranging community resources for clients. They sought assistance in learning about charting, managing caseloads and setting priorities:

Today was very stressful. I was very busy & for some reason I had a hard time prioritizing my clients. I accomplished a lot but the day still felt unproductive. I sat down with one of my colleagues to discuss priorities. Who become a priority? (Nancy, journal).

I can easily say that much of my learning and ideas comes from the team-nurses, doctor and physios. Discussing cases with them-especially the nurses who work closely with the pt's I'm able to get a lot of information. Nurses are able to answer specific questions and allow me to assess pt's as needed. (Estelle, journal).

Support for learning extended beyond the health care team to include professionals in the community such as teachers and equipment vendors. The occupational therapists most

frequently learned in collaboration with physiotherapists performing client evaluations together, practicing clinical skills such as transfers, and problem-solving client situations. The physiotherapist often identified a role for the occupational therapist on the health care team and eased the way for their involvement:

But it's gotten to the point where the physiotherapist and I kind of see patients together all the time. Because we, we work really closely together and we help each other out, so I think the physiotherapist on on that floor anyhow is, is my best team, team member I work with. Just for learning-wise and she's knowledgeable. (Nancy, initial interview).

Peer mentoring was a source of support for some of the participants who shared their challenges and successes with fellow classmates. They called friends to ask questions, advice, and share their experiences of practice. For the therapists who worked in private practice, the lack of support in their work setting was highlighted in their conversations with peers:

After work in the evening two of my friends called me at 9:30 p.m. and 10 p.m. They asked me what I was doing. I said 'working.' They seemed so surprised! I have told them that I work in the evening and weekends, didn't they believe me? They have a rough time adjusting to a career as an OT, but they don't seem to work as much. At least they have someone around helping them out, maybe that's why they don't work as long hours? (Carole, journal).

Interaction with peers in their work setting provided opportunities for participants to learn about the system and the role of occupational therapy with different clients:

I learnt from my peers about smaller things like if I have to put certain info on a form going to the CLSC [le centre local de services communautaires] How OT goes about a scooter prescription and trying to define my role at the MS clinic and hers at the CLSC, or even when to hand in the statistics-yuck! (Amy, journal).

Mentoring: Learning from occupational therapists. The participants preferred to learn from an experienced occupational therapist and recommended that beginning practitioners should ensure that this type of support is available in their first job:

Work in a big sector. Don't work in a place where.. Work where there's a big team of OT's. That's where you'll learn the most from. . . . Go where you can have some support because as long as you have... like a resource person you can go to, then you're fine because you have all the skills to do what you need, it's just sometimes you're not sure. With support you'll learn faster too, they can teach you tricks here and there. (Marie, second interview).

I think the most important thing is to go into a setting where you have that support. For me that was the biggest thing.(Nancy, second interview).

They felt that someone in the same profession could induct them into the culture of occupational therapy, “show them the ropes, ” and help them develop their competence.

Experienced therapists could share their knowledge and skills, identify helpful resources for practice, answer questions, and teach new practitioners the appropriate therapeutic procedures for different client populations. The availability and type of support were important considerations for these therapists. They wanted to have timely access to advice and be able to interact with experienced therapists in person. The participants felt they could learn from both peers and supervisors and did not distinguish these relationships in terms of support. Discussing problems in the work place context assisted them in understanding the clinical reasoning process and the connection between theory and action:

So even if you're somewhere and you haven't had any practical experience, they can show you the practical part and you have the theory part. So you're not alone.

(Marie, second interview).

The participants who worked in hospital settings had the support of one or more experienced occupational therapists for their learning, who was available in their work environment or through telephone contact. They talked about learning through participation in daily work activities, alongside a more experienced colleague who would model assessment and treatment activities and guide them as they learned different therapeutic procedures. In the following excerpt one of the participants described how an experienced therapist guided her through the aspects of splinting in which she needed help. Learning was structured by talking her through the process, an example of an experienced therapist scaffolding a new practitioner through their zone of proximal development (Lave & Wenger, 1991):

We're two OT's that are doing splints. And she has quite a few years of experience. And at first she was there when I was doing splints and she sort of leaned off eventually saying, okay you see the client and you assess. Before you go do the splint, come and see me just to make sure that you're making the right splint. And that's fine. And now I'm more or less at the point to where I'll do it on my own. And if I have questions I'll go see her. So that's kind of progressing really good. And which I appreciate. I like doing the splints too, so that motivates me too, because I'm doing what I like. (Amy, second interview).

Learning was situated in the context of a meaningful activity and adapted to the therapist's level of knowledge.

The ideal situation would be as if I would have a chance to try it and have another OT there. But sometimes it's not the situation. You have to go do it on your own with your client right away. . . But I learned reading is good, but I get the best learning experience from trying it and doing it. (Amy, second interview).

The two therapists in private practice liked the autonomy of their role but missed the support of an experienced occupational therapist. This was a significant challenge for them and a source of stress and frustration. They expressed the need for validation that they were on the right track and that they were making knowledgeable and competent practice decisions:

But I find that as a new grad, I feel like I'm missing a lot of support. . . Like I would have liked to have somebody with more experience, just kind of a mentor, just to comfort, not to comfort, but you know, when you try something new and you're not sure if it's a good or not? (Marie, initial interview).

