

ABSTRACT

AMINI, DEBORAH ANN. An Exploratory Study of the Professional Beliefs and Practice Choices of Novice Occupational Therapy Assistants. (Under the direction of Tuere Bowles.)

The purpose of this basic interpretive qualitative study was to explore how novice occupational therapy assistants begin to understand their profession, form practice beliefs, and subsequently select and initiate certain treatment methods and approaches with clients. The primary source of data for this study was obtained via semi-structured interviews of 10 purposefully selected men and women novice occupational therapy assistants who each graduated from the same southeastern North Carolina community college in either 2008 or 2009. Participants ranged in age from 23-38 years and were employed as OTAs for between two weeks and 10 months. Secondary data obtained for this study included participant observations, document review, critical incident essays and observations of participant workplaces. The research questions that guided this study include: (a) How do novice OTAs understand and describe the profession of OT? (b) How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting? (c) What environmental factors shape the practice choices of OTAs within the clinical setting? (d) How do novice occupational therapy assistants enact their professional belief within the clinical setting?

Data were analyzed and interpreted using the constant comparative method that revealed the following: (a) OTAs define and describe the profession as embodying practitioners who have great care and concern for clients and use relationship building as a therapeutic tool; (b) novices have learned about their profession through interactions with clients and peers, their academic program, workshops and periodicals; (c) OTAs feel both supported and challenged in their practice by the work environment including managers, the organization and third party payers; and (d) the practice decisions made by novice OTAs are

consistent with their espoused beliefs about the profession, despite the fact that they do not hold a belief consistent with the new professional paradigm of occupation-based practice.

Three conclusions were drawn from the data: (a) novice OTAs possess two divergent professional identities that impact their espoused and enacted practice beliefs; (b) novice OTAs engage the process of OT in a linear and hierarchical manner that is not in keeping with the tenets of the profession, addressing client factors (e.g. strength, motion and endurance) prior to engaging clients in functional tasks; and (c) the practice of OT by novice OTAs is impacted by hegemonic environmental factors such as direct management, the organization and third party payers. The findings of this study have implications for theories of adult education, and the education and practice of occupational therapy.

Recommendations include the suggestion that educational and national organizational activities promote reflexive practice of both novice and experienced clinicians in addition to the creation of an initiative to enhance OT based communities of practice within physical disabilities work places.

An Exploratory Study of the Professional Beliefs and Practice Choices of
Novice Occupational Therapy Assistants

by
Deborah Ann Amini

A dissertation submitted to the Graduate Faculty of
North Carolina State University
in partial fulfillment of the
requirements for the Degree of
Doctor of Education

Adult and Community College Education

Raleigh, North Carolina

2010

APPROVED BY:

Tuere Bowles, PhD
Chair of Advisory Committee

Duane Akroyd, PhD

Diane Chapman, Ed.D

Julia Storberg-Walker, PhD

DEDICATION

I dedicate this paper to those individuals who have made it possible for me to realize my dream of one day earning a doctoral degree. To those who, through their mere presence in my life, have given me the chutzpah to pursue a degree that I once believed to be beyond my reach.

To my parents, who may not realize the power of the simple adventures they created for me as a child. From picking up rocks to holding backyard stuffed animal zoos and taking long autumn walks in the woods, Mom and Dad instilled within me a love for life and the ability to see the humor in a world that often challenges the spirit. Those seemingly small childhood activities have given me the belief that life has purpose and that all things are possible with hard work, commitment and perseverance.

I also dedicate this work to my children, Lia, Rabi and Aaron, whom I love with all my heart. I thank you for allowing me to be a student again, complete with complaints about homework and celebrations for good grades. Thank-you for not being completely embarrassed when your mother wrote on your Facebook wall or just wanted to hang out with you at the local Zaxby's.

And to my husband Ali, who made sure the kids were fed on the nights that I commuted to Raleigh for class...no promises, but the house may finally get cleaned.

In Loving Memory

Leroy C. Whitaker, Jr.
March 2, 1938-March 7, 2010

BIOGRAPHY

Debbie was raised in the small northeastern city of Pittsfield, Massachusetts. She graduated from Quinnipiac University in 1983 with a Bachelor of Science degree in Occupational Therapy. Since earning her undergraduate degree, Debbie has raised a family with her husband and has worked as a hand therapy specialist. In 1991, she moved to Wilmington, North Carolina where, in 1998, she became the director of the occupational therapy assistant program at Cape Fear Community College. In 2001 she received her Masters' degree in Education through the University of North Carolina at Wilmington. Since 2001, Debbie has become increasingly involved with the American Occupational Therapy Association, holding several volunteer leadership positions. She has authored chapters in profession textbooks in addition to writing several articles that have appeared in *OT Practice* magazine and special interest section newsletters; she authors a monthly column in *Advance for Occupational Therapy Practitioners*. Debbie has presented workshops related to hand rehabilitation and occupational therapy at both the state and national level. In 2005, she enrolled in the doctor of education program offered through North Carolina State University in Raleigh, NC. This dissertation represents the culmination of her academic, and the beginning of her scholarly journey; blending her passions for teaching and advancing the profession of Occupational Therapy.

ACKNOWLEDGEMENTS

As I reach this milestone in my life, I would like to acknowledge all those who made it possible. First and foremost is my family, those near and far away, who have my undying gratitude for offering me support and reminding me time and again that my goals were achievable.

I would also like to acknowledge and thank all of my professors at NCSU, particularly those in the Adult and Higher Education department who taught me so much about myself and the world. I thank Dr. Tuere Bowles for her belief in me; for encouraging me to think, for knowing that I could.

I thank my study participants who so willingly gave their time and thoughts to this effort. I certainly could not have completed my doctoral work without all of you. And to those at Cape Fear Community College; I thank colleagues and students who tolerated my schedule and allowed me to bend their ears with stories of adventures on I-40 and the passionate recounts of lessons learned the night before.

Any task as large as this cannot be accomplished in a vacuum, I am fortunate to have had the support of such a caring group of people.

TABLE OF CONTENTS

LIST OF TABLES	vii
LIST OF FIGURES	viii
Prologue	1
CHAPTER 1 INTRODUCTION	5
Background	5
Statement of the Problem	12
Purpose of the Study	13
Significance of the Study	16
Definition of Terms	18
CHAPTER 2 REVIEW OF THE LITERATURE	21
Learning Theories	24
Power	48
Theories of Identity	60
Espoused versus Enacted Beliefs	67
Chapter Summary	73
CHAPTER 3 METHODOLOGY	75
Design of the Study	75
Sample Selection and Setting	80
Data Collection	84
Data Analysis	91
Ensuring Validity and Reliability	96
Investigator Biases and Assumptions	102
Chapter Summary	104
CHAPTER 4 FINDINGS	105
Participant Profiles	106
Findings	123
Chapter Summary	215
CHAPTER 5 SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS	220
Summary	220
Conclusions	223
Implications for Theory and Practice	244
Recommendations	250
Chapter Summary	252
REFERENCES	255
APPENDICES	267
A Participant Demographic Form	268
B IRB Approval	271

C	Letter of Invitation to Participate.....	274
D	First Interview Guide.....	275
E	Participant Observation Tool.....	277
F	Context Observation Tool.....	278
G	Document Review Form.....	280
H	Critical Incident Activity.....	281
I	Consent forms.....	282
J	Second Interview Guide.....	284

LIST OF TABLES

Table 4.1 Participants' Demographics	108
Table 4.2 Findings	125

LIST OF FIGURES

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Figure 1.	Schematic of elements that contribute to novice OTA understanding	226
-----------	----------------------------------------------------------------------------	-----

PROLOGUE

During a professional transitions class, a student returning from an eight-week internship within an adult physical disabilities setting commented that she did not feel that her occupational therapy assistant (OTA) program prepared her for the “real world.” She went on to say:

I know that the profession of occupational therapy has changed through the years, and that our program has taught us how to be holistic therapy assistants, but I am concerned. During my internship, I spoke with several past graduates of this program who told me that they needed to learn a lot about strengthening and range of motion exercises after they graduated. They said that holistic OT is nice to hear about in school, but that it is not a realistic for the real world, for the way that OT is being practiced in the field. They told me that we have to maintain productivity and make sure that people have endurance and can move their limbs in order to take care of their daily needs like dressing and bathing. OTs in the field cannot take the time to do things like meaningful activities because of time constraints, a lack of equipment, concerns with third party reimbursement and the risk of losing the respect of others who might think that OT is just playtime. OT is not what I thought it was.

The disconcerting words of this new OTA represent the thoughts of many who comprise the next generation of occupational therapy (OT) practitioners; individuals implicitly charged with shepherding the profession into the second decade of the 21st century. The dilemma experienced by this individual pertains to a paradigm shift currently underway within the profession of occupational therapy.

In 1998, the Balanced Budget Act (BBA) was enacted by the US congress and caused the Centers for Medicare and Medicaid to take a close look at the rehabilitation services being offered to individuals experiencing physical dysfunction. The financial focus of that time was on services within inpatient settings such as skilled nursing facilities, a primary employer of occupational therapy practitioners. With little societal understanding of the unique role of OT and congressional rulings that equated to federal cutbacks in funding for services, many practitioners lost jobs.

Funding cutbacks were not isolated to the profession of OT, physical therapy (PT) and speech-language pathology (SLP) were also facing similar challenges. What was to become an additional challenge to OT however was uncovered when leaders of the American Occupational Therapy Association (AOTA) attempted to educate payers about the unique role and societal need for the profession. Differentiating OT from other allied health professions such as PT became an unanticipated and difficult task.

Through the years, the actual day-to-day practice of OT had become so aligned with the medical model paradigm (that guides professions such as medicine and physical therapy) that OT treatments were almost indistinguishable from PT in the clinical setting. Occupational therapy practitioners could be observed placing clients on upper body bikes, having clients spend time standing with little to do beyond flipping through pages of a magazine, mindlessly placing clothespins on a pretend clothesline and unfolding and refolding towels from a linen cart. This fact did not bode well for the future of a profession that was originally founded on the premise that the mind, body and spirit are linked in a constant transactional relationship.

OT founders believed in the power of occupation (engagement in activities that have meaning and relevance for the individual, such as gardening, cooking and care of others), for its inherent ability to bring wellness to the collective mind, body and the spirit. Early OTs did not seek to primarily heal body structures for eventual engagement in occupations, or to provide mindless exercise or contrived activities. The physical body focus came about during the mid-twentieth century and contributed to the OT paradigm shift toward reductionist practice, which is based upon the notion that a moveable body ultimately leads to healthy mind and spirit; this belief does not represent the founding tenets of OT.

With the concerns of the BBA, the approaching 100th anniversary of the profession (2017) and a forward thinking AOTA president, the early 21st century brought a shift back to the founding tenets of OT. The founding director of the aforementioned North Carolina OTA program also embraced the beliefs of AOTA; setting both a personal and program goal to reclaim the profession and to move it forward as it was originally purposed so long ago. The program sought to instill a sense of professional pride within the developing practitioners, to challenge them to become change agents prepared bring the new paradigm to the clinical setting.

New educational standards for OTA education that provide a strong emphasis on the power of occupation were integrated into coursework. Critical thinking exercises and activities that demonstrate the use of occupations versus rote exercise in the rehabilitation process were utilized. The program director sought to equip graduates with the understanding of what OT is according to the current professional paradigm espoused by the AOTA.

As illustrated in the opening paragraph however, despite the efforts of this program and those of other colleges with professional training programs, the change in actual practice is slow in coming. More disconcerting than slow change is the reality that those who are trained within the new paradigm are actually practicing a medical model approach once they take on positions within adult physical disabilities settings. Instead of becoming agents of change in practice, graduates are becoming part of a seemingly unchangeable clinic culture.

CHAPTER 1

Introduction

In 2005, the *Journal of the American Medical Association* reported that approximately 700,000 strokes occur in the United States each year; 500,000 of these are first or new strokes (Carandang et al., 2005). With the baby-boom generation's movement into middle age, it is expected that by 2030, six out of every ten adults will battle chronic diseases that may affect their function and quality of life. An increase in the population of those 75 years and older, an age group that also suffers from high incidences of chronic diseases, combined with expected medical advances suggests that more patients with critical problems will survive; patients who may require extensive therapy.

This aging of the American population, as well as the documented increase in developmental problems affecting children (e.g. autism), will spur an increase in demand for occupational therapy (OT) services, the objective of which is to enhance the quality of life and facilitate return or acquisition of independent life skills functioning (Bureau of Labor Statistics, 2010).

Occupational therapy has been a part of the allied health community for nearly 100 years and is defined by the American Occupational Therapy Association (2008) as:

The therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those

who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.

Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. (p. 673)

Occupational therapy practitioners can choose two levels of professional training and practice. The first level is that of the occupational therapist; this level requires a masters' or clinical doctorate degree for entry. Occupational therapists (OTs) are clinicians who can work directly with clients, but who are increasingly found managing rehabilitation departments and programs as well as overseeing the client care of the occupational therapy assistant. Occupational therapy assistants (OTAs) enter the profession with an associates' degree and are more often found working one-on-one with clients in the clinic setting, although they are found in managerial positions and do have autonomy in practice in so far as they choose daily treatment activities for their clients.

Occupational therapy practitioners are found working in skilled nursing facilities, school systems, neonatal intensive care units, hand therapy clinics, in-patient psychiatric facilities, day treatment programs, prisons, home health care, wellness centers and driving programs, to name but a few. In all clinical settings (workplace settings), therapists and assistants should be interested in facilitating client engagement in meaningful activities and occupations in order to restore or develop their physical, cognitive and motivational abilities; to do everyday things that bring purpose and meaning to life. Daily occupations are classified

by AOTA documents into what are known as *areas of occupation*; these include activities of daily living (care of self), instrumental activities of daily living (care of objects and others) work, leisure, play, education, social participation and sleep (AOTA, 2008).

Since its inception, OT has had difficulties with professional identity and limited societal understanding of the distinction between OT and other health professions such as physical therapy, recreational therapy, activities therapy and vocational therapy. In recent years, an occupation-based practice paradigm, grounded in the understanding that humans are occupational beings who seek to be active participants in the experience of life, has re-emerged as the unique guiding philosophy of the profession. This philosophy holds that occupational therapists should not be engaging clients in treatments designed to focus solely on client factors such as muscle strength, movement of limbs and physical endurance. Treatment should instead involve occupations, which are the actual life activities in which the client desires to function. Engagement in occupations may have the effect of changing the aforementioned client factors and are used, in part, for this purpose. However, to be true occupational therapy, treatment must provide engagement in occupations and activities that are desirable to the client and are important in their psychosocial, cognitive, contextual and physical reality.

The efforts to put occupation back into the practice and professional definition of occupational therapy began shortly after the Balance Budget Act was enacted by congress in 1998. At that time, those within the profession faced job losses due to a reduction in federal health care spending. The American Occupational Therapy Association proactively

determined that to ensure future viability, the profession must be understood as and provide service as a unique entity. The process of growth and change was put into motion in the year 2000 as part of the effort to position the profession as a viable, sought after, needed and reimbursable service (Baum, 2000).

The belief in the power of occupation and its application is unique to OT and is considered a key element in preserving the quality of life of all individuals, particularly the aging baby-boomers. The field has a body of knowledge to support its role in society as an effective force leading to enhanced function and quality of life for those who are recipients (AOTA, 2008; Christiansen, Baum, & Haugan, 2005; Christiansen & Townsend, 2009; Law, Baum, & Dunn, 2005; Letts, Rigby, & Stewart, 2003). An expanding base of empirical evidence is supporting the premise that clients who are engaged in meaningful relevant activities of their choosing as part of their treatment plan report an enhanced quality of life. One such study completed by Duncan-Myers and Huebner (2000) found that choice of activities, offered to clients by OT practitioners in a skilled nursing facility empowered clients; introducing control and self-efficacy back into their lives and ultimately enhancing their quality of life.

A study conducted with children who sustained second and third degree burns to the upper extremity found that meaningful play activities used as a means of increasing movement and strength were much better tolerated and enjoyed by the children in contrast to rote exercises that are typical of medical model treatment (Melchert-McKearnan, Deitz, Engel & White, 1999). A case report of the occupation-based management of a 53-year-old

woman diagnosed with primary shoulder adhesive capsulitis found that occupation-based interventions used as soon as diagnosis was made immediately decreased pain, improved range and quality of motion, and enhanced occupational performance (Earley & Shannon, 2006).

A study of three individuals who had experienced spinal cord injury was conducted to add to the evidence regarding the use of occupation-based practice and its effects on social and occupational participation in adults with spinal cord injury. The community based participants received services from an occupation-based practitioner. They each described positive outcomes from seven occupation-based approaches that directly supported their level of occupational and social participation (Ward & Mitchell, 2007).

Despite the recognition that the profession, through the use of the occupation-based paradigm is effective in supporting occupational engagement and ultimately quality of life in recipients, practitioners are not embracing the evolving practice paradigm at the needed pace, and are therefore slowing or stalling forward movement of the profession. As stated by past AOTA president Carolyn Baum, the occupation-based paradigm perspective and the type of intervention associated with it, continues to be elusive, especially within physical disabilities settings (2000).

The need to educate all new practitioners in the constructs of the new professional paradigm has been recognized. The Accreditation Council for Occupational Therapy Education (ACOTE), a body of the AOTA, published new standards for occupational therapist (OTR) and occupational therapy assistant (OTA) educational programs in 2006.

These standards require educational programs to teach future occupational therapy professionals a method of practice that revolves around an occupation-based and client-centered approach to treatment. According to ACOTE (2007) *Standards for an Accredited Occupational Therapy Assistant Program*, students will demonstrate the ability to:

Select, adapt, and sequence relevant occupations and purposeful activities that support the intervention goals and plan as written by the occupational therapist. These occupations and purposeful activities shall be directly related to performance areas, performance components, and performance contexts. They shall be meaningful to the client, maximizing participation and independence. (p. 7)

Not only have these standards been created and adopted by the AOTA, every program that trains both levels of professionals must abide by them in order to maintain accreditation, thus allowing program graduates the option to sit for the national certification exam. Despite the understanding that some variations in teaching methods and instructor viewpoint always exist, each institution must document the plan that they have for ensuring that this standard is being met as well as to provide physical evidence during accreditation reviews.

Despite these mandates, evidence suggests that those being educated within the new paradigm are not engaging in this type of practice in the workplace following graduation from their respective programs. Crist (2004), past president of the National Board for Certification in Occupational Therapy, recognized the disparity between occupational therapy ideals and the reality of everyday practice in terms of evaluations and treatments utilized by practitioners. She discussed the fact that other professions evaluate and practice in

the way that OT has adopted, which is making it increasingly difficult to determine the occupation-based outcomes. Crist goes on to describe the impact of the practice versus belief disparity upon student learning, students whose next role will be novice practitioner, when she wrote:

I am acutely aware of the dilemma our profession experiences....while understanding occupation, most practitioners report that their work setting does not support the use of occupation and occupation-centered practice. As a result, our fieldwork students do not see models and are not challenged to do occupation-centered practice. Of course, to respond to these questions, we are going to have to muster the strength to admit that everything an occupational therapy practitioner does, is not always occupational therapy. Likewise, because an occupational therapist does something, does not warrant it being referred to as occupational therapy.

This debate will be difficult, but its time has come. (p. 2)

This statement is further supported by Lee, Taylor, Kielhofner and Fisher (2008), who reported that OT practitioners surveyed, described barriers to the use of occupation-based models of practice such as the facts that they do not fit within the philosophy or focus of services provided within their practice setting, and that other OT professionals did not support their use of these methods.

With regard to current research and knowledge generation that supports occupation, Kielhofner highlighted the fact that there is evidence that the growth in theory and research about occupation produced by academics is not consistently translated into occupational

therapy practice. Practitioners often report finding such theory and research to be of limited relevance to and difficult to implement in their everyday work (2005).

Statement of the Problem

A disconnect exists between the new, occupation-based paradigm being taught within educational programs and actual practice being conducted by those in the field who are trained in the new paradigm. At this time, there is limited empirical evidence available that provides an understanding of the interplay of the multiple elements that exist within the clinical workplace that either support or inhibit specific professional belief system development within, and subsequent treatment choices made by, the OT practitioner.

As the guiding professional organization, AOTA has demonstrated commitment toward establishing OT services as unique, viable and useful to society. Studies have shown that the required change in the actual practice of the profession has not yet fully occurred; this is necessary for the professions' identity to be understood by all stakeholders. Novice practitioners continue to be exposed to the manner of practice embraced prior to the year 2000.

In order to understand how practitioners make meaning of and ultimately enact their perspective of the profession, we must first gain knowledge of how they experience and negotiate the social culture of the clinic or work setting. This notion was put forth by Silverman (2004) who stated that we must understand how people construct meaning and action in order to understand why they act the way that they do. We must explore how they internalize their daily experiences and how they come to understand their profession while in

the work context. Equally important is the understanding of how newly created professional beliefs inform treatment choices. Knowledge of how perspectives are formed within the context of the clinic can assist adult educators in creating effective curricula and venues that support the individual practitioner as they gain and operationalize espoused concepts within a pre-established culture.

The findings from this study respond to a gap in the literature that relates to the elements within the workplace that inform the perspective and practice choices adopted by therapy assistants who were educated according the 2006 ACOTE standards. The literature enhanced will include that of adult education, social learning theories, espoused and enacted beliefs, occupational therapy, workplace learning, identity theories and workplace power dynamics.

The intent is to assist those who provide adult education with an enhanced understanding of paradigm choice in the healthcare context. This information can be used to inform the planning of educational programming that will equip OT practitioners with intellectual tools such as reflective thinking, critical thinking skills, and values clarification skills, required to embrace or continue to embrace and use the occupation-based paradigm.

Purpose of the Study

The purpose of this qualitative study was to explore how novice occupational therapy assistants begin to understand their profession, form practice beliefs, subsequently select, and initiate certain treatment methods and approaches with clients. The research questions that guided this study are as follows:

1. How do novice OTAs understand and describe the profession of OT?
2. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?
3. What environmental factors shape the practice choices of OTAs within the clinical setting?
4. How do novice occupational therapy assistants enact their professional belief within the clinical setting?

The knowledge of how novice practitioners come to understand their profession and how this embodiment drives treatment choices is considered a fundamental piece in understanding the paradigm disconnect occurring in the field of OT. A qualitative research design was used to explore the creation of the professional beliefs of the novice OTA as described above. The research questions and focus of this study required the rich and detailed descriptions of the experiences, beliefs and perceptions of the OTA as they take part in the culture and context of the OT clinical setting. The depth and breadth of information required to understand the meaning making of the OTA was best explored through qualitative methods.

This study was based upon the epistemological underpinnings of constructivism, a relativistic perspective that asserts that both knowledge and meaning are socially constructed and fluctuating phenomena that occur in context while individuals (or groups) interact within their world (Creswell, 1998; Crotty, 2003; Merriam & Associates, 2002). Social constructivism, which puts its major emphasis on the social construction of knowledge by an

individual's interaction with a social milieu in which he or she is situated, is the perspective of constructivism used to guide this study. According to social constructivism, construction of knowledge and meaning eventually results in a change in both the individual and in the milieu (Airasian & Walsh, 1997 p. 445). Within this perspective, knowledge is believed to have a social component that cannot be created by an individual acting in isolation of the social context. This perspective was appropriate for a study that sought to explore the meaning that novice professionals make of their profession when working with others within the context of the clinic. This study also explored the literature of social learning theories, power, identity and espoused versus enacted beliefs for use as lenses through which to examine the meaning that OTAs make of their profession.

This study explored the experience of novice occupational therapy assistant practitioners. Novices were chosen as participants for this study because they are still learning and forming their professional perspectives and understanding of OT; other people and events within the workplace context can influence their meaning making and practice choices (Dreyfus, 2004). In addition, there exists an understanding that newer OTAs have been trained to understand the occupation-based paradigm due to ACOTE standards. To ensure that the occupation-based paradigm underpins their initial knowledge of the profession because it was a strong component of their academic program, participants were selected from a pool of recent southeastern North Carolina OTA program graduates.

Assistant level practitioners were chosen over therapist level because they are primarily found working directly with clients, applying their professional perspectives on a

daily basis as they make treatment choices. This is in contrast to the OTR who may be involved in managerial and supervisory roles that decrease the amount of time engaged in actual client care. Exploration of the meaning making of seasoned clinicians, both OTAs and OTRs was beyond the scope of this study.

Significance of the Study

By looking at the ways that novice OTAs construct meaning of their profession and make treatment choices, this study provides a number of theoretical and practical contributions. First, the study contributes to the literature of communities of practice, social cognitive theory, identity theory and the theories of espoused versus enacted beliefs. The current adult learning literature speaks to the positive effects of learning that occurs through interaction with others, but does not discuss the effects of negative learning upon a health care practitioner when the social environment does not offer insight or feedback required to reinforce academic learning. The literature that describes espoused versus enacted beliefs is supported through the findings insofar as incorrect beliefs lead to incorrect behaviors that will not change, unless the individual engages in critical reflection and changes their behavior as a result.

This study also contributes to theories of identity and describes the phenomenon of two divergent therapist identities existing simultaneously without explicit recognition of these identities on the part of the OTA. These identities represent parts of the OT paradigm, but do not represent the complete picture of occupation-based OT. Identity theory does recognize that multiple identities exist within a person in a particular context, but does not

describe identities that are mistaken in their beliefs or are seemingly at odds with each other.

Additionally, findings from this study are of significance to adult educators who design continuing education venues for practicing clinicians. Designers of these educational venues may consider the development of activities that support and facilitate the establishment of OT communities of practice. Workshops that teach techniques to enhance skills of self reflection will also benefit clinicians who are not reflective practitioners; who do not recognize the disconnect between what they believe about OT and what the professional association supports and promotes.

This study has impact on the future viability of the profession. At some point, all therapists must learn to embrace the new tenets of the profession to enhance desired client outcomes as described in the literature and espoused by the professional association. The power dynamic between the professional association, educators, clinicians and learners is acknowledged as a hegemony that must exist to steer the profession of OT in an era of diminishing healthcare dollars and economy that calls for transparency of the unique contributions of each reimbursable profession (Wilding & Whiteford, 2008). Through educational experiences that can potentially be made more effective with improved understanding of the meaning that practitioners make of their profession within context, OT practitioners may begin to adopt the beliefs of the professional association, gaining observable strength of professional identity and cogent purpose. Lawmakers must see the unique contribution of OT in order to include provisions for this service in new healthcare reform measures. At this writing, the current presidential administration and congress are

creating a plan for reforming health care within this country. In order to survive, the profession of occupational therapy must be an integral part of any reform plan (Bureau of Labor Statistics, 2010).

Definition of Terms

Various terms and concepts used within this research study require explanation for clarity. These selected terms appear below and are listed in alphabetical order.

Novice. A *novice* is popularly defined as someone who is new to a particular field; a beginner. Dreyfus (2004) describes the novice as one who is at the stage of learning procedures for tasks that have been deconstructed by others. In addition, he outlines the novice as one whose knowledge is general and not bound to a particular context and who does not have the ability to see many variables in order to choose a particular perspective. The novice makes decisions in an analytical as opposed to tacit way and is not yet immersed in the learning situation when it comes to understanding and deciding on outcomes (Dreyfus, 2004).

For the purpose of this study, the novice will be further defined as one who has been working within the profession of occupational therapy for a minimum of zero months and extending up to between six months and one year. These time frames are consistent with those used in studies investigating the problem solving abilities of novice versus expert teachers (Carter, Cushing, Sabers, Stein, & Berliner, 1988; Swanson, O'Connor, & Cooney, 1990)

Occupation-based occupational therapy. For the purpose of this study, the definition of occupation-based practice (OBP) as put forth by the AOTA Ad hoc work group on implementing occupation-based practice (Nielson, C. et al., 2005) will be used. This definition reads:

OBP is inherently client centered allowing choice, influence and power to be shared in the intervention process. Occupation is explained to the client and then used in assessment and intervention to clearly address the client's life, goals and roles in both their current and historical contexts. OBP begins with understanding the client's valued occupations, and ends with getting them back into those life activities. OBP infuses occupation into the intervention phase through activity selection, analysis and modification. The therapist's activity analysis and environmental/activity modification skills are critical to the linkage process described above and are key factors in using occupation in an integrated approach to intervention. Occupation-based practice culminates with documentation that illustrates the client's status or progress in his/her ability to actively and meaningfully participate in the activities of his/her life.

This definition contributes to the understanding of what it means to practice as a holistic OT or OTA who embraces the tenets of the new OT paradigm.

Occupational therapy assistant. For the purpose of this study the occupational therapy assistant (OTA) is defined as an individual who has earned an associate degree in occupational therapy assistant at an accredited college and who has earned the designation Certified Occupational Therapy Assistant through the National Board for Certification in

Occupational Therapy. OTAs work under the supervision of the occupational therapist (OT) but are able to independently chose treatment interventions that work toward goals established in the plan of care (AOTA, 2004; AOTA 2006).

Paradigm. This study embraces the understanding of the term paradigm as it was described in one form by Thomas Kuhn. “A disciplinary matrix—commitments, beliefs, values, methods, outlooks, and so forth shared across a discipline” (Schwandt, 2007, p. 217).

Practice choices. For the purposes of this study, practice choices refers to the activities, methods and techniques that occupational therapy practitioners decide to use during the course of client treatment. Good practice choices are considered to be those that are in keeping with the *Standards of Practice for Occupational Therapy* (2005), which explicitly states that OT professionals shall practice according to the philosophies of the profession. “An occupational therapy practitioner delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice” (p. 663).