To have somebody... even shadow somebody for a week or two, just to see what they do as their job. Even two days would be very useful. Maybe having somebody you can actually... you have meetings times like every couple of days or once a week you actually make a time to sit down and have an hour or two to ask your questions. (Carole, initial interview).

Only one of the participants used the term mentor to describe an experienced therapist that was assigned to her by her employer. Contact with the experienced therapist occurred only a few times by email and was discontinued because the participant found it was not helpful. She found it difficult to describe all the issues related to her practice question through email and described this form of learning as “one-way”; she was asking all the questions with no opportunity for collaboration.

Learning from clients. One of the emergent themes of this study was that the occupational therapists also emphasized the importance of learning in collaboration with their clients. This was one aspect of the client-centred model of practice that was implemented. The client identified their need or problem and possible solutions, and the client and therapist worked together in treatment. This often involved a process of trial and error to achieve the optimal treatment outcome. In the following journal excerpt, a therapist helped her client fulfill his personal goal of walking with a walker despite his terminal diagnosis. She described her belief in client-centred practice:

Overall if this day taught me something it is to listen to your pt.[patient]. And you can learn a lot from them. They are telling you their needs, their goals, their culture. And it's up to us therapist to utilize this info.[information] to maximize therapy and be client-centred. Bottom line is without my patients I would not be learning and would not be able to apply the concepts I have learned. -My patients are the greatest teachers of all-(Jane, journal).

Therapists discussed how an experience with one client would inform their interaction with the next client with a similar diagnosis. This enabled them to learn concepts that could be applied to new situations:

When you're starting out. You see a lot of new things and just working with them and learning... you know, will this work with them and this didn't work with them, and so next time when you have somebody with the same sort of situation, well you can remember that patient and say, okay well I tried this with them and this worked. (Jane, second interview).

Clients were able to often make the link between the practitioner's existing knowledge about the disability or illness, and the practical implications. The following example illustrates how an experience with a client scaffolded the therapist's learning. The client helped the therapist understand the implications of her disability:

I got to see a client with MS [Multiple Sclerosis] today, I felt confident, I was ok with telling the person I was new at the clinic. She was fine with that. I learned a bit from her and how MS can affect daily living. You do learn from clients, how an illness can affect you, how to deal with it. (Amy, journal).

Clients also taught therapists about the complexity of patient care and the practice context which influenced the therapist's activity. In the following excerpt, the occupational therapist had a plan of what she hoped to accomplish with a client, however quickly realized that this was not possible:

So, I guess it's continuous learning with them, knowing, you know, simple things like how their pain is... You know, you always take that for granted you're going to go in and you're gonna do this and this and this but you go in and they're so much in pain that you can't do anything with them. (Nancy, initial interview).

Professional Development. Some employers offered continuing education courses and in-services for the occupational therapists. The content of the courses varied and related to the therapists' area of practice. In-services appeared to be beneficial for some of the participants in acquiring knowledge about diseases and the role of other health professionals in treatment. They felt however, that courses and readings did not allow for the learning of specific treatment approaches that they desired.

Chapter 5: Concluding Discussion

Summary of Perspectives

The essence of the experience of transition for the participants in this study revealed that the support of colleagues and peers were critical to the occupational therapists' learning and eased their adjustment from student to occupational therapist. In their initial months of practice they struggled with their lack of practical experience, responsibilities of client-care, challenges to client-centred practice and competing work demands. They were not prepared for system issues such as financial restraints, limited equipment and personnel resources, and difficulties in communication among team members. There was a feeling of greater responsibility in practice, and this was described as an important difference between being a student and being an occupational therapist. Team members' knowledge and perception of occupational therapy was important to the participants' professional identity. For the participants that worked in hospital settings, the role of the occupational therapist was more recognized because of the established occupational therapy departments. For the participants in private practice the role of occupational therapy was often unknown and confused with physiotherapy or teaching.

All of the practitioners identified that they preferred to learn from an experienced occupational therapist. The availability of this support and previous fieldwork experience in a practice area, influenced the new practitioners' choice of their first job. For those who did not have supervision and support, greater feelings of frustration and insecurity were experienced. For all of the occupational therapists, their relationship with clients was particularly valuable to the participants' learning and professional identity. They talked about

how they worked collaboratively with their clients to identify needs or problems and determine treatment goals and possible solutions. The greatest rewards for these therapists were experienced in seeing progress and making a difference in their clients' lives.

In essence, mentoring was evident in collaborative approaches to learning among colleagues and clients who provided guidance, support and knowledge to the beginning practitioner. Formal, structured mentoring relationships or programs, with specific goals or practices did not exist, but mentoring occurred in informal interactions in the day-to-day activities of practice. Situations in which the new practitioner sought the assistance of a more knowledgeable colleague for help in overcoming a problem, occurred more often among those occupational therapists who worked in hospital settings, where this type of support was more available. The occupational therapists who worked in private practice were more isolated from colleagues and relied more on client interaction for learning about practice.

Although the participants' work environments varied in the type of client population, area of practice, and practice setting, common themes were expressed in the interviews and journals. The discussion of experiences of professional transition in occupational therapy will be presented in relation to the research questions;

- 1) What is the experience of transition from student to practicing occupational therapist?
- 2) What are the challenges faced by occupational therapists in their entry to practice?
- 3) How do occupational therapists learn in a practice context?
- 4) What is the role of mentoring in supporting new therapists' learning?

Experience of Transition and Practice Challenges

For the occupational therapists in this study, transition involved learning new skills, behaviours and attitudes of their chosen profession; and norms of their work setting. Similar to Tryssenaar's findings (1999), factors contributing to one's identity as an occupational therapist included confidence in their knowledge and skills, recognition from team members and clients, and the congruence between academic and clinical learning. All of the participants perceived a gap between the skills taught in university and those actually required for practice. This disjuncture was evident in the need to know how to "do" occupational therapy including understanding the meaning of assessment information and determining treatment activities. The new practitioners did not feel prepared for specific assessments such as wheelchair prescriptions, or treatments such as splinting. Several reasons have been proposed to account for this gap including lack of practical learning activities in the curriculum, difficulty in identifying core knowledge and competencies required in practice, and differences between the academic and practice context in which therapists are required to apply knowledge (Rolfe & Sanson-Fisher, 2002; Steward, 1996). The discrepancy perceived between academic education and practice has been noted previously in the literature (Atkinson & Steward, 1997; Greensmith & Blumfield, 1989; Parker, 1991; Tryssenaar, 1999; Tryssenaar & Perkins, 2001). Knowledge created in one setting does not easily transfer to another, because of the contextualization of knowing. The occupational therapists identified their communities of practice as important "sites of learning" (Knight, 2002, p. 232). This study supports the importance of linking theory with practice and the need to facilitate the student-to-therapist transition through curriculum and

workplace strategies.

Occupational therapists are concerned with occupation as an essential and organizing structure of life. Illness, disease and disability can interfere with a person's ability to perform the meaningful activities or occupations of daily life. The focus of occupational therapy is to promote occupational behaviour by teaching a client new skills, adapting the environment to facilitate performance, or modifying the occupation. Medicine concentrates on the similarities among clients' disease and symptoms, whereas occupational therapy focuses on what is unique to clients' experience of disease and the impact of the disease on their life (Kielhofner, 1997). Occupational therapists must therefore be able to identify strategies to address a client's complex problems, considering their individual needs, experiences and environment.

Every client is unique and the information about a client may be incomplete or imperfect leading to the "indeterminate situations" of practice described by Schon (1987). Tryssenaar and Perkins (2001) proposed that theory is "explicit and formalized, but clinical practice is always more complex and presents many more realities than can be captured by theory alone" (p. 25). The application of theory to practical problem-solving is complex and requires skills in clinical reasoning and professional judgement. Development of these capacities has been termed professional artistry and is defined by "an advanced level of clinical competence characterised by a unique, highly skilled approach to clinical practice, built up through extensive introspective and critical reflection upon, and review of, clinical practice" (Higgs & Titchen, 2001, p. 528). Proficiency in clinical reasoning requires years of practice experience and is reflective of the therapist's understanding of a client's problems

and flexibility to individualize therapy (Neistadt, 1996; Yarett Slater & Cohn, 1991). In the initial months of practice, the participants struggled with sorting out significant client data and determining treatment priorities. However with experience, their ability to recognize the subtleties of a clinical problem and consider the interdependence among the client, their environment and their daily activities, improved (Yarett Slater & Cohn, 1991). At the final interview, the participants acknowledged feelings of competence gained through the day-to-day experience of practice, and expressed confidence in their skills (Rolfe & Sanson-Fisher, 2002, Tryssenaar & Perkins, 2001). Evidence of competence was found in stories about their ability to prioritize client needs, perform assessments and treatments, and focus on the important aspects of a client's clinical problem. They gained confidence in communicating with clients, and in their role as an occupational therapist. From the initial months of practice, the participants reported feeling prepared for reading literature to answer a clinical problem or researching effective therapeutic interventions. They were satisfied with their ability to communicate with other health professionals, families and the public.

The occupational therapists' expectations of practice were somewhat different than the experience of practice, similar to previous research findings. The challenges that they did not anticipate were dealing with client and work-related responsibilities, charting, and hospital and community organizations' policies and procedures (Adamson, Hunt, Harris, & Hummel, 1998; Allen & Cruickshank, 1977; Rugg, 1996; Tryssenaar & Perkins, 2001). They were challenged by issues of time management and supervising support workers, areas that they may have been protected from as students (Atkinson & Steward, 1997). These findings suggest the need to include courses in the education of occupational therapists

about the organization and management of health care services including private practices, roles of various health care professionals, team communication, and administrative aspects of working in the healthcare field such as record-keeping and statistics. To facilitate the student-to-therapist transition, the curriculum must focus on real world practice. Teaching methods such as the use of case studies that involve decision-making and prioritizing among competing client and other work-related demands, may prepare students for the challenges of practice. Small group work and interdisciplinary collaboration may prepare students for working in teams with shared client goals and may provide opportunities for learning about the roles of other professionals in the health system.

The move to a Master's degree in occupational therapy as the minimum entry requirement to the profession in Canada in 2010 has significant implications for the education of occupational therapists. Beginning practitioners need to be prepared for autonomous practice, provide evidence-based service and "have the ability to market their services in an expanding and competitive global environment" (CAOT, 2002a, p. 115). The Canadian Association of Occupational Therapists (2001) states that "Master's graduates will be prepared to easily integrate into the existing workforce as well as work in emerging areas of practice" (p. 2). The transitional experiences of these graduates and how "easily" they integrate into the profession remains unknown. However, it is likely that supporting therapists in making a connection between the knowledge acquired in the academic setting and the knowledge required in the practice setting, will continue to be an important consideration in the education process. Furthermore, recognition that learning is embedded in the day-to-day activities of practice is critical to the socialization of occupational

therapists into the profession.