CHAPTER 2

Review of the Literature

This study sought to understand the meaning that novice occupational therapy assistants make of their profession while experiencing the various elements within the clinical setting, therefore a constructivist theoretical framework was adopted. The four bodies of literature that were reviewed and served to ground exploration of participant reports are situated learning/communities of practice and social cognitive learning theories; theories of power; identity development theories; and literature that addresses espoused and enacted beliefs in the work place. These literature bases are congruent with the constructivist perspective as all involve the experience of the individual, within context and through interaction with others. Prior to reviewing the literature that addresses theories of learning, power, identity and enactment of espoused beliefs, this chapter will provide an overview of the literature search conducted to locate existent empirical studies and conceptual work that addresses the topic explored.

Review of Relevant Literature

A review of scholarly databases focusing on literature published between 1998 and 2009 was conducted to locate empirical and conceptual projects previously completed on the topic of professional belief and practice choices made by novice occupational therapy assistants in the context of the clinical setting. Databases explored included the dissertation data base Proquest, which publishes more than 60,000 new graduate projects each year; Scirus, a comprehensive scientific web based research tool with over 450 million indexed

scientific items; Academic Search Premier, a database containing articles from over 3000 scholarly journals; Google Scholar, a web based search engine containing scholarly articles, conference papers, preprints, theses, books and technical reports; Web of Science, a database that includes articles from 8000 scholarly journals and; JSTOR, a database containing articles that focus on the humanities and social sciences from over 400 scholarly journals. In addition, the journal databases of the American Journal of Occupational Therapy and the Occupational Therapy Journal of Research: Occupation, Participation and Health, were explored using relevant search terms. When searching for seminal work, time limits did not apply.

No empirical studies or conceptual papers that provide adult educators with insight into, or that specifically explore the subject of professional perspective creation of the novice OTA within the context of the changing occupational therapy work environment, were found during the search of the literature. Work of this nature is considered particularly salient to the problem addressed by this study due to the acknowledged disconnect between what is espoused by the profession as identified through the national association and that which is being enacted in the field.

Despite the lack of research that addresses the specifics of this research topic, studies were found that describe the professional learning and skill development of healthcare providers such as OTs, nurses, physicians and physical therapists as they develop their professional identity through the early years of practice. In addition, a conceptual piece written by Mackey (2007) discusses the power and knowledge influences found in the

workplace and the effect that they have upon professional identity formation as seen through a Foucaultian lens.

Conclusions from these various studies include the findings that novice healthcare professionals must pass through a period where they are socialized to the context of the workplace and to the constructs of the profession itself (Ajjawi & Higgs, 2008; Tryssenaar & Perkins, 2001). Richardson (1999) found that the construction of professional knowledge by Physical Therapists is the individual and subjective integration of procedural and experiential knowledge occurring within the context of the workplace. Daley (1999) adds that novices may have not yet learned how to make meaning of their context or profession and therefore rely on others as role models. She describes a period where novices are fearful of making mistakes in the eyes of others, and as a result are more comfortable engaging in procedural type tasks the execution of which, by more experienced individuals, can be observed.

The use of leadership power has been described and is evidenced through the literature as producing the outcomes of desired subordinate behavior. Social identity of the leader and the member of a participant group, as well as the use of language and various influence tactics, play a role in how and why a subordinate will chose to respond within a specific context (Reid & Ng, 2003; van Knippenberg & van Knippenberg, 2003). In the conceptual piece where she compares power constructs of Foucault to occupational therapy practice, Mackey (2007) states that the discourse within the occupational therapy workplace regulates and disciplines members of the profession. She goes on to say that this regulation can change based upon context, is socially constructed and potentially biased. Power laden

discourse, in addition to constant surveillance by those with power, influence the formation of professional identity in the workplace (Mackey, 2007).

Authors agree that the internal process through which subordinates are influenced by elements within the workplace context have not been adequately explored (van Knippenberg & van Knippenberg, 2003). Minimal understanding of the internal process and meaning making inherent in relationships opens the possibility that multiple sources of power as well as multiple constructs of change, such as learning and identity formation, may inform the meaning making that occurs as novice practitioners enter the workforce and establish an understanding of their profession.

This study of novice occupational therapy assistants adds to the literature by offering a more explicit view of how meaning making occurs within the social context of work and how it informs the construction of professional beliefs and identity leading to the emergence of professional practice. To this end, it was important to review literature that may add insight into sociological and psychological elements that exist within the context of the clinical setting. Theories of learning, power, identity formation and enacted beliefs served as a lens through which our understanding of the meaning that OTAs make of their daily experiences was focused.

Learning Theories

Two learning theories reviewed are *communities of practice* (CoP) as described by Lave and Wenger (1991), Wenger (1998) and Wenger, McDermott and Snyder, (2002) and *social cognitive theory* as described by Bandura (1986). These theories each posit that

learning occurs within a social context through the interactions that individuals have with others and the environment. These suppositions also share additional commonalities such as the belief that learning results in development and transformation of the learner and, that the learner must be actively involved in the process whereby knowledge is constructed internally through reflection that follows engagement in activities external to the self. These views of learning are in contrast to other theories of knowledge acquisition such as operant conditioning described by Skinner, and drive reduction theory described by Hull. Both of these theories view learners as being dependent upon the receipt of externally derived rewards that reinforce behavior/learning (Kearsley, 2009). The theories to be discussed are congruent with both the social constructivist theoretical perspective that informs this study, and the study's focus that addresses novice practitioner learning within their workplace environment.

Communities of Practice. The concept of *communities of practice* (CoP) was originally described by Lave and Wenger (1991) and has since been expanded by Wenger (1998) and Wenger, McDermott and Synder (2002) who describe CoPs value to organizations as an educational and motivational entity through which like-minded individuals can join together to informally learn from and support each other. Communities of practice can either be formally planned and supported through the organization, or can be a spontaneous coming together that is not a formal part of the workplace. They are big or small, temporary or permanent, local or expansive and homogenous or heterogeneous (2002).

Background. According to Wenger et al. (2002), communities of practice are “groups

of people who share a concern, set of problems and passion about a topic and who deepen their knowledge and expertise by interacting on an ongoing basis” (p. 4). All communities of practice, despite the many varieties that exist, are each comprised of a basic structure that include a domain of knowledge, a community of people that care about the domain and shared practice that they are developed to be effective within their domain (Wenger, McDermott, & Snyder, 2002). Communities of practice are not purposed for purely pragmatic outcomes and should not be thought of as existing exclusively for this reason. They are about knowing and learning, but also about being together, living meaningfully the development of satisfying identity and generally, being human (Wenger et al., 2002).

Prior to further discussion about CoP, it should be noted that Wenger (1998) clearly states that he uses the term CoP as a point of entry to describe a broader conceptual social learning framework of which CoPs are a constitutive element. Wenger begins to ground his socially based theory of learning framework through sharing a set of basic assumptions that describe the nature of knowledge, knowing and knowers; they are summarized through the following four points:

1. We are social beings-far from being trivially true, this fact is a central aspect of learning.
2. Knowledge is a matter of competence with respect to valued expertise—such as singing in tune, discovering scientific facts, fixing machines, writing poetry, being convivial, growing up as a boy or a girl and so forth.
3. Knowing is a matter of participating in the pursuit of such enterprises, that is, of

active engagement in the world.

4. Meaning is our ability to experience the world and our engagement with it as meaningful—is ultimately what learning is to produce. (p. 4)

Wenger asserts that learning is what gives rise to communities of practice and therefore learning is a source of social structure (Wenger, 1998).

Wenger et al. go on to describe the necessity of social participation in learning. Participation is not just being present with others, but the actual process involved in participating in practices of the community and the development of an identity based upon these communities (2002). Additionally, they state that a social theory of learning must have substantial integration of the components that characterize social participation and the process of learning and knowing. The following are the components of Wenger's belief about learning occurring in practice:

1. Meaning: a way of talking about our (changing) ability—individually and collectively – to experience our life and the world as meaningful.
2. Practice: a way of talking about the shared historical and social resources, frameworks and perspectives that can sustain mutual engagement in action.
3. Community: a way of talking about the social configuration in which our enterprises are defined as worth pursuing and our participation is recognizable as competence.
4. Identity: a way of talking about how learning changes who we are, and creates personal histories of becoming, in the context of our communities. (p. 5)

Learning. Wenger (1998) believes that CoP should be thought of as shared histories of learning. He believes that the creation of meaning and ultimate transformation of personal and community identity is a temporal process that occurs in the time it takes for the mutual engagement of individuals to lead to significant learning or shared meaning making. There is no specific time frame in which learning must occur or time that a CoP must be in existence. In this sense, history and shared learning are dynamic combinations of the personal and collective experience of individuals and their interaction or reification with artifacts and institutions (Wenger, 1998). Wenger does not see learning as something that exists outside of practice or the community, learning is learning about practice itself while dwelling within the community.

Wenger describes learning through CoP as involving remembering and forgetting, as well as continuity and discontinuity; both dynamic states relying on the concepts of reification and participation. Reification refers to the investment in, and beliefs about, tools and artifacts that are used by communities of practice. These items perpetuate the knowledge and beliefs of the community. Even things, objects or beliefs that are known to be less than optimal, to either impair or stall community growth, continue to be used by a CoP because of the continuity and history that they represent. Participation refers to the willingness of people to take part in a CoP, to belong to this grouping. Some individuals are core members, others are active members and still others act out in the periphery.

CoPs can be active or inactive, and can also cease to exist or be created anew. Viable communities can leverage the power of their change and evolution through choosing

to maintain the status quo or choosing to set off in a new direction; to create new artifacts and new ways of knowing. CoPs that are faced with new members who bring in new ideas, or faced with external forces that challenge espoused beliefs, must change or risk becoming obsolete. Old ideas must be discarded by the community and new ideas and artifacts adopted. The tension that exists when change is called for will fuel the decision of the community to either move forward or to make sense of the new information so that it fits with old beliefs (Wenger, 1998; Wenger et al., 2002).

Individuals within CoPs interact with others and negotiate meaning with others through their identities as they exist within that context; formation of communities of practice is therefore a negotiation of identities. Identities are not static, they are constantly formed and changed over time; they do not follow a specific trajectory, but can respond to the context of the situation. Identities are further developed based upon the level of participation within the CoP and based upon where in the structure of the CoP the individual exists. Individuals belonging to multiple CoPs have several identities both within various communities as well as in life roles in general (Wenger, 1998; Wenger, et al., 2002). Although it is hard to transform quickly and radically in terms of ones identity when involved in a typical and slowly evolving CoP, it is equally difficult to evolve if not part of this type of dynamic system. CoPs are fueled by others, people who bring new ideas and new ways of knowing into the community from the periphery or neighboring communities (Wenger, 1998).

Fenwick (2000, 2003) uses the term *situated cognition* to describe learning that is

rooted in the situation in which the person participates. She believes, as do Wenger, Lave and others, that knowing and learning occur in a particular community and require active engagement in change processes. Knowledge, according to this perspective is described in a fashion very similar to Wenger's social theory of learning and states that knowledge creation is part of the very process of participation in the immediate situation (Fenwick, 2000, 2003). Situated cognition according to this description shares the common belief with constructionism that knowledge is constructed through interaction with other people within a social context. According to Crotty (2003), constructionism is constructivism with an emphasis on meaning making through social interaction and is also congruent with the theoretical perspective used for this study. One of the early constructivist theorists, Lev Vygotsky also described the theory of situated learning in the early 1900s; his work has contributed to the current situated theories as described by Lave and Wenger (Wolfson, & Willinsky, 1998). For the remainder of this discussion, the terms situative learning and situated cognition will be used interchangeably with the terms social theory of learning and communities of practice; each term referring to the belief that learning occurs in social situations through involvement in dynamic interactions with others.

Membership. Communities that arise spontaneously or from a grassroots movement will gain the membership of interested individuals who share a common domain, passion and area of practice (Wenger et al., 2002). Members can choose various roles and ways of interacting within the CoP based upon their choice, time commitment, belief in ability to contribute, and acceptance of ideas by the community. As stated previously, these levels of

participation are known as *core*, typically including *old timer* members and leaders, actively participating members who may be newer and not yet leaders, and peripheral members who participate but do not typically offer ideas or leadership. CoPs that are more formally created may actually interview individuals for membership and assign specific roles (Wenger, 2002).

Relationship to organizations. Communities of practice can share several types of relationships with the organizations in which they are found. These relationships include unrecognized, bootlegged, legitimized, supported and institutionalized (Wenger et al., 2002). Unrecognized CoPs are invisible to the organization and sometimes the members. This relationship creates difficulty with new membership and with valuing the contributions of the CoP. Bootlegged relationships are only visible to people “in the know” and make it difficult to obtain resources, have an impact and gain legitimacy. Legitimized relationships are officially sanctioned by the organization, but are challenged by rapid growth and higher demands and expectations. CoPs supported by organizations are provided with direct resources yet are challenged by scrutiny and accountability for the use of the resources, effort and time. Finally, institutionalized relationships are given official status and function within an organization, but can be challenged by over-management, a fixed definition, and living beyond their usefulness (Wenger et al., 2002).

Value of membership. Involvement in CoPs and resultant social or situative learning, offers value to the individual, and the organization. The value to the individual will be highlighted here and is divided into two types of value; improved experience of work and enhanced professional development. According to Wenger et al (2002), the following list

highlights the improved experience of work value:

1. Help with challenges.
2. Access to expertise.
3. Better able to contribute to team.
4. Confidence with one's approach to problems.
5. Fun of being with colleagues.
6. More meaningful participation.
7. Sense of belonging. (p. 16)

The value of enhanced professional development is found in the following points:

1. Forum for expanding skills and expertise.
2. Network for keeping abreast of a field.
3. Enhanced professional reputation.
4. Increased marketability and employability.
5. Strong sense of professional identity. (p. 16)

People work not only to earn a living, but to achieve a future state of self-actualization; to find meaning in life. To maximize the experience of work from both a day-to-day experience perspective and the larger professional growth and development perspective, can be of significant value to the working professional involved within a community of practice.

Critiques. The situated theories/theory of social learning have not been without critics who have cited these theories for their lack of attention to the details of how cognitive learning takes place and acceptance that learning can occur out of context. According to

Wolfson and Willinsky (1998), this critique by Anderson, Reder, and Simon (1996) is not well founded since situated learning theory does indeed accept the fact that learning can occur in various environments including the classroom and can occur without constant social interaction, as when listening to a lecture. The theory is not dismissive of the fact that learning itself occurs in the brain, and it does not purport to know how the brain creates knowledge; only that it can and indeed does so in meaningful and relevant social situations (Wolfson & Willinsky, 1998).