Socialization involves how therapists make meaning of their world and how they develop the competencies required for their roles. In Canada, occupational therapists are expected to pursue a client-centred model of practice based on the requisite competencies described in the document, the Profile of Occupational Therapy Practice in Canada (CAOT, 2002b). Although the participants in this study found client-centredness difficult to implement, they learned from their clients and worked collaboratively to find the means to achieve the client's goals, which are features of client-centredness (Law, Baptiste & Mills, 1995). In Tryssenaar and Perkins (2001) study, "the client-centred perspective seemed to develop as participants' confidence in their competence and abilities increased"(p. 25). In this study, however, this perspective was present from the initial months of practice and interaction with clients may have provided a buffer for the more negative or challenging aspects of the job. Therapists felt encouraged by a client's smallest gain in health or simple acknowledgement of the therapist's efforts. Participants were committed to the client-centred model but challenged by limited health care resources and differences in treatment philosophy among team members. Studies have discussed the organizational barriers that render it difficult for occupational therapists to practice in a client-centred manner (Wilkins, Pollock, Rochon, & Law, 2001). Limited funding in health and education and changes in the delivery of health services will likely present ongoing obstacles to the implementation of client-centred practice.

Learning in a Practice Context

In this study, the occupational therapists commented about a different learning process between the academic and practice settings, which was similar to the results of Thompson and Ryan's study (1996b). In the academic setting, learning was described as structured and linear, in practice it was unstructured and unpredictable. The ability to bridge theory and practice requires "negotiation between a form of knowledge that is general and a form of knowledge that is specific to a context" (Kielhofner, 1997, p. 309). The occupational therapists in this study, learned through social interaction and participation in their practice context. They learned how to use the tools of their culture and how to negotiate the organizational system which included various clinical assessment procedures, equipment, and documentation. They reflected on their progress in clinical reasoning; they drew on success experiences that worked with previous clients and applied these to new situations, scaffolding their own learning. The opportunity for dialogue with an experienced colleague helped the practitioners understand the rationale behind different assessments and treatments, and the choice of certain actions. In the hospital settings, an experienced practitioner provided guidance to bridge the boundaries between the participant's existing knowledge and their "knowledge-in-waiting" (Spouse, 1998, p. 264). The opportunity to "scaffold knowledge-in-waiting to knowledge-in-use" (Spouse, p. 264) depended upon the practice setting and the resources available to the occupational therapists. The private practice setting provided few opportunities for the beginning practitioners to work alongside experienced practitioners. In this setting clients, and professionals in the community such as teachers and equipment vendors provided some support for the therapists' learning. This

was limited in efficacy because the therapists often encountered problems beyond their level of development which required scaffolded or collaborative support.

Similar to the findings of Hummell and Koelmeyer (1999), transition from student to new graduate was eased by an orientation period which introduced the therapist to the organization, policies and procedures, personnel and the occupational therapy role. Transition was also eased by their relationship with colleagues who provide guidance and support concerning practice issues. The two therapists that worked in private practice expressed more difficulties in the first year of practice which was attributed to lack of support from other occupational therapists, and conflict in values held by the therapist and those of others in their work setting. Sarbari (1985) identified that new therapists must accept the goals of the organization as being valid and mutually compatible as part of their socialization process. These two therapists left their job after one year of practice to find a position that was consistent with their values and beliefs about how occupational therapy should be practised.

The participants in this study did not appear to have difficulty defining their role as other research has identified (Leonard & Corr, 1998; Rugg, 1996). Participants who worked in settings where there was support of other occupational therapists were more comfortable in knowing their role and explaining it to clients, families and colleagues. The sense of identity for the two therapists in private practice was more tenuous, determined by their work setting and colleagues, rather than their profession.

Fieldwork experience contributed to the socialization process of these occupational therapists. Fieldwork placed learning into a meaningful context allowing the therapists to learn the culture and practices of the workplace. It also influenced the choice of their first job position, a finding that is consistent with other studies (Atkinson & Steward, 1997; Crowe & Mackenzie, 2002). However these practitioners faced a new professional context with a different role; as a therapist instead of a student. The need for support in an unfamiliar context “compounded by the lack of practical competence which characterizes novices” presented challenges (Cope, Cuthbertson & Stoddart, 2000, p. 855). There were aspects of daily practice which were markedly different than fieldwork; therapists no longer had a fieldwork supervisor and the corresponding support or supervision, they received little or no feedback on client treatment, and they had more responsibility for client care. As well, they had to learn the norms and rituals for communicating at team meetings, charting, ordering equipment and maintaining statistics. This suggests that the fieldwork experience that is incorporated in the existing university curriculum is valuable in developing practical skills and a sense of professional identity and ability. However, more research is required to determine the most effective learning strategies in fieldwork for supporting the independence and competence of future practitioners. As well, how the type and duration of fieldwork placements influence therapists’ learning and socialization into the work role, requires further exploration.