Learning theorists who adopt a constructivist perspective have argued that the situative claims are misguided and overstated in their insistence that knowledge is context dependent (Anderson, Reder, & Simon, 1996). These critics believe that learning must be thought of as being acquired based on the kind of knowledge and the way that the material is engaged in context. In other words, all learning experiences cannot be expected to lead to the same level or type of knowledge acquisition. Transfer of learning is also a concern with a situated perspective since learners have proved that they can master abstract knowledge in one context and apply this knowledge to a different context (Anderson et al., 1996). These critics believe that the key of education is to help people develop transfer skills during initial learning events and to remind and help learners in unfamiliar situations to adapt and apply concepts with which they are already familiar. Anderson et al. (1996) believe that what is important in learning is "the cognitive processes a problem evokes, and not what real world trappings it might have" (p. 9).

Contu and Willmott (2003) offer a critical perspective of situated learning that seeks

to pull out what they believe to be the implicit and important references to the forces of social power that contribute to the learning that occurs within communities of practice. According to these authors, Lave and Wenger did describe the influences of power upon workplace learning within their writings, but seemed to shy away from a critical view, choosing instead to focus on a more generic view of communities of practice that are power neutral (Contu & Willmott, 2003).

Contu and Willmott revisited the 1996 study conducted by Orr that looked at workplace learning practices of photocopier technicians. They critically viewed the results of this ethnography from the perspective of communities of practice and the influence that power had upon the identities of the technicians as they were formed within the context of work. Contu and Willmott found that despite the corporate power dictate (power) that standardized how photocopy machine fixing and customers should be approached (a rule that diminished technician autonomy and ownership of fixing a problem), the technicians created their own community of practice that was perpetuated by storytelling wherein they described their technical prowess and ability to fix machines. This storytelling enabled technicians to take back power through acknowledging the heroics of their problem solving abilities, thus reinforcing their status within their own communities of practice. This reclamation of power and building of community added to the learning of photocopier repair amongst members of the community in situ. In addition, it had the unexpected effect of creating satisfied customers and reinforcing the belief of the company that their restrictive tactics worked (Contu & Willmott, 2003).

This conceptual piece also highlights several references to various power dynamics that can occur within the context of communities of practice. One such reference is found within Lave and Wenger (1991, p. 42) and is the proposition that participation in work practices is shaped by hegemony over resources for learning and alienation. In the above scenario, the attempts of the company to codify knowledge actually limited the sense of autonomy experienced by the technician regarding knowledge of how to fix machines. This was not acceptable to the technicians who then went on to create their own knowledge and share it with others within the community through storytelling; this prevented alienation from the company from occurring.

Storberg-Walker (2008) also critiques Wenger's "theory" of communities of practice and does not believe that it meets the criteria of being an applied theory that can be used to explain practice or guide program creation with any certainty. Wenger himself reports that he believes his work on the social theory of learning and communities of practice to be most appropriate as a contribution to social theory--which he describes as being ill defined. He states that the purpose of his book "is not to propose a grandiose synthesis of ...intellectual traditions or a resolution of the debate they reflect; my goal is much more modest" (Wenger, 1998, p. 15).

Storberg-Walker (2008) found very specific instances of difficulty with the CoP literature when using a theory-building research analysis. Firstly, she found that Wenger's word choices and definitions were neither consistent nor specified to a level appropriate to be considered applied theory-building research. Secondly, she found that levels of analysis

issues are not adequately addressed or resolved by analytical components. Finally, Storberg-Walker states that “Wegner proposes a synthesis of disparate intellectual traditions, representing different levels of analysis, without specifically addressing the levels problems” (p. 568).

Summary. The purpose of this study was to explore how novice OTAs begin to understand their profession, form practice beliefs, subsequently select, and initiate certain treatment methods and approaches with clients while in the clinic. Understanding the learning that is situated within, and occurs through, communities of practice will enhance understanding of the roles that these communities play in the meaning making of the domain and execution of practice choices of novice clinicians (Contu & Willmott, 2003; Lave & Wenger, 1991; Wenger, McDermott, & Snyder, 2002).

Clinicians, of all types, by the nature of their chosen career, are continually engaged in exchanges with clients, families and other health care providers. On a day-to-day basis, professional and personal lessons are potentially learned through this social interaction and its inherent feedback. Newcomers to the healthcare context may join communities of practice already established within a facility, using them to learn the ways of knowing of the old timer and to contribute new ideas and understandings; healthcare providers learn their trade while interacting with others. Learning as a social entity does not happen as a phenomenon separate from the work setting; learning is about learning about work that occurs in the context of work.

Learning in the social context can either be a perpetuation of old thinking visited on a newcomer, or may be the learning of new ideas by old timers. Incorrect learning, or

perpetuation of old ideas through the learning of the newcomers may not be in the best interest of a profession that is hoping to initiate major long lasting change in practice habits and beliefs. From a critical perspective, the idea that bad habits can be learned is problematic. Critics have pointed out that unsupervised people learning in authentic environments may make due, finding ways to participate that actually reinforce negative practices that a community is trying to eliminate. Salomon and Perkins (1998) argue that people who are apprenticed in particular ways may pick up undesirable forms of practice, wrong values, or strategies that subvert or profoundly limit the collective and its participating individuals. Although this concern that may explain why novice OTAs make choices that do not represent their academic learning, it does not say that CoPs attempt to create specific learning experience for individuals or propose that only certain things should be learned by the learner.

Conversely, communities of practice change and evolve through the infusion of new ideas that are brought into play by outsiders entering the community (Lave & Wenger, 1991; Pare & LeMaistre, 2006; Wenger et al., 2002). Communities of practice respond to both internal and external forces that initiate change. Internally, a community changes by the infusion of newcomers who are forming meanings that are unique. Externally, communities must modify themselves to continue to fit into, and be supported within, the contexts in which they exist. Communities of practice can be designed for sustainability, to automatically account for and respond to changing environments and challenges (Wenger, 1998; Wenger et al., 2002).

Social Cognitive Theory. In his seminal text *Social Learning Theory*, Albert Bandura (1977b) provides us with a base understanding of what is meant by social learning and how it is informed by behavioral psychology and cognitive theory. Bandura believes that the best learning is that which occurs in social context, where actions can be modeled and feedback provided.

Background. This early theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences, but according to Pajares (2002), was missing an important and unifying element, self-beliefs. *Self-efficacy*, first described in 1977, now stands at the center of Bandura's *social cognitive theory* (Bandura, 1977a).

In his article *The Self-system in Reciprocal Determinism*, Bandura forwarded the concept of *reciprocal determinism* which is the belief that *personal factors* that include cognition, affect, and biological events, in addition to behavior and the environment, interact in ways that influence each other bi-directionally to create *triadic reciprocity* (Bandura, 1978; 1986; 1989). Bandura goes on to explain that these factors may not necessarily affect each other equally or simultaneously, and it may take time for a causal factor to exert its influence and thereby create reciprocal influence (Bandura, 1978; 1986; 1989). This new construct as well as the acknowledgment that self-efficacy drives the motivation for behavior, began the evolution of social learning theory into social cognitive theory.

In 1986, Bandura published *Social Foundations of Thought and Action: A Social*

Cognitive Theory and altered the label of his theory from social learning to social cognitive theory. This change in terminology emphasizes the notion that individuals are self-organizing, proactive, self-reflecting and self-regulating rather than reactive entities who behave as a result of, and at the mercy of, environmental forces or driven by concealed inner impulses. According to Bandura, people are able to construct reality, self-regulate, encode information, and choose to perform or not to perform behaviors. Accordingly, how people interpret the results of their own behavior informs and alters their environments and the personal factors they possess which, in turn, inform and alter subsequent behavior (Bandura, 1986; Pajares, 2002). Social cognitive theory is explicit in the guiding belief that humans create meaning through cognitive activity resulting from their inherent capacity to be reflective, form symbols, have forethought, learn vicariously from others and self-regulate (Bandura, 1986; Pajares, 2002).

Key aspects. The key aspects of this theory that most specifically speak to the phenomenon associated with growth and learning within health care setting are those of self-efficacy and reciprocal determinism. Firstly, the notion of *reciprocal determinism* describes the pyramid-like interplay of cognition, affect and human biology with behavior and the environment, and underscores the significance of the individual in thinking, reflecting, acting, growing and behaving within the context of the work. This can be linked with the idea that *people make sense of their own psychological processes by looking into their own conscious mind*, and supports the premise that the cognitive influence is strong. In healthcare, the context is rich with clinician created behaviors leading to specific, identifiable outcomes.

It is also rich with other professionals and clients who provide feedback and judgments on the behaviors of the new and experienced practitioner. The novice clinician can observe the actions of those with more experience and couple that knowledge with their personal interpretation and plan. Following this reflection, or looking into their conscious mind, behavior is created; the environment, that includes other clinicians and clients, provides the feedback that is then used to inform future behaviors.

Social cognitive theory describes the importance of all of the factors of reciprocal determinism in guiding learning and behavior; if one or more of the three are missing, appropriate learning cannot occur. For example, if a clinician administered a treatment that did not lead to a change within the environment, they would not receive feedback and therefore have anything upon which to base future choices, either to continue or to modify behavior. Additionally, if the practitioner did not think about the effects of their behavior, and perhaps modify according to feedback, they would be behaving as simple automatons, not as skilled professionals; they may potentially continue to administer treatments that are not effective. Lastly, if a clinician thinks of a treatment or method but does not carry through with the behavior in order to see the actual results, there can be no reflection and there can be no change in, or feedback from, the environment; what is thought to be learning is only a cognitive game that does not lead knowledge gain. Hence, as stated by Bandura, learning through experience within context requires the interrelated three attributes of the pyramid (1986).

Self-efficacy is at the center of the social cognitive theory and anchors the motivation to learn, change and attempt new behaviors. It is the engine that drives human interactions within their context, it is a person's judgment about their own capabilities to formulate and accomplish actions required for specific performances. These beliefs provide the foundation for motivation, well-being, and personal accomplishment; unless people believe that their actions can produce desired outcomes, they have little interest to act or persevere in a task (Bandura, 1978, 1986, 1989).

Self-efficacy is created through four avenues described as mastery experience, vicarious experience, social persuasion and physiological states. The first, *mastery experience* (enactive attainment), occurs when a person engages in a behavior and has authentic success with that behavior. In time, they will believe that they are capable of and responsible for the outcome. Once self-efficacy is achieved in one context through the mastery experience, it will generalize to other experiences (Bandura, 1978, 1986, 1989). In the context of the healthcare environment and the new OTA practitioners (for example), self-efficacy is at a minimum because the recent college graduate has only a few mastery experiences that were acquired during internship experiences while they were being closely supervised. Novice clinicians are likely to carefully observe the outcomes of their treatment choices and to put a great deal of stock in feedback from the context. If seasoned therapists do not embrace the type of approach used, their feedback may be of a negative vein that could ultimately diminish a sense of novice mastery.

Vicarious experience is the second avenue toward self-efficacy and involves observing others perceived to be similarly competent. People who are strongly influenced by vicarious experience typically are not certain of their own capabilities, have little prior experience and have strong sense of the social significance that the observed behavior held within the social structure (Bandura, 1978, 1986, 1989). In the case of the novice practitioner, observing the behaviors of other therapists who appear to be successful in the clinic will greatly influence their sense of self-efficacy if they make a point of planning to repeat what they have seen. Learning of negative behaviors can occur through vicarious experience because the choices are being made by what is seen and not by what is right or wrong.

Social persuasion, which includes verbal persuasion, can be effective in enhancing self-efficacy if it is perceived to be a realistic assessment of capabilities. Although not difficult to thwart perceived self-efficacy with words, it is difficult to convince someone with words along that they are successful (Bandura, 1978, 1986). If a new clinician is told that the approach that they learned in school is not realistic for the clinic, and they are verbally rewarded for using an approach more common to the context, self-efficacy will improve for the technique rewarded and diminish for the methods that are not embraced within the context.

The last avenue for achieving self-efficacy is *physiological states*. People who have a negative emotional reaction to a behavior will be less likely to continue with that behavior

(Bandura, 1978. 1986). Clinicians who have difficulty with self-efficacy and who are particularly vulnerable may have physiological symptoms of anxiety or pain if they feel that their choices are not embraced by others within the context. The anxiety produced would be enough to keep the new clinician from repeating the behavior in the future.

According to Bandura, environments and social systems influence human behavior through psychological mechanisms of the self-system that includes self-efficacy. Factors such as economic conditions, socioeconomic status, and educational and familial structures do not affect human behavior directly; instead, they affect it to the degree that they influence the intervening variable of aspirations, self-efficacy beliefs, personal standards, emotional states, and other self-regulatory influences. In other words, forward movement in social and cognitive development is not a factor of one or two isolated positive experiences from which learning a skill occurs, but is influenced by many conditions that exist in the environment (1986). It is the intertwining of the aforementioned environmental conditions with personal plans, values, sense of self and emotional states that control the motivation to seek learning experiences and then determine which learning experiences to attempt.

The fact that people have a sense of self-efficacy underpins the concept *that individuals are agents proactively engaged in their own development and can make things happen by their actions*. In other words, with self-efficacy, people have a sense of empowerment and will engage in behaviors and create experiences that enhance their personal growth; they are not afraid that they cannot do something or that bad things will happen to them.

Bandura also explains how change can be created in a work environment when new thoughts are brought into the context. He posits that human development is altered bidirectionally (Bandura, 1978, 1986, 1989). This may explain the influence that new clinicians could potentially have on the workplace, learning and change can occur in both directions. As novice clinicians enter a work environment they bring with them new ideas, paradigms and methods that others within that context will observe. As experienced clinicians vicariously observe the behaviors of the new clinician, in time they may see that new treatment methods can be equally effective in creating change in clients.

Core Themes of Learning Theories

The learning theories of situated learning, a social theory of learning occurring within communities of practice and social cognitive theory share many similarities as well as many differences in the concepts that form their theoretical perspectives. Similarities between the theories include: (a) recognition of the importance of the experience of the individual involved in the process of learning, (b) recognition of the importance of the social context in learning, (c) belief in the transformation of the learner as a result of the process, and (d) recognition of the role of motivation in the learning process. Differences between the theories include: (a) the explicit use of reflection in the process of learning, (b) differences in the view of motivation, and (c) different beliefs in movement of the learner from one social position to another.

One of the most notable similar themes present within the two theories is the recognition of the importance of the social experience of the individual involved in the process of learning.

Situated learning is based in the assumption that learning is not resultant from internalized knowledge, but of results from increasing participation in communities of practice, the learner acting on the world (Wenger, 1998; Wenger et al., 2002). Social cognitive theory also describes learning as occurring through interaction within a social context. Learners must engage in observations of and dialogues with others, and must themselves engage in behaviors for which the context will provide feedback (Bandura, 1986).

The importance of social context is explicitly described and a necessary component of situated learning and social learning. Both describe the roles of others in the learning process of the individual. In the case of situated learning, it is the social entity of the community of practice, with which the learner interacts in an effort to learn the morays of the culture of which he/she wishes to become an official and fully integrated part. Social cognitive theory involves interactions with others through vicarious observation, modeling of their behaviors, accepting feedback and engaging in the actual behaviors themselves within the context. The focus upon others within context and the environment as contributors to learning in the workplace are especially significant for those working in healthcare. Healthcare workers who operate as caregivers do not work in isolation at any time. Typically, another professional involved in the care of the client. If not, the clients themselves become the provider of feedback for the healthcare worker.

Both theories describe the learner as undergoing a transformation resulting from the knowledge they acquire. One outcome of the social theory of learning is that the learner is 'transformed' from a novice to an expert, from newcomer to old-timer. Transformation in

this sense is accomplished when the newcomer forms an identity within the culture of the CoP and interacts with actively or observes practice from the periphery. Social learning theory also implicitly supports the notion that individual transformation occurs as a result of the engagement in thought, action and behavior over and over within the social context (Bandura, 1978). Most healthcare professionals, including occupational therapy professionals, view themselves as practitioners who are moving along a continuum of professional growth from novice to expert. For this group of workers, the idea of transformation is a comfortable theoretical fit as change is integral to their professional growth.

Finally, each theory deals with the issue of motivation for learning, the drive to continue to engage in context in order for change to occur. The situational/social theory of learning model describes the inherent desire or mandated role to become a participant within the community of practice. Social cognition relies on the concept of self-efficacy to describe motivation; when an individual feels confident in their ability to engage in appropriate and successful behaviors, they will be interested in repeating those behaviors. Healthcare providers are taught in academia and may literally take an oath concerning their responsibility to gain and maintain professional competence. For this group, motivation for learning and development can be assumed to be an intrinsic factor, which is in keeping with the tenets of these learning theories.

A focus on the differing characteristics of the learning theories assists us in determining which theories are a good conceptual fit when trying to understand the

phenomenon of learning in the healthcare environment. One difference between the theories is in the area of reflection/reflective learning. Although each describes the learner as a constructor of knowledge, who must consider and think about previous actions and the associated feedback to determine the most appropriate future behavior, both only briefly delve into reflection as a mechanism through which learning occurs, and both have a different frame for this process.

Within situated/social theory of learning, reflection is implied as a mechanism through which novices begin to understand the community and the lessons to be taken as they move from peripheral participation to full old-timer status. Reflection is also briefly mentioned by Lave and Wenger (1991) as the mechanism through which old-timers learn through novices who bring new perspectives to the community. Social learning theory on the other hand, does not describe a process of reflective thinking that leads to learning, but does describe the learners' capabilities for self-reactive influence. This type of reflective/reflexive process involves the learner creating an internal set of performance standards and then evaluating their own actions and outcomes in relation to these standards. A type of feedback loop, the outcomes of this reflective process will lead to a decision regarding future behaviors (Bandura, 1986).

Differences in the view of motivation also exist between the theories. Despite that fact that both see motivation as existing within the learner, social cognitive theory has identified a structure that explains the phenomenon of motivation and entities that influences it such as emotional regulation and persuasion on self-efficacy and ultimately learning. This

is in contrast to situated learning theory that makes only brief mention of factors that enhance or diminish motivation, choosing instead to view it as a necessary attribute that should and will exist within the learner given an interactive environment.

Situated learning is the theory that has the greatest focus on the movement of the learner from one social position to another. Through legitimate social participation, learners gain knowledge and experience and identity within a community of practice until they become part of the community. This is a desirable state for the learners and describes the experience of health care providers, especially occupational therapy practitioners who describe professional growth as the transition from novice to expert practitioner. Despite references to personal and professional transformation, social learning does not describe actual movement of the person within the social structure, simply the concept of internal change leading to behavioral change. In reality, the internal change accompanied by a change in professional position within the context is the most intuitively realistic within healthcare.

Each of the theories described contribute to our understanding of how health care professionals learn informally through active engagement within the context of the work environment. Although there are some differences between the theories, they both address the constructs of the environment, learner experience, motivation and growth inherent in the learning process. These constructs will be used for data coding and analysis.

Power

Based upon interdependence theories, which are the logical analysis of the structure of interpersonal situations (Rusbult, & Van Lange, 2003), social power is described by

several contemporary scholars (including French, Raven and Yukl) as asymmetrical control over another's desired outcomes. Such outcomes may be tangible, such as economic outcomes, or intangible such as approval seeking. This particular definition highlights one belief that power is unidirectional and points to the inherent lack of control that subordinates have over those in powerful positions (Goodwin, 2003).

French and Raven (1959) described five types, or bases, of social power found within organizations. The five bases are expert, referent, coercive, reward, and legitimate power, and are contained within the overarching categories of formal power and personal power. Yukl, a published scholar, author and professor at SUNY Albany has studied the areas of organizational theory including power and influence, training and development, and leadership. He has added to the empirical understanding of the five bases of power by describing and publishing the additional concepts of information power and ecological power (2009).

The taxonomy of these bases of power has been used by several authors as a framework to describe the power that individuals within social context have over others. In addition, the taxonomy of *influence tactics* can serve as an added method of framing and understanding the ways in which those in power positions actually exert control over other individuals. Influence tactics are the techniques used by those with power to exert control over subordinates.

Three expected outcomes of influence are described by Yukl and include commitment, compliance and possible resistance. These three expected outcomes can be combined with

one or more *processes* that lead to the actions of commitment, compliance or resistance. These three processes are instrumental compliance, where the subordinate carries out a request in the hope of receiving a reward or avoiding punishment; internalization, subordinate compliance resulting from the internal belief that the required action corresponds to their values and belief system and is therefore desirable and; personal identification, where the subordinate desires to please the power holder for acceptance and esteem (2009).

For the purposes of this study, the bases of power, influence tactics, outcomes and processes will be utilized as a framework through which to better understand the forces occurring within the workplace that may inform the learning of novice OTAs. Several of the contemporary authors to be highlighted in this section write about power dynamics inherent in the workplace, either eluding to or explicitly making reference to bases of power and influence tactics.

Bases of power. As stated above, the bases of power can be divided into two groups. The first grouping being formal power and the second being personal power.

Formal power. This division refers to power that is held as a result of someone's position within an organization and that can be used to exert control either by coercion (fear), through reward system (financial and non-financial), through legitimate power (formal authority), information power (controlling access to information) and ecological power (control over the physical environment). In the healthcare environment, formal power is the most understood and easily accepted form of power because it is transparent and defined (French & Raven, 1959).

In the healthcare environment of today, most practitioners are held to certain productivity standards, work hours, quality in care provision and currency in knowledge base. The formal supervisor influences the adherence to the standards of the context through coercive measures, financial rewards and formal authority. In other words, newcomers will not typically ask questions, but simply do as they are told by ‘bosses’ to avoid punishment, and will then seek raises during annual evaluation time for a job well done (according to workplace standards). They will also behave and not behave in certain ways fearing the consequences of negative feedback from authority figures which could affect their sense of self-efficacy and standing within the professional and social dimensions of the workplace.

Although seemingly a negative relationship based on punitive consequences, when competent managers execute formal supervision, the newcomer can easily negotiate the terrain; they will understand their power and limitations and will abide by the organizational demands. Even in cases of apprenticeships where a master may make seemingly harsh demands upon a novice, the power dynamic is not considered problematic (Lave & Wenger, 1991). This notion is reinforced by Clouder and Sellars (2004) who posit that formalized supervision and surveillance can be effective when created to allow for learning and to enhance practice.

According to Wenger (1998), power is neither good nor evil but is energy that can be used for both. In the workplace, novice individuals can use power of alignment to enhance their own influence by becoming an astute follower of the mission and rules. Through the lens of situated and social learning, working to become aligned with power sources is a

realistic goal that can be accomplished through observation, reflection, modeling, and collaboration (Bandura, 1986; Lave & Wenger, 1991). Alignment is also a desirable transformative step for the professional who seeks to gain both personal and formal power within an organization on their way to becoming an old-timer.

The power held within communities of practice can also be of benefit to the newcomer who seeks stability and security in the workplace. Despite the fact that some healthcare providers may aspire to become independent practitioners who own and operate their own businesses (therapists, physicians, audiologists), there is consistency and safety to be found in the formal structure of a healthcare facility. As described by Wenger, an enterprise cannot be fully mandated to behave a certain way by an outside entity. When faced with a directive, the community will rise in response and will respond as a collective whole in the best interest of the community (Wenger, 1993, p. 80). There is power in numbers.

Of course, the formal power found within organizations can also be used for gain that is not altruistic in nature. Healthcare work settings are no exception to this despite the fact that their typical operational mission is to provide care for sick and injured people. Profit or not-for-profit organizations existing within capitalistic cultures are primarily concerned with profitability either to make money for shareholders or to sustain operations. Formal power in settings that seek to turn a profit may appear to be interested in the needs and growth of the individual, but instead may be interested in their growth only insofar as the productivity and growth of the organization will be positively affected (Fenwick, 2008).

Despite the interest the newcomer has in learning the organizational culture, working hard and 'playing by the rules' to gain knowledge and old-timer status, the ultimate goals of the organizational agenda may either support or limit the experience of the individual. Power relationships within a workplace can actually impede or deny access to an individual; the same power forces that can grant entry to the in-group (Contu & Willmott, 2003). In the meantime, as the newcomer works through this covert hegemonic behavior, the company benefits from the efforts of a hard working individual (Hogan, 2002).

Critical culture theory as discussed by Fenwick (2008) can be used as a lens to discuss the influence of this type of overt power over the individual as well as power plays that may be much less apparent. It should be understood that use of power as a means of controlling behavior does not occur by accident in the organizational environment. A study conducted by Enns and McFarlin that investigated methods of persuasion used by corporate executives seeking to encourage individual change, openly describes tactics purposefully used by the executives. These methods called for use of personal power in addition to formal power and included techniques such as using a consultative approach with employees to give them a sense of inclusion, personal persuasion to drive home the notion that the organization and the individual share the same values and overall goals and role modeling (2003). These techniques are identifiable, openly acknowledged and formally developed.

Wenger also describes a potential for negative consequences from organizational power dynamics with regard to the values of the organization and its interest in embracing ideas that are divergent. This can be driven by the value of profitability or a cultural value

that legitimately exists within the organization (1998).

Personal power. The second category of power is possessed by individuals within organizations. Personal power comes from individuals' unique characteristics, not from their official position within a workplace. Expert power, a type of personal power comes from the knowledge or special skill possessed by the individual (French & Raven, 1959). According to Robbins and Judge, this type of power is becoming one of the most influential within the workplace of today due to the increasingly technical nature of jobs (2008). In a healthcare setting, this type of power can be seen between intern and resident physicians when the new doctors literally chase after the expert old-timers as they quickly walk down the hallway describing patient symptoms, asking questions of and giving feedback to the new comers.

Referent power, the second type of personal power refers to the influence exerted by those who are held in esteem based upon personal traits. If workers want to please a person within the work setting because they respect or admire qualities about them, the admired individual is able to exert influence, to have power over the workers' decisions and actions (French & Raven, 1959).

In healthcare, this form of power can be seen in the relationship between new comers and those who have worked within the setting for a long period. Personal power can be used to the advantage of the novice or newcomer in a manner similar to aligning oneself with the known formal power holder, novices can also align themselves with and model the behaviors of those with personal power including both expert and referent. According to Robbins and Judge, personal power is actually a more powerful form of influence over others than formal

power. Formal power is much more likely to fail and much less likely to be sought after when coercive methods becomes detrimental, such as when an annual evaluation does not yield the hoped for results (2008).

The newcomer may observe the power and influence held by a popular co-worker, or the respect given to an expert clinician. If they choose, they can work toward their personal and professional status transformation through observation and behaving in a manner similar to the powerful individual. According to Pare and LeMaistre (2006), the ability to change the power relationship can be accomplished by the newcomer through social interactions that they may seek within either the work setting (e.g. eating lunch with the powerful individual) or outside of the work setting (e.g. attending social and educational events that will be attended by the power holder) or both.

The power possessed by the newcomer lies in their ability to make the conscious decision to become involved, to seek experiences, to engage with peers and be present during all workplace events. According to van de Wiel, Szegedi and Weggeman (2004), it is not talent, but hard work, a stimulating environment and motivation that determine growth and change in the novice. By making personal connections they will not only gain referent power, but will also gain expert power more expediently through modeling and active reflection, this will likely prepare them for future acquisition of legitimate power (Pare & LeMaistre, 2006).

The inner strength to take the perceived risk of putting oneself 'out there' with old-timers requires that new comers possess a certain level of self-efficacy. As described by Bandura (1986), self-efficacy is best obtained through self-mastery of a behavior; the caveat

being that if one does not become engaged, they will not learn that they can be successful. Doing is thus becoming.

Influence tactics. Influence tactics described by Yukl (2009) are those tactics that are used by power holders to gain compliance from others. Van Knippenberg and van Knippenberg define influence tactics as the way in which power can be used to get something done, and describe them as being proactive behavioral actions that are taken to change the attitudes, beliefs and behaviors of others (2003). As described above, when a person holding positional power makes a demand on a subordinate, the typical subordinate response is to do the task. However, in situations where formal power is not in play, a person interested in exerting power must use influence tactics, which often involve language, to obtain the desired result. Yukl (2009) describes eleven influence tactics. These include:

1. Rational persuasion: the use of logical arguments and factual evidence to support need for request to be carried out.
2. Apprising: explaining how completing the task will benefit the individual personally or professionally.
3. Inspirational appeals: target the emotions of an individual to gain compliance with the request.
4. Consultation: requests for help of the subordinate to gain buy in.
5. Exchange: exchange of favors and incentives.
6. Collaboration: promise to provide help and resources if task is undertaken.
7. Personal appeals: asks for compliance as a personal favor.

8. Ingratiation: Praise and flattery used to gain compliance.
9. Legitimizing tactics: refers to rules, policies and documents to make request legitimate.
10. Pressure: use of demands, threats and constant reminders.
11. Coalition tactics: use of others to persuade the individual to act or use of support of others as a reason for agreement to do task. (p. 160)

Power bases and influence tactics provide a basis for understanding from where power arises and how power is used. They allow us to more easily understand and anticipate the outcomes associated with combining power bases and influence tactics; these outcomes are commitment, compliance or resistance. The processes through which the subordinate arrives at commitment, compliance or resistance were previously described as instrumental compliance, where the subordinate carries out a request in the hope of receiving a reward or avoiding punishment; internalization, where subordinate compliance results from the internal belief that the required action corresponds to their values and belief system and is therefore desirable and; personal identification, where the subordinate desires to please the power holder for acceptance and esteem (2009).