The Role of Mentoring

Mentoring in this study was not the same as supervision; mentoring was defined as an interactive, collaborative approach to learning among individuals with different capabilities and experiences in a community of practice. Within the Vygotskian framework, the specific values, knowledge, and skills of the community were mastered by the practitioners' participation in context-specific activities. Mentors in this study were team members and clients who supported the new practitioners' learning and served as mediators between the therapist's existing knowledge and the demands of the practice setting. Mentoring was informal and unstructured, and occurred spontaneously in the work environment for four of the six participants. The two therapists in private practice experienced more difficulty in the transition from student to therapist perhaps limited by a context that was isolated, with few opportunities for support and interaction with experienced therapists.

The preferred method of learning for all of the participants was alongside an experienced occupational therapist. They acknowledged a need for a mentor to learn assessment and treatment skills: the practical aspects of occupational therapy practice. An opportunity to shadow or model an occupational therapist increased the participants' confidence and ability to assume more complex client responsibilities. This form of mentoring creates the zone of proximal development defined as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (Vygotsky, 1978, p. 86). Examples of the zone of

proximal development in practice were evident in participants' collaboration with an experienced therapist to learn how to make a splint, complete a complicated medical form or assist a client in moving from a bed to their wheelchair. In this study, learning was a process of enculturation where the therapists learned how to use the theory of their profession to act on the daily problems they encountered in practice. For example, a participant's knowledge of the biomechanics of seating was applied to practice through observing an experienced occupational therapist assess a client for a wheelchair, experimenting with the features of different wheelchairs, and trying the wheelchairs with a client to learn about its suitability for their function in daily activities. Similarly, an occupational therapist learned how to lead a therapy group in a mental health setting through participating in the group alongside an experienced co-leader, who counselled the therapist in group facilitation techniques.

All of the participants identified that they learned through participation in activity, trial and error, and interaction with colleagues and clients. Books, journals and in-services were not as helpful to their learning because they felt that these forms of professional development did not address their need for practical information. This is consistent with Knight's (2002) view that the value of an in-service or structured course depends on the "fit with the community of practice" (p. 232). Informal interactions and learning opportunities such as colleagues sharing assessment methods, treatments and resources, are critical to learning. For the occupational therapists in this study, the availability of support needed to be immediate; this highlighted the importance of contextuality in the learning process (Sfard, 1998). Feedback on their learning was also important as well as confirmation from an experienced occupational therapist that the new practitioner was on the right track in their

actions as a therapist. An opportunity for reflection on experience was also critical to their learning. While the journals were extremely valuable in learning about the therapists' experiences, participants also revealed that writing in the journals assisted them in reflection; identifying changes that occurred in themselves as a therapist and identifying learning goals. They appeared to be more open about their experiences in the journals than in the interviews. Their writings revealed their struggles and successes at a very personal and emotional level.

Recommendations: Bridging the Gaps Identified by Practitioners

How can we prepare students for the world of occupational therapy practice today? How can we support the learning of new practitioners? In the second interview the participants were asked explicitly what would make the transition process easier. Their responses focussed on the need for more practical experiences in their university learning and the need for support from an experienced occupational therapist. Based on their responses and the findings previously presented, the following opportunities are suggested to ease the difficulties of the transition period.

Incorporate active learning, case studies and real-world experiences in the curriculum. Situated learning theory stresses the importance of collaborative learning experiences in the context of meaningful activities. Although some situated learning strategies are incorporated into the existing Occupational Therapy Program at the University of Ottawa, more emphasis is required. Expert practitioners in the community are key

resources for students' learning in the classroom. Experts may serve as models for students by problem-solving meaningful activities and verbalizing the reasoning process behind their actions. They may also support students' learning by performing some components of the activity, while students perform other components; an example of scaffolding students' learning. The expert practitioner may be viewed as a mentor, providing guidance for students, acting as a resource, and incorporating both theoretical and practical knowledge and skills in the classroom. Framing learning in the context of authentic practice activities can be accomplished through workshops, tutorials, case studies and small group discussions. These methods provide students with opportunities for shared understanding of clinical problems, interaction with occupational therapists and other students, and reflection. The emphasis on situated learning and the collaboration between learners and experts, is invaluable in bridging the gap between theory and practice.

Mentoring sessions held outside of the classroom in the work setting of experienced practitioners, may be a means of incorporating cultural and contextual information in learning, as well as introducing students to future colleagues and others in their community of practice. Small group work with students from different health disciplines and peer teaching are other strategies to promote real-world practice. Clinical problem-solving that demands interdisciplinary collaboration would provide students with a richer understanding of working as a member of a health care team. These learning interactions would also allow students an opportunity to understand the perspectives of different disciplines, and develop communication and conflict resolution skills (Clark, 1997).

An expanded model of mentoring. Beginning practitioners require mentoring from experienced colleagues, and occupational therapists in particular. Whether mentoring is formal or informal, structured or unstructured, an important consideration appears to be the immediate access to experts to support the learning of new therapists in the specific context in which they work. Prior to graduation, students should be encouraged to seek out mentoring relationships and to determine what type of support would be available in their first position. Interaction with expert practitioners is important for socialization of beginning practitioners into the occupational therapy profession. The need to feel connected with someone who can support and teach them is critical to ease the transition from student to therapist. Meetings with final year students and recent graduates of occupational therapy can open the dialogue about the experiences of beginning practice, including the challenges and rewards. This effort to build community partnerships would contribute to linking the academic and work context and assist students in learning about the culture of occupational therapy. Establishing a network of occupational therapists who are interested in acting as mentors during students' final year of study and during their transition to beginning practitioners would provide further opportunities for learning. Mentors would be participants in the learning process framing educational activities in the context of the workplace (Schlager, Poirier & Means, 1996). A collaborative learning approach benefits experienced and new practitioners with an emphasis on practical and emotional support for those involved. The role of the mentor is non-evaluative role, unlike that of the fieldwork supervisor who is responsible for a formal evaluation of the student's performance. Modelling, coaching, and scaffolding the learner are some of the strategies that could be

used to support final year students and beginning therapists.