Further investigation is required to determine the conduit through which power is exercised and by whom can power be exercised. For power to have a role in the meaning making of novice practitioners, it must have a means of being transmitted that is understood either overtly or tacitly by the individuals involved in the community of practice or workplace context.

Several authors (Mackey, 2007; Reid & Ng, 2003; Wenger, 1998) describe the mechanism through which individuals make common meaning and communicate within their context as *discourse*. Mackey defines discourses as “languages, representations and practices . . . they consist of a set of common assumptions that, although rarely consciously recognized, provides the basis for fields of knowledge. Discourses do not identify objects, they create and constitute them” (Mackey, 2007. p. 97). This definition is furthered by Wegner who goes on to posit that “discourses can be imported or exported across boundaries, and reinterpreted and adapted in the process of being adopted within various practices” (Wenger, 1998, p. 129). This statement highlights the nature of discourse and the power it represents. It is used as a tool; taking on the meaning (knowledge) ascribed to it, and understood by those within the context in question.

Mackey (2007), through the lens of Michal Foucault believes that discourses are imbedded with knowledge that creates and holds power, and that the power it holds is contextually based, operating within a particular society at a particular time. Foucault believed that power is not possessed, centralized or oppressive, but is instead, exercised by many simultaneously. Butler (2001) reminds us that Foucault believed that power is everywhere and that it is created moment by moment and at every point and every relation. As a means of expressing his notions of governmentality, Foucault described four technologies that are each associated with a type of domination:

1. Technologies of production, which permit us to produce, transform and manipulate things.

2. Technologies of sign systems, which permit us to use signs, meanings, symbols or signification.
3. Technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject.
4. Technologies of the self, which permit individuals to effect their own means or with the help of others a certain number of operations on their own bodies and souls, thought, conduct and way of being so as to transform themselves in order to attain a state of happiness, purity, wisdom, perfection, or immortality.
(Butler, 2001, p. 68)

The fourth technology highlights the proposition that individuals have the ability to be self-dominating; that, through the use of discourse (with the help of others) and reflexivity create their own state of being. Recalling from the previous discussion that one of the outcomes of a power relationship is resistance, it is understood that an individual can resist the power influences inherent in work relationships with others by changing the power dynamic to power over themselves and the choices that they make (Mackey, 2007).

This notion is challenged by the writings of Wenger who sees the dual nature of power and believes that one is constantly striving to belong to a group of others in order to find meaning, but is also constantly working to maintain personal power (Wenger, 1998). From this perspective, the power discourse that is always present in social contexts, such as work environments, cannot be completely silenced, but must be constantly negotiated to avoid marginalization.

The discussion above assumes that power relations are overt and understood by all individuals, it is the means of negotiating the relationships that must be learned. However, this study will also seek to understand if the novice OTA is aware of the power within the workplace, or if these forces are perhaps more covert, are hidden and therefore are able to control individuals without challenge or question. In the educational setting, this covert power dynamic is known as the hidden agenda and must be acknowledged and made obvious before change can occur (Johnson-Bailey, 2001). This may also be the case for the novice clinician who is unaware of the power dynamic that impacts their meaning making. This study hopes to make power dynamics inherent in the workplace explicit, using the framework of power bases, influence tactics, processes and outcomes while understanding the discourse that drives the relationships with work communities.

Theories of Identity

In addition to learning theory literature that describes the social and contextual nature of learning, and theories of power that reinforce the notion that human engagement occurs in a field of formal, personal and political power dynamics, theories of identity also enhance understanding of the ways in which individuals form their outward and internal *selves*. A belief in the concept of a stable yet dynamic identity that allows the individual to choose some attributes and behaviors as belonging to their respective *self*, and others as not (depending upon the circumstance), has been described in the literature since James in 1892 (Hitlin, 2003). More recently, identity has been discussed from the perspectives of both psychology and sociology but also has roots in the literature of social science, education,

psychoanalysis, history and political science (Stryker & Burke, 2000). This literature review will focus upon the psychological and sociological psychological perspectives of identity theory as it relates to the context of work and communities of practice.

In the psychology literature, the concept of identity is termed social identity theory and from the sociological perspective simply, identity theory. According to Hogg, Terry and White (1995), identity theory is a microsociological theory that explains role related behaviors of individuals whereas social identity theory, a social psychological theory, is useful in explaining group processes and inter-group relationships. Although differing in several basic constructs resulting from the guiding paradigms, there are many similarities between these two theories that have been addressed in related literature. The following literature review will discuss identity theory from both perspectives. This study engages identity theory as a combination of the two perspectives.

Identity theory. Identity theory, originally formulated by Stryker and Stryker and Serpe (Hogg, Terry, & White, 1995), views identity as an organized and multifaceted construct that is a reflection of society. The impact that identities have upon society occur through the notions of identity salience and role identities. Role identities are considered a product of social interaction through the construct of symbolic interaction, according to Mead and Cooley (as cited in Hogg et al., 1995). Burke and Thoits (as cited in Hogg et al., 1995) further define them as self-conceptions, self-referent cognitions and self-definitions that people apply to themselves as a consequence of the structural positions that they occupy (p. 256). Role identities provide meaning for the self because they provide needed structure

and understanding of social standing, they also provide a recipe for actions that should be undertaken by the individual in a given social situation (Stryker & Burke, 2000). This notion fits well with the ideas of coming to belong to a community of practice as described by Wegner (1998).

Role salience, another concept inherent in identity theory speaks to the idea that some roles are more relevant than others are, and that roles are conceptually placed on a hierarchy in the mind of the individual. There are critics of this notion, for example Stryker who argues that the choice to behave according to one context or another is more of a behavioral tendency than a psychological one (Hogg et al., 1995). Regardless of the underlying mechanism for its existence, the notion of identity salience may account for the differences in behavior displayed by individuals within the same context. It is their own personal hierarchy of their roles and responsibilities within that context that drive their behaviors (Hogg, et al., 1995). For example, within a health care environment, two nurses may choose to behave in two different ways when interacting with a physician. A nurse who is hoping for a good report of his/her teamwork skills due to a desire for a promotion may respond immediately to a physicians request and even anticipate requests. A nurse who does not have the desire for promotion at the top of his/her hierarchy may respond in a more typical manner and complete requests within the order that they were received.

Role salience also affects commitment to a group; two types of commitment described by Stryker (1980) are interactional commitment, which indicated the number of roles associated with a particular contextual identity, and affective commitment referring to

the importance that a particular role holds for an individual. The higher the affective commitment, the higher salience that role holds for the individual.

Social identity theory. Social identity theory is a social psychology theory that describes intergroup relations, group process and the social self (Hogg, et al., 1995). According to Hogg et al., Henri Tajfel was one of the first to describe the impact of racism, prejudice and discrimination upon identity development. An evolving theory, social identity theory describes the category into which one falls (political, nationality, sports team, etc.), and to which one feels belonging and provides a definition of who one is in terms of the characteristics of that category (p. 259). Self-categorization is a defining belief of social identity theory where individuals view belonging as being to either an in-group or an out-group. Based upon the meaning ascribed to their personal sense of belonging, an individual will engage in behaviors that create their roles within an in-group. These beliefs and behaviors will be in contrast to being a member of an out-group; the individual and the context in which they exist (Hogg et al., 1995; Howard, 2000; Reicher, 2004) determine the in-ness or out-ness of a group.

Similarities. Both theories of identity, social identity theory and identity theory, are congruent with the paradigm of social constructivism used within this study because both espouse the notion that the self is socially constructed and that it exists within the context of the individual. This thinking is in contrast to a purely cognitivist perspective that focuses on internal cognitive structures and their transformation through the communication of information (Wenger, 1998). An additional similarity lies in the belief that the individual

organizes behavior into meaningful units. These units are either described by roles (identity theory) or norms, stereotypes and prototypes (social identity); both espousing the notion that multiple self-identities are interrelated in various important ways (Hogg et al., 1995). A third similarity found in the beliefs of both theories is that identities do indeed define the self. Social identity theory describes this as social identification and self-categorization whereas identity theory describes the naming of oneself as a member of a social category or commitment (Hogg, et al. 1995).

Differences. Several differences are found between these two theories and stem for the most part from the different schools of thought that underpin them. For example, social identity theory that stems from psychology more strongly emphasizes the cognitive processes responsible for the creation of the self. In contrast, when addressing identity theory, Burke (1991) describes a dissonance-reduction process in which the self, as a cybernetic control mechanism, is motivated to bring the self-concept into line with others as they behave with the group.

Differences are also found in the dynamic and changeable nature of the self. Identity theory, due to the belief that the individual changes to alleviate dissonance is considered much more dynamic and changeable than social identity theory that relies on the slower evolution of role position within a group (Hogg et al., 1995). Intergroup behavior is yet another difference between the theories where identity theory focuses more upon role behavior and social identity focuses more on the socially significant forms of identity that come from belonging to a larger group (Hogg, et al., 1995).

Relationship to work context. The remainder of the literature reviewed will address identity formation as a combination of the theoretical perspectives of identity theory and social identity theory. In a study that sought to tie the two theories together with a common core, Hitlin (2003) found evidence to support his notion that the personal values of an individual drive the decisions that they make regarding role and group identity. He posits that our values shape our personal identities, which in turn cause us to choose certain groups and roles. The behaviors that we engage in due to these roles cause us reflect upon our values that in turn drive either a change in values or a change in role or group identity. His findings, although self-admittedly limited to being a starting point in the discourse, suggest that indeed, personal values can underpin the roles and social identities that individuals chose and that these values can be a stable force as the individual takes on many roles and many identities across the many domains that they find in their life (Hitlin, 2003). This information has significance for a study that sought to understand meaning making with regard to identity. Professional values, having been instilled within novice practitioners during their academic experience have a role to play within the meaning-making phenomenon.

Wenger speaks of identity development as it is connected to building communities of practice. According to Wenger, participants in a community must share common beliefs and traits when in the context of that setting. Whether spoken or unspoken, individuals within communities of practice share common ways of being that identify them as a part of the community. Communities of practice are therefore a negotiation of identities, especially for a new comer who is trying to become a member of the community (Wenger, 1998, p. 149).

Identities are the construction of the self through the negotiation of meaning within context.

As a means of summary of the characteristics of identities within practice, Wenger offers the following five attributes:

1. Identity is a negotiated experience.
2. Identify is membership within a community.
3. Identity is a learning trajectory, people define who they are by where they have been and where they are going.
4. Identity involves membership within multiple contexts.
5. Identity is a relation between that which is local and that which is global.

(p. 148)

Wenger (1998) also describes the negotiation of identity as having a power component, power relationships are highly intricate as they exist within the community and are often implicit. According to Wenger, to identify with a group yet have no say in the negotiation of that identity equates to powerlessness and vulnerability. Conversely, the ability to negotiate, but to gain no identity, is empty power; it is meaningless (p. 208). For real power to exist for an individual, the concepts of negotiation and identity must co-exist.

Fenwick describes the workplace as a powerful site of identity formation. She quotes Chappell et al. who describe the construction of our identity through the discursive practices in which we speak and that in turn speak to us (as cited in Fenwick, 2008). She believes that the individuals' sense of their own knowledge of work and the value held by the group within which they belong is a strong element in identity. This manner of work identity requires

learning and for workers to figure out their position within an organization. As with theories of identity and social identity, Fenwick sees the self as being able to fit into multiple contexts and to use multiple identities (Fenwick, 2008).

Ibarra (1999) describes a professional identity that is relatively stable. She is critical of identity theory that describes a morphing of identity to fit changing context in the workplace and instead believes that individuals go through a period of adaptation, where they use provisional selves, when work situations change. Following the adaptation, the provisional self is discarded and the individual returns to a relatively static identity within the relatively static demands of their role (Ibarra, 1999). This notion can also be applied to the health care setting where professionals take upon different roles within a context that still require use of their professional skills and identities but in a slightly different way. An example may be the therapy practitioner who advances to the level of a unit manager. Despite differing expectations of the job, the individual will still identify with their role as a clinician, simply adapting to the new position and adding attributes to their sense of self as needed. An entirely new identity for this change is not required.

Espoused versus Enacted Beliefs

Learning, understanding and being able to apply what you believe and understand are all components of becoming a practitioner of a craft, a competent doer of a trade, profession or hobby. Unfortunately, it is possible to have learned knowledge and beliefs of a topic without the ability to utilize them in actual practice. Argyris and Schön (1974) described these concepts as theories of action and theories in use, where theories of action are the

espoused theories or the beliefs and knowledge that a person has, and theories in use are the actual ways in which they behave or conduct practice.

According to Argyris and Schön, when someone is asked about how they would respond in a certain situation, the answer they give is their espoused theory of action for that situation. This is the theory of action to which they give allegiance, and which, upon request, they communicate to others. The theory that actually creates actions is the theory-in-use or enacted theory, which may or may not be compatible with the espoused theory. The person performing the task may or may not be aware that the theories do not match up or that they may, in fact, be incompatible, leading to a gap between that which is believed and that which is done. Theories in use or espoused theories cannot be determined by asking the person, they must be constructed from observations of behavior (1974).

The significance of the concepts of espoused versus enacted theories for this study lie in the discussion of the gap that may exist between the beliefs of the novice OTA and their actual practice of the profession of occupational therapy. To better understand how this gap is created, found to exist and remedied, we will first describe the concepts of theories of action and theories in use more specifically.

Theory of action. A theory of action describes a deliberate human behavior, the behavior that the individual believes that they will engage in when practicing the profession or skill in question. A theory of action can be used to explain or predict behavior when congruence exists between that which is espoused and that which is enacted. Theories of action must be related to theories of practice which are a sequence of actions actually undertaken by a person.

Theories of action are highly complex and interwoven concepts that contain many variables used to enact consistent behavior when in the context of the ever changing social and professional landscape. In fact, that these concepts are described as concepts and theories and not facts or truths because of the necessary flexibility required in order for the individual to maintain an even keel of beliefs while making a adjustments for inconsistencies in the environment. Without flexibility, an espoused theory would become useless if the world in which to enact that theory was significantly modified. Nonetheless, the variables of espoused theories should be internally consistent with each other, theories that are held with multiple conflicting variables will be difficult to enact. In addition, theories of action must be compatible with the profession or practice (Argyris & Schön, 1974).

Theories in use. Learning a theory of action so as to become competent in a profession does not consist of learning to recite a theory; the theory of action has not been learned in the most important sense unless it can be enacted or used in practice. As with theories of action beginning comprised of many beliefs and variables, all theories in use include assumptions about self, others, the situation and the connections among action, consequence and situation. They also include knowledge about the behavior of physical objects, and making and use of artifacts, the marketplace, organizations, and every other domain of human activity. Each profession contains a set of grounding beliefs and the knowledge of how to actually apply these beliefs in practice (Argyris & Schön, 1974). In the case of the novice OTA, the focus of this study, the espoused theory would be knowledge of the tenets of OT learned in the academic setting, and their actual application as part of the

process of treatment implementation.