Management and peer support are critical for mentoring relationships. It may be difficult for experienced occupational therapists to implement mentoring without the support of the environment in which they practice (Wilkins, Pollock, Rochon, & Law, 2001). Organizations must recognize and reward mentors for their role in supporting the professional development of colleagues (Schlager, Poirier & Means, 1996). Recognition can be accomplished by allocating time for mentoring within therapists' job descriptions, incorporating mentoring as part of the annual performance review and providing payment or flexibility in workload or caseload to support mentoring.

Clients are also mentors; it is important to recognize the critical role of clients in learning to practice as an occupational therapist. This perspective is consistent with the client-centred model of occupational therapy practice in which the therapist benefits from client interaction as a valuable source of learning. Client interaction is not only the greatest reward that new therapists identify, but clients are also a valuable source of learning. The findings from this research reveal that therapist and client work together to solve problems, each bringing their personal experiences and information to the process; this is an illustration of learning through participation in the sociocultural practices of a community.

Mentoring is a strategy to support therapists and is integral to the entire system of training, professional socialization and ongoing development. When mentoring is conceptualized in this manner, it can address the needs of occupational therapists with varying levels of experience, not just new therapists. An awareness of the challenges new therapists face in the first year of practice is the first step towards determining the learning

strategies to best support new therapists. Curricula that bridge the gap between theory and practice, and mentoring interactions are means to assist in clinical learning and to support continuing competency (Hanft & Anzalone, 2001). The profession of occupational therapy is more likely to thrive if there is dialogue among occupational therapists with varying levels of experience, education, strengths and interests. Mentoring has the potential to create a new culture of learning, benefiting all of those involved!

Limitations of the Study

Credibility and fairness of this research study were challenged by restricting the constructions of reality to a small sample of six participants, and describing the transition and learning experiences of graduates from the same occupational therapy university program. The study is further limited by gathering data from only two sources; interviews and journal writing. The restricted time-frame, may provide a narrow view of the new graduates' experiences, focussing on adaptation to work rather than professional development. The researcher was a past lecturer of the participants and this is a possible bias. However, the knowledge of their university curriculum and the relationship with the participants also enhanced the study by providing insight into understanding their experiences. Personality characteristics, age, and support outside of the workplace, were not considered in this study and may influence the transition process for new therapists. This study does not reflect the transition experience of male occupational therapists which may be different than the study participants.

Contribution to Research

This study is unique in using Vygotsky's sociocultural theory of learning to explore the voices and experiences of occupational therapists in the context of transition. Other research in this area have been quantitative in nature using theories of development, skill acquisition, and level of clinical reasoning. This has not allowed access to occupational therapists' perception of beginning practice. The concepts of legitimate peripheral participation, the zone of proximal development, and social learning were used to understand how occupational therapists learn the complexities of practice. The study results indicate that learning to become an occupational therapist is a process of acculturation; learning the language, skills, behaviours, and values of the profession in the authentic context of practice.

This research confirms the work of Hummell and Koelmeyer (1999), Parker (1991) and Rugg (1996) who identified that support and supervision from experienced therapists was critical to assist in the transition from student to therapist. The results of this study expand on this literature by identifying the challenge of implementing a client-centred model of practice. Without the support of the environment, it was difficult for occupational therapists to practice in a client-centred manner. The findings of the present study also identified the importance of therapists learning in collaboration with clients. Clients were able to often make the link between practitioners' existing knowledge about the disability or illness, and the practical implications for clients' daily activities. Finally, this study suggested that clinical reasoning was challenging for occupational therapists as they tried to apply the principles learned in school to the work context, which was complex, unpredictable and

characterized by considerable uncertainty. These results clearly indicate the need to assist learners in bridging theory and practice, and to develop knowledge in the work setting. The sociocultural theory of how people learn provides a rationale for an expanded view of mentoring as a strategy to support beginning therapists.

Future Research

No Canadian studies were found that focussed on the attrition of new practitioners and the potential influences on the retention of this group of therapists. Further understanding of the transition process is required, and the relationship between university education and occupational therapy practice. As well, the influence of a Masters level of education in occupational therapy on the transition process begs consideration. Finally, research into the availability, type and functions of supportive relationships for new practitioners is an area that requires further investigation.

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Appendix A: Research Evidence on Transition from Student to Occupational Therapist with Themes, Sub-themes and Examples

Category	Themes	Sub-themes	Research Evidence	Examples
Occupational therapy knowledge and skills	Gap between theory and practice	-need for practical knowledge and skills: treatment activities, specific procedures such as splinting and wheelchair prescription	Atkinson & Steward (1997) Greensmith & Blumfield (1989) Parker (1991) Schon (1987) Spouse (1998) Steward (1996) Tryssenaar (1999)	“Not enough emphasis was placed on the practical aspects of occupational therapy, such as learning more about equipment, the practical application of occupational therapy theory including models, and planning treatment using creative activities” (Atkinson & Steward, 1997, p. 341).
		-gaining competence and confidence in occupational therapy skills	Spalding (2000)	“She felt her confidence grow when she knew that they saw her to be competent: others listen to what I’ve got to say” (Spalding, 2000, p. 393).
Professional Identity	Role definition	-role clarity	Leonard & Corr (1998) Sutton & Griffin (2000)	“Conflict between my perception of my role and others’ expectations of me” (Leonard & Corr, 1998, p. 259)
		-recognition from team members	Hummell & Koelmeyer (1999) Parker (1991) Tryssenaar (1999) Tryssenaar & Perkins (2001)	“The majority indicated that poor recognition by other professionals impeded job satisfaction-70% to be exact” (Parker, 1991, p. 165).

Category	Themes	Sub-themes	Research Evidence	Examples
Professional Identity	Fieldwork experience and professional socialization	-prepares student for practice	Crowe & Mackenzie, (2002) Hummell & Koelmeyer (1999) Parker (1991) Sarbari (1985) Tompson and Ryan (1996)	Fieldwork enables students to experience different clinical settings and treatment modalities (Crowe & Mackenzie, 2002, p. 26)
		-influences career choice	Atkinson & Steward (1997) Crowe & Mackenzie (2002)	“The results indicated that the fieldwork experience stage had the greatest influence on the development of preferences for areas of clinical practice” (Atkinson & Steward, 1997, p. 338).
		-shelters from organizational issues, reality of practice	Tryssenaar & Perkins (1999, 2001)	Academics and fieldwork supervisors are often so focussed on seeing that students learn the clinical essentials that they shield them from the messy world of real practice, with its professional strains, demands and imperfect solutions (Tryssenaar & Perkins, 1999, p. 19)

Category	Themes	Sub-themes	Research Evidence	Examples
Expectations	Challenges encountered in practice	-dealing with responsibility -time management -determining priorities -caseload management -decisions about client care -time required for treatment planning	Hummell & Koelmeyer (1999) Leonard & Corr (1998) Rugg (1996) Spalding (2000) Tryssenaar & Perkins (2001)	Aspects of practice which therapists found difficult included the number of clients treated, finding time for work responsibilities, collaboration with others and authority at work (Rugg, 1996). New therapists commented about “not being as fast or as skillful as experienced therapists and needing more time” (Tryssenaar & Perkins, 2001, p. 22).
		-learning the charting language (report writing)	Tompson & Ryan (1996)	“Learning to communicate professionally was akin to learning a foreign language” (Tompson & Ryan, 1996, p. 67).
	Learning the system	-knowledge of policies and procedures -working with a team -financial restraints -limited resources	Atkinson & Steward (1997) Hummell & Koelmeyer (1999) Parker (1991) Tryssenaar (1999) Tryssenaar & Perkins (2001)	Aspects of the workplace which hindered new graduates transition included “lack of equipment and resources and staff conflict” (Hummell & Koelmeyer, 1999, p. 355). Too much paperwork, limited resources for client/patient care and staff shortage were considered stressors by over half of the respondents (Leonard & Corr, 1998, p. 259).

Category	Themes	Sub-themes	Research Evidence	Examples
Learning in Clinical Practice	Mentoring	-learning from team members, support from colleagues	Hummell & Koelmeyer (1999) Tryssenaar & Perkins (2001)	Mentors, supervisors and other relationships with professionals assisted participants in mastering their new environment (Tryssenaar & Perkins, 2001). “Assistance and guidance provided by co-workers as influential” in new graduates adjustment to their first position (Hummell & Koelmeyer, 1999, p. 354)
		-need for support of an occupational therapist to model practice -support of peers and classmates	Atkinson & Steward (1997) Hummell & Koelmeyer (1999) Parker (1991) Schon (1987) Sutton & Griffin (2000)	New graduates should have an opportunity for “shadowing a more experienced occupational therapist” as a strategy to ease the transition process (Parker, 1991, p. 166).
	Professional development: literature and courses	-lack of practical component	Atkinson & Steward (1997) Rugg (1996)	New practitioners attended professional development opportunities “out of personal choice or interest and to increase their own confidence or competence” (Atkinson & Steward, 1997, p. 342).

Appendix B: Initial Interview Questions

Transition

Please describe the setting in which you work.

What factors influenced you to take this as your first job?

Tell me about your first month of practice.

In general, what has the transition from student to new practitioner been like for you?

What made you most apprehensive in your new job?

Have your ideas about occupational therapy changed since you started your career?
If yes, how? If not, why not?

Challenges, Occupational Therapy Knowledge and Skills

What skills have you acquired or developed since you started your career?

What skills do you feel you have to acquire or develop to evolve as an occupational therapist?
How do you think you will achieve this?

What challenges do you experience in your work? How do you handle the challenges? What would help you?

What aspects of your work do you find rewarding?

What, if any, aspects of your work are dissatisfying? What would help you?

How would you describe your skills as an occupational therapist at this time?

Occupational Therapy Identity

How do you feel about your role as an occupational therapist?

One of the aims of the university curriculum is to prepare you to practice as an occupational therapist. How did your academic training prepare you for your role? What aspects of practice were you not prepared for?

Tell me about an experience at work that made you feel like a therapist.

How do other health professionals view your role? How do clients view your role?

Learning and Professional Development

How are you learning in the workplace?