Testing enacting versus espoused beliefs. In order to determine if there is congruence between the theory of action held by an individual and their enacting of that theory, the behavior that should be driven by the theory of action must be observed by an outside entity. This entity can be another person who is able to make objective observations of behavior, or the individual themselves. In order for the individual to assess their own congruence, they must be able to separate themselves from the situation and engage in reflexive practice (Schön, 1987). Reflexive practice is the ability of the individual to take a critical look at their behaviors, compare the behaviors to their espoused beliefs, determine if there is incongruence and then make changes to either the behavior or the belief that the hold guiding their practice (Schön, 1987). This process can be difficult for some individuals who become defensive or protective of their actions and do not see the benefit of enhancing congruence. Vella (2002) refers to the process of reflection in action as *praxis*. Unlike simply practicing a task, praxis occurs when individuals engaged in a task are also actively in the process of inductive or deductive reasoning about the task. Praxis and reflexive practice are necessary for an individual to observe their own behavior and make changes to that behavior in order to gain congruence between espoused and enacted beliefs.

Challenges to enacting espoused beliefs. It is possible, according to Argyris and Schön (1974), for some people to have strong espoused beliefs that they cannot, for some reason, use in practice. Despite the fact that theories in use must be observed in order to test congruence with theories of action, it is possible that this cannot be done if an outside social

or political force is making it impossible for the individual to enact their beliefs. In order to determine congruence in this situation, the individual must be able to articulate in detail the tacit information they possess about the task that would be enacted. This is the process of making the implicit, or tacit, explicit and can be used to test how a person will behave when actual behavior is limited by outside forces. This situation may be occurring with novice OTAs who are unable to conduct the type of OT that they have learned and espouse, if outside sources of power are dictating how they believe practice should be enacted. In this case, a practitioner should be able to clearly describe their beliefs and how they see them in practice; making the tacit explicit.

Maben, Latter and Macleod-Clark (2006) describe the phenomenon of tacit knowledge being blocked from becoming theories- in -use in a study involving newly qualified nurses in the United Kingdom. New nurses were able to identify their beliefs about practice, which were congruent with those taught in their academic program. Unfortunately, pressure from peers and managers made it impossible for them to practice nursing according to these beliefs. In a similar study, Clouder (2003) also found that health care providers were able to articulate their tacit and espoused beliefs, yet were not able to use these theories in practice due to work and political influences.

Information gaps. An information gap is said to exist when there is a difference between the tacit knowledge and the explicit knowledge held by an individual (Argyris & Schön, 1974). However, it is possible for an individual to hold beliefs tacitly and be unable to put those beliefs into words. An example of such an occurrence is the case of an expert

therapist who knows exactly how much to challenge a client with a task, but when asked how they make this determination, they are unable to pinpoint the variables that lead to their decision making.

The importance of seeing differences. Understanding theories of action and how they are manifested in behaviors helps the individual to make choices in, and modifications to, performance that is needed to help achieve desired outcomes. Because there are so many facets to and details of the situation being addressed, individuals must have a strong understanding of their beliefs in order to create priorities and chose the best direction for the moment. Sometimes when challenges occur they significantly impact a desired outcome. In such a situation, when a choice must be made to either get a certain outcome or maintain a theory in use based upon espoused beliefs, the belief will be kept whole and the outcome will be compromised (Argyris & Schön, 1974). This phenomenon may apply to the novice OTA who would choose reductionist practice when they state that they are occupation-based. They are more likely to maintain an espoused belief and sacrifice outcomes through use of reductionist practice than to change the espoused belief itself. In this case, congruence would not be observed between espoused and enacted beliefs despite the knowledge of this fact on the part of the individual. In a different scenario, OTAs who claim to be occupation-based but who are not, may be observed switching practice habits and espoused beliefs to a reductionist perspective when outside forces make real occupation-based practice too difficult.

For learning, change, and professional growth, the disconnect between espoused and

enacted beliefs must be recognized. It is through the ensuing cognitive discord that the stage is set to change behavior. Conflicts between espoused theories and theories in use eventually become dilemmas when they start to affect the self-concept of the individual. When the discomfort becomes great enough to overcome the tendency to rationalize and ignore the incongruence, change will be prompted. A dilemma may exist long before it is addressed. Unfortunately, most people do not think about theories in use. As stated previously, this is the process of reflexivity or praxis; individuals must be cognizant of the fact that their actions may be skewed and then be willing to look closely at this in order to effect change. In the bigger picture, learners should be confident in their theories in use, but at the same time be willing to question them. It is only through having a strong and accurate espoused belief system, that has been reflectively determined to lead to the behavior required for successful outcomes in practice, that authentic learning can be said to have occurred.

Chapter Summary

The literature reviewed in this chapter is intended to add insight into sociological and psychological forces that exist within the context of the clinical setting. Theories of learning, power and identity formation serve to ground our understanding and focus our attention on those forces that are experienced by the novice OTA on a daily basis.

Learning as a phenomenon that requires social interaction and internal drive to grow, reflect and change are concepts described throughout social cognitive and situated learning theories. The concepts of role and community belonging also underpin the notion of identity development where social interaction works to create the sense of self as experienced by the

individual, which in turn affects the creation and perpetuation of the socially structured community of practice.

The dynamics of power that exist within work settings are formal power, which is obtained via job role, personal power gained through experience and social standing or political power undertaken by those in positions of authority used to control decisions and behavior of the organization or group. As a social force, power dynamics have the potential to become part of the experience that participants have within in the community and can impact the development of their beliefs about the context and their role within it.

The notion of espoused versus enacted beliefs adds further insight into the formation and use of treatment beliefs as enacted by the novice OTA. Consequences of espoused beliefs not equating to enacted beliefs and the potential for incorrect learning will be further explored as we discuss the detailed findings of this study.

CHAPTER 3

Methodology

The purpose of this qualitative study was to explore how novice occupational therapy assistants begin to understand their profession, form practice beliefs, subsequently select, and initiate certain treatment methods and approaches with clients. The research questions that guided this study are as follows:

1. How do novice OTAs understand and describe the profession of OT?
2. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?
3. What environmental factors shape the practice choices of OTAs within the clinical setting?
4. How do novice occupational therapy assistants enact their professional belief within the clinical setting?

In this chapter, I describe how this study was conducted to accomplish its intended purpose. I explain the design of the study, sample selection, data collection and analysis, issues of validity and reliability and investigators biases and assumptions.

Design of the Study

This study was created following the tenets of a qualitative approach to research. As described by several contemporary authors, a qualitative approach embodies many characteristics that distinguish it from a quantitative approach. In general, a qualitative approach is based on the understanding that meaning is a socially constructed and fluctuating

phenomenon that occurs in context while individuals (or groups) interact within their world (Creswell, 1998; Crotty, 2003; Merriam & Associates, 2002). In other words, qualitative inquiry is guided by a philosophy that multiple realities exist; there is not one fixed, measurable and physically perceptible reality as is believed from a positivist, quantitative perspective. This study embraces the interpretive qualitative design; it is distinguished from critical and postmodern approaches and is concerned with how individuals experience and interact with their social world (Merriam & Associates, 2002).

According to Merriam and associates, there are five characteristics of qualitative inquiry that cut across various qualitative design forms. The first characteristic is that qualitative inquiry is exploratory in nature, seeking to understand phenomenon, not to explain why events occur from the perspective of a natural science and objectivist truth. Qualitative inquiry often starts with the research questions of *how* and *what*, seeking to explore and describe the experience of the subjects in the context of their experience, not seeking to discover *why* or a cause and effect or relationship between two variables (Creswell, 1998). This study explores how the experience of being in the context of the clinical workplace informs the professional beliefs of the novice OTA and their understanding of how OT should best be administered to clients. It does not seek to establish a causal relationship between workplace dynamics and the outcome of treatment choice, but instead, through analysis of rich description, seeks to understand the experience of being within the work context. This study will explore how those experiences are interpreted and inform practitioner construction of their professional beliefs that potentially ground treatment

choices (Merriam & Associates, 2002).

The second characteristic of qualitative inquiry, as we are reminded by Denzin and Lincoln (2003) and Merriam and Associates (2002) is that qualitative inquiry occurs in naturalistic settings and can involve multiple methods of data collection to acquire many types of raw, empirically sound data that describe significant moments and meaning in the lives of subjects. Examples of data include interview transcripts, historical documents and visual media, among several others. As part of this study I interviewed clients within their place of employment, and utilized facility documents and observations as methods of data collection.

A third characteristic as described by Creswell is that the investigator builds a complex and holistic picture, analyzes words, and reports detailed views of informants (Creswell, 1998, p. 15). Creswell also points out that Ragin (as cited in Creswell, 1998) has described qualitative investigators as working with a small number of cases containing many variables, whereas quantitative inquiry uses many numbers of subjects and focuses on a very small number of variables; each approach contributes to the understanding of the world in which we live. Merriam and associates consider qualitative inquiry to be richly descriptive, with words and pictures conveying what the investigator has learned as opposed to the numbers used to convey information in quantitative inquiry. This study utilized two semi-structured interviews of 10 participants. When feasible, at least one interview was conducted on-site at the participants place of employment; a naturalistic setting for that participant. At the time of the interview, informal observations of the workplace were made by the

investigator to further add to the richness and breadth of data gathered (Merriam & Associates, 2002).

The fourth characteristic of qualitative research is that the investigator is the primary instrument for data collection and data analysis. The human instrument, who is immersed within the study, is able to immediately respond and adapt to the context of the moment during data collection. He or she is able to understand verbal as well as nonverbal communication, process information immediately, clarify and summarize material, perform accuracy checks and explore unusual or unexpected responses (Merriam & Associates, 2002). The primary investigator for this study is an occupational therapy professional who also directs an occupational therapy assistant program that embraces the occupation-based paradigm of practice. This insider perspective enabled me, as that principle investigator, to use personal insights and understanding when collecting data, ensuring that follow up question and artifacts were selected that add richness to the study and trustworthiness to the outcomes.

Unfortunately, there is a negative side to the investigator having prior knowledge and using themselves as instruments of the study. The investigator may bring biases that impact the study such as personal values, additional knowledge of the phenomenon under investigation and positive or negative feelings toward the participants. Any and all potential biases, or subjectivities must be acknowledged, identified and monitored throughout the process of the data collection and analysis (Merriam & Associates, 2002). An investigator subjectivity statement appears later in this chapter.

The final characteristic of the qualitative approach is the utilization of an inductive versus deductive (as is found in quantitative inquiry) process. An inductive approach is best employed when existing theory is inadequate in explaining a phenomenon. In this case, I chose to gather data to build concepts, hypothesis and theories as opposed to testing hypothesis that exist. This study sought to understand the meaning that novice OTAs make of their profession, an area that had not been previously investigated. Rich and descriptive data was collected and then analyzed and organized to create concepts and theories that enabled me to understand this internal process.

A basic interpretive approach was used for this study. Merriam and Associates (2002) describe this approach as one of several that can be used within qualitative design. According to this approach, the investigator acts as a mediating instrument while gaining an understanding of how participants make meaning of a situation or phenomenon. The strategy is inductive in perspective; the outcome is descriptive. When conducting a basic qualitative study, the investigator seeks to discover and understand a phenomenon or a process; the perspectives and worldview of the people involved or a combination of these. (p. 6)

A basic qualitative approach embodies all of the characteristics of qualitative research in a somewhat generic manner; it does not contain extra elements that are found in other approaches such as phenomenology, ethnography, grounded theory research, narrative analysis and qualitative case studies (Merriam & Associates, 2002). This approach was further informed by a social constructivist epistemology (Merriam & Associates, 2002). According to the theory of social constructivism, construction of knowledge and meaning

eventually results in a change in both the individual and in the milieu (Airasian & Walsh, 1997). Within this paradigm, knowledge is believed to have a social component and cannot be created by an autonomous individual acting independently of the social context. I, as the investigator, engaged in a qualitative basic interpretive inquiry that embraces a social constructivist perspective, in order to understand the meaning that an entity or event has for the subjects of study.

This study sought to understand the meaning made of social workplace elements (learning, identity, power) that go on to inform construction, in context, of the professional beliefs and treatment choices of novice practitioners. The guiding belief that novice practitioners do not develop their professional belief system within isolation or separate from the culture of the clinical workplace setting is congruent with the basic interpretive approach that is informed by a social constructivist perspective.

Sample Selection and Setting

Sampling methods used in qualitative inquiry vary from those used in quantitative research with respect to the logic that underpins their selection. Whereas quantitative research seeks to obtain a large number of randomly selected participants, qualitative inquiry seeks to purposefully select participants who can shed light on the phenomenon under investigation. Time spent with participants, richness of dialogue and the tacit information held by the participants enhance the rigor of the qualitative approach (Patton, 1990).

A purposeful sampling method was selected for this study. Purposeful sampling, also termed purposive, is defined as the purposeful selection of information rich cases from which

the investigator can learn a great deal about the central issue of the study. Samples can include participants, observations and documents (Patton, 1990).

According to Patton (2002) there are several strategies an investigator can use when selecting a purposeful sample. These include methods such as typical case sampling, intensity sampling, opportunistic sampling and convenience sampling to name but a few. For this study, I chose to employ purposeful sampling based on criterion. Criterion sampling involves picking all cases that meet some criterion selected in advance (Patton, 2002).

The central issue of this study is the meaning about the profession of OT that novice OTA practitioners make while working in the context of a physical disabilities practice setting. Therefore, criterion sampling that included components of the central issue investigated was used. The unit of analysis was the individual OTA practitioner, the four criteria that were used in selecting the sample for this study included: (a) a homogenous group of OTA program graduates; (b) individuals who graduated in May of 2008 or May 2009; (c) OTAs working less than one year in a single, or total of several, sites that meet criteria; and (d) OTAs working within physical disabilities practice settings such as skilled nursing facilities, hand therapy clinics, rehabilitation hospitals, outpatient rehabilitation clinics and acute care settings dealing with physical as opposed to psychiatric pathologies. Ten participants were selected; this number was limited by the participant pool that matches the selection criterion (Patton, 2002).

The rationale for each criteria were based upon beliefs that I hold, and that are supported in the literature about novice OTAs working in physical disabilities settings. First,

I chose individuals who have graduated from an OTA program with which I have intimate knowledge. Knowing that this group of individuals was provided the same level of focus on the occupation-based paradigm during their academic program will remove a potential variable from this study. The variable being that the participants are not equally aware of what an occupation-based paradigm is prior to entering the workplace. Were there to be a difference in this prior knowledge, it could have led to differences in how novice practitioners make meaning of the profession while in the workplace and skew study outcomes.

Novice clinicians were identified as the participant group to support the research questions that seek to explore meaning making of new practitioners. Novices have not yet solidified their belief systems and still rely on the role modeling of others when it comes to decision making. They are still in the process of learning who they are and how they fit into the community of practice; they are in the process of making meaning, of constructing their knowledge of their profession (Dreyfus, 2004).

Occupational therapy assistants working in physical disabilities settings were selected based upon the research questions that seek to explore meaning making in a clinical setting that has built a practice paradigm (medical model) innately different from the occupation-based paradigm now being embraced by the profession. Baum (2000) explicitly acknowledges that physical disabilities settings are a major area of practice where clinicians are having difficulty embracing the occupation-based paradigm. It was the expectation that clinicians working in physical disabilities settings share richly detailed descriptions of their

experiences and that these experiences may differ from the occupation-based client and clinician experiences described and espoused within the academic program. Physical disabilities practice settings included in-patient and outpatient rehabilitation facilities, skilled nursing facilities, hand therapy settings, adult home care and acute care hospital settings that are physical pathology oriented. Participant demographics were recorded just prior to interviews at the time of the first interview (See Appendix A).

The professional level of OTA was chosen for two related reasons that support the premise of the research questions that guide the exploration of the social construction of meaning in the workplace context. (a) OTAs are more likely to be working within a community of other practitioners based upon licensure laws governing supervision, and (b) OTAs are likely to be engaged in actual treatment of clients within physical disabilities settings at a higher frequency than OTs due to the added responsibility that OTs have for documentation and managerial tasks. Because of rising health care costs, third-party payers are beginning to encourage settings to hire occupational therapy assistants to take hands-on responsibility for clients (Bureau of Labor Statistics, 2010). Despite differences in educational levels and their supervision requirements, OTAs do have the same treatment choice options as OTs; they are able to independently determine their professional perspective and treatment approach used with clients if they so choose. The OTA is typically responsible for the selection of activities used during each treatment session and in that sense, is an independent practitioner. Additionally, OTAs were selected as a participant group based upon my relationship to an OTA training program and knowledge of the

educational process that they have undergone.

Data Collection

In qualitative inquiry, the investigator is considered an instrument whose job entails interpreting or translating the experiences and perceptions of the subjects to arrive at understanding of the phenomenon. Qualitative methods allow the investigator to approach the research process without the limitations of predetermined categories, thus allowing depth and detail in data collection and analysis, as well as richly narrative description in reporting (Merriam & Associates, 2002; Patton, 1990).

Following approval of the NCSU IRB (See Appendix B) and formal request for participation (See Appendix C), several methods were used to gather data for this basic interpretive qualitative study. These methods include (a) in-depth interviews held face-to-face and via telephone as required (See Appendix D), (b) participant observations (See Appendix E), (c) field notes (See Appendix F), (d) document analysis (See Appendix G), (e) critical incidents (See Appendix H), and (f) investigator journal.

Interviews. According to Rubin and Rubin (2005), interviewing is a method of data gathering in qualitative research that permits an in-depth exploration of a particular topic or experience of which the investigator may have little or limited knowledge. It is particularly helpful when using interpretive inquiry as in this study. Semi-structured and open-ended questions allowed for guiding the general direction of the interview, and also allowed for deviation as required to better understand the experience of the participant. Semi-structured interviews allowed for the investigator to move beneath the surface of the described

experience, stop to further explore a topic or statement, request more detail, come back to an earlier point and to shift the immediate topic as needed, to name but a few attributes of this technique (Charmaz, 2006). According to Charmaz, participants expect their interviewers to ask questions that invite reflection versus simply yes or no responses.

The primary method of data collection for this study was the completion of two semi-structured and recorded interviews of 10 participants. Following completion of the signed consent to participate (See Appendix I), open-ended questions were asked of the participants through the course of one interview each for two participants, and two interviews each for eight participants that totaled a minimum of two and a maximum of three hours. The first interview was used to acquire base information for the purpose of analysis and to identify early themes. The second interview was used to ask additional open-ended questions that provided further information, as in theoretical sampling, within the areas identified as recurring themes (Charmaz, 2006). In addition, the second interview allowed an opportunity to verify early themes in order to enhance the trustworthiness of the analysis. Both sets of recorded interviews were transcribed with the assistance of a transcriptionist, were read against the audio tapes and reviewed several times during the process of analysis with the assistance of appropriate research software (NVivo8). Data were drawn and coded from the transcripts that allowed for rich and thick descriptions of the experiences and phenomenon described by the participants.

If a participant chose not to be interviewed in person due to time constraints, an initial telephone interview was conducted in place of the face-to-face interview. In those cases, the

participant was asked to gather brochures or marketing documents from the facility and send them to me. Second interviews were conducted either by telephone or at a site chosen by the participant; this interview was conducted out of the workplace if the participant desired.

An interview guide for the second interview was created prior to member checks and was based upon analysis of data from the first interview (See Appendix J). Exploring gaps, obtaining detailed descriptions of phenomenon and enhanced richness of description of concepts were the focus of the second interview. In addition, second interviews were conducted to clarify comments made during the initial interviews and to check early themes through questioning. The themes discovered within the critical incident essays were shared with participants as a form of member checking; participant feedback being requested to ensure trustworthiness of interpretation (Charmaz, 2006). Second interview data were handled in the same manner as initial interview data, but member checking was not utilized.

Interviews as a method of data collection were congruent with this qualitative study being undertaken from a social constructivist perspective. This method allowed me, as the investigator, to explore the tacit knowing of the OTA participants and to facilitate the bringing of the unconscious to the forefront of thought. Semi-structured questions allowed me the freedom to follow the naturally occurring lines of thinking as clinical experiences were recounted. Additionally, this form of questioning provided adequate structure to keep the focus of the interview on the research questions guiding the study. Interview questions that are congruent with the research questions were prepared in advance to facilitate adequate coverage of the phenomenon and to provide rich, copious amounts of data from which to

build concepts and create theories. Through questioning, hearing and ultimately analyzing the rich words and descriptions of participants as they are prompted to discuss the phenomenon, I began to understand the ways in which meaning and perspective of OT is constructed and how that perspective informs practice options. (Maxwell, 2005; Patton, 1990; Rubin & Rubin, 2005).

Participant observations. Marshall & Rossman (2006) describe observation as a fundamental and highly important method in all qualitative inquiry. Observation is the systematic noting and recording of events, behaviors, and objects found within the social context of the study. Field notes, a term often used to describe the written record created from observation, includes detailed, nonjudgmental, and concrete descriptions of what has been seen. Observations allow the investigator to see theory in action according to Maxwell (2005), making it a particularly salient method of data gathering for a study that seeks to explore perspective and the potential utilization of that perspective.

The research questions of this study outlined the context of the workplace as a primary consideration in the exploration of the meaning making of OTAs. As a method of data collection that supports this component of the research questions, visual observations of the participant and their physical work environment were collected. Public spaces within the clinical site were observed just prior to, during and/or following the interview. Observations focused upon: (a) the types of equipment available for administering OT treatments, (b) the physical layout of the environment, (c) the attire of the individuals within the environment, and (d) size of the therapy space. The physical arrangement of the setting was also noted, and

included parameters such as: (a) the arrangement of furniture used for the clients when being treated, and (b) the existence or lack of functional spaces such as kitchens, bedroom set-ups, and bathrooms that can be used by clients for engagement in occupation-based experiences.

Observations of the participant made during the interview included notation of body language, proximity to investigator, attire, voice tone and general affect. These observations were used to support and enhance trustworthiness of the verbal data collected. Participants were made aware that observations would be made via the IRB consent form. Written notes were made as appropriate while at the site and upon departure, voice recordings were used as a method of immediately filling in informational gaps.

Critical incident. Additional data was collected via a modified critical incident technique. This technique was originally described by Flanagan (1954), and has been modified by several practitioners and used within several disciplines since. Approximately 1-2 weeks prior to the interview, I asked participants to describe (in writing) a particular incident that they felt exemplified a treatment interaction where they provided particularly beneficial treatment to a client or group of clients. Clinicians answered questions such as: what occurred, how it occurred, what was their role, how did they feel following this experience, and what did they learn as a result of this experience. The clinician was then asked to reflect upon their answers in order to gain a deeper understanding of the choices that they made and the outcomes that they experienced. This information was collected as part of the first interview and was used to inform questions that were part of the second interview.

Document review. Documents used within or by a setting are a rich source of information for the qualitative investigator who reads them. Documents can be valuable because they provide a stimulus for generating interview questions and areas for observation. Documents also can serve as a means of gaining insight into the history, activities and beliefs of the context or program that is serving as the context of the study (Patton, 1990). Documents gathered for this study served as descriptors of the context of the workplace of the study participants; context is outlined within the research questions and is considered an integral part of the phenomenon studied.

I secured various marketing and facility information documents from the workplace settings of my participants. I also obtained documents that were made available to the public in either hard copy or Internet form, and sought those that describe the methods employed by the facility in addition to the culture of the facility. I was interested in exploring how the administrators of the facility view and market their rehabilitation program, OT services in particular. I was interested to see the level of congruence between the information provided within marketing documents and the actual facility that I observed in person. If pertinent, findings from early document analysis were shared and discussed with participants during the second interview for the purpose of testing investigator logic and assumptions.

I utilized a document review form to outline findings from the various documents and websites. Information gathered includes the type of document, the purpose, the appearance, the audience, and the explicit message. Expressed permission was not required to view or obtain these documents; participant and client privacy were not at risk.

Research journal. A researcher journal is one method by which an investigator is able to record their reasoning and spell out the development of ideas. In addition, it allows for the development of an audit trail that can be used to demonstrate the validity of the study through documentation of researcher concerns, biases, thoughts and feelings. This creation of a journal implies an open-minded and critical individual who is willing to reflect upon their thoughts and actions in order to minimize the potential for bias when analyzing and interpreting data (Bloomberg & Volpe, 2008). Ortripp adds to this understanding by describing modifications that he was able to make to his personal research through the critical reflection that he engaged in through journaling. In addition, he reminds us that since all investigator biases cannot be controlled in any study, a researcher journal allows for transparency of those biases and beliefs that are held by the investigator. A well-conducted journal demonstrates, for all interested parties, that issues that could potentially interfere with data gathering and interpretation are under constant reflection and modification (2008).

I kept a field journal in electronic format to document relevant observations not otherwise recorded, and personal reflections during data collection activities. My researcher journal was also used to critically reflect upon any biases that became obvious during this stage of the study. Participant profiles were stored in the researcher journal, and if needed, it would have served as the place to document modifications to data collection protocols that would have been submitted to IRB.

The personal reflective nature of the journal is also congruent with the design of this research, where I constructed knowledge of the research process and made meaning of the

daily experience of this undertaking. In keeping with theories of social learning, identity formation as well as the enactment of espoused beliefs, I sought to become a learner immersed within the experience and constructed and developed my self-understanding and identity through the process of learning about others within their context.

Data Analysis

Qualitative data analysis is the process of bringing order, structure and meaning to the large amount of data collected. During the analysis phase, I attempted to summarize the data in a dependable and trustworthy way. This process is inductive in nature in that it begins with large quantities of raw information that are then formed into meaningful groupings of concepts and themes. In qualitative inquiry, there are no predetermined slots into which the data should fit. My task as the investigator, as the instrument, was to read, reflect, compare, and code to make explicit the meaning inherent in the data (Bloomberg & Volpe, 2008).

Data collected through this basic interpretive study was analyzed according to methods found within grounded theory. According to Charmaz, grounded theory methods are systematic yet flexible guidelines for collecting and analyzing qualitative data to construct theories that are “grounded” in the datum itself (2006, p 4). As a basic interpretive study, this work used grounded theory tools in order to bring order to the data through coding, constant comparison and in theme discovery. However, being that this is not a grounded theory study, theories were not derived from the data. Utilization of these methods of data analysis were appropriate for a basic interpretive project that sought to discover the meaning made by novice OTAs as they gain a perspective on their profession. No hypothesis was utilized; the

data were compared to form themes and to gain insight into the experience of participants.

Grounded theory was originally used as a data analysis method by sociologists Glaser and Strauss during the 1960s when they studied dying patients in U.S. hospitals. The defining characteristics of grounded theory described by Glaser and Strauss include construction of codes leading to the discovery of categories from the data, absence of pre-created hypothesis, use of constant comparative method and memo writing (Charmaz, 2006).

Various scholars such as Corbin and Strauss, Charmaz, Miles and Huberman and Merriam have described the processes of data analysis according to grounded theory since the 1960s. Although based on the work of Glaser and Strauss and similar in guiding tenets and process, differences in interpretation are found within the terminology used to identify techniques and explicitly describe stages.

As stated above, this study utilized several methods originally described by Glaser and Strauss. The first phase of the data analysis for this study involved accurate transcription of the first phase interviews with placement of hard copies of the transcripts in an organized and secure location. Transcripts were also kept in a file on my private computer. Additional artifacts such as documents from the facility and critical incident activity write-ups were also organized into a labeled file.

The second phase involved reading and re-reading the handwritten or participant typed critical incident essays and interview transcripts to get a feel for the data and sense of what is being revealed through the interviews and documents. During this phase, I was mindful of the research questions posed in the study and began to identify early themes and categories.

During the third phase of analysis, the transcripts were read against the tape recordings of the interviews to ensure accuracy of the transcription and to fill gaps where the transcriptionist was unable to decipher the words spoken. The third phase of classifying information also involved the use of basic grounded theory techniques as described by Glaser and Straus (1967) and Charmaz (2006), known as open coding. Codes emerged from the data immersion and early themes were discovered. I had ideas from the literature review process that guided code choice yet did not limit the seeing of early codes and themes. I monitored (through journaling) my pre-existing ideas regarding the research concerns as well as the literature, and bracketed as much as possible to decrease bias. Early coding was followed with focused coding that focused attention to those codes that stand out as making the most analytical sense for final data categorization (Glaser, 1978). Techniques such as line by line coding described by Charmaz were used during open coding; incident coding was conducted on observation and facility documents to discover repeating text and early themes (2006).

After open coding, axial coding was utilized to sort, synthesize and organize the data around early central themes being identified (Creswell, 1998). A constant comparative method was utilized throughout the coding process whereby codes and themes were compared both between different participant interviews and first and second interviews of the same participant. This technique allowed for the establishment of analytical distinctions and began the process of finding similarities and differences in the data (Glaser & Strauss, 1967).

Memo-writing was conducted as part of the analysis process and is described by Charmaz as a crucial method in grounded theory that prompts the investigator to analyze data

and codes early in the process; it is an intermediate step between data collection and writing draft papers (2006). This technique was used to record early findings and to draw out similarities and working theories of phenomenon being uncovered. Memoing also included writing impressions of the life stories of participants that were derived from their demographic information as well as disclosures that occurred during the interview and observations of the workplace. Memoing continued throughout the data analysis process and connected codes to emerging themes and constructs (Charmaz, 2006).

In the fourth phase, I categorized ideas into larger groups that represent a common theme. A theme