What type of support do you have for your learning?

What type of support would you like to have for your learning?

Tell me about a memorable learning experience for you. What did you get out of this experience?

How do you learn the best i.e. consulting with others, conferences, reading journals?

What opportunities have you had to develop your professional skills?

What kind of professional development activities would you like to pursue?

What would you suggest to ease the adjustment from student to new practitioner?

Appendix C: Second Interview Questions

Transition

Have your ideas about occupational therapy changed since you started your career?
If yes, how? If not, why not?

Challenges, Occupational Therapy Knowledge and Skills

The following are some of the challenges in your work that you identified in the initial interview and journal (insert challenges). How are you managing these now? What has changed and why?

Explore journal entries that described problems, conflicts, emotional highs and lows.

What changes in your knowledge and skills have you seen in the last three months? Explore the specific skills that were discussed in the journal. What skills do you want to learn?

What is your most significant learning since you started your job in (month)?

What aspects of your work do you find rewarding?

What, if any, aspects of your work are dissatisfying? What would help you?

Learning and Professional Development

Explore journal entries that described learning experiences.

How do you learn the best in this practice setting?

How much of your learning comes from discussion with team members? Reading? In-services?

Do you think that the team learns from you also? In what way?

Explore journal entries that described relationships with clients. Tell me about the role that clients play in your learning. Has this changed your practice? If yes, please describe.

What opportunities have you had to develop your professional skills?

What kind of professional development activities would you like to pursue?

What was the role of fieldwork in preparing you to practice?

Recommendations

Please describe any recommendations that you have for beginning practitioners.

What would help new practitioners learn to “do occupational therapy” in the clinic/practice setting?

What would you suggest to ease the adjustment from student to new practitioner?

Please describe any recommendations that you have for the university curriculum?

Appendix D: Consent Form

Principle investigator:

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Description of Research

I, Darene Toal-Sullivan, am a graduate student at The University of Ottawa in the Faculty of Education. I am conducting a research study that will explore professional transition in occupational therapy and the role of mentoring in this transition. This research is under the supervision of Dr. Barbara Graves.

The specific objectives of this study are to explore the experiences of occupational therapists in the initial months of their career with a focus on how collaborative interactions support the transition from student to new practitioner. The challenges faced by occupational therapists in their entry to practice and the role of mentoring in supporting learning will be explored. The forms and functions of supportive relationships found in the practice context will also be investigated.

This study has implications for occupational therapy education and curriculum, and how the profession can maximize the learning experiences of students and new graduates. The research findings may inform educational practice by understanding the needs of new practitioners and the role of mentoring in the workplace context. Finally, knowledge of how new therapists cope with transition from a school to work context and the process of professional socialization, may help us understand issues related to job satisfaction and attrition in occupational therapy.

Participants

I _____ am interested in collaborating in M.A. (Ed.) research conducted by Darene Toal-Sullivan, Faculty of Education at The University of Ottawa. My participation will consist of two, one hour in-person interviews during which I will be asked to answer questions pertaining to my learning needs, how collaborative interactions support my learning, and the role of mentoring in learning in the practice context. The sessions will be tape recorded. I will also be asked to maintain a journal for one month describing my everyday experiences of practice. It is expected that my participation in this study will last 3 months, from September to November 2001. The interviews will occur in the first month of the research study and during the third month of the study. The journal will be maintained during the second month. I understand that the contents of the interviews and journals will be used to fulfill the requirements for the M.A. (Ed.) thesis and as a foundation for future research in the area of mentoring among new occupational therapists.

I understand that this research deals with very personal information. The interview questions may cause discomfort or anxiety by drawing attention to interpersonal relationships within my workplace and my own learning needs, as well as highlighting stressors. I have received assurance from the researchers that every effort will be made to minimize these occurrences by focusing on both learning opportunities and challenges in my transition as a new practitioner. Mentoring will be presented as a collaborative, supportive, interaction. I may benefit from the study by identifying my own learning needs and ways to enhance mentoring relationships in my workplace. Discussion with an experienced colleague may also provide a form of support for me.

I have received assurance from the researchers that the information I will share will remain strictly confidential. My confidentiality will be respected by my name, the city in which I reside, my workplace and my university affiliation, remaining anonymous.

Participation in this research is entirely voluntary. I am free to withdraw from the project at any time.

Tape recording of interviews and other data collected will be kept in secure manner, stored in a locked file cabinet in the researcher's office. The data will be kept in a secure manner for 10 years after the Thesis submission. Dr. Graves and the principal investigator will be the only researchers who will have access to the information.

Any information requests or concerns about the ethical conduct of this research project may be addressed to Lise Frigault, Protocol Officer for Ethics in Research, University of Ottawa, 30 Stewart Street, Room 301, Ottawa, Ontario, K1N 6N5. Telephone: 613-562-5800 extension 1787. If I have any questions about the conduct of the research project, I may contact the researcher or her supervisor at the numbers and addresses listed on the first page of this consent form.

Informed Consent

I have read and understand the above description of the research and I agree to participate. I have been assured that my participation is voluntary and that my identity will remain confidential. I am aware that I am free to withdraw from the study at any time without any negative consequence. I am aware that there are 2 copies of this consent form, one of which I may keep.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Please check if you would like to receive a summary of the findings of this research, which will be available by contacting the principal investigator: yes _____ no _____

Your participation in this research is greatly appreciated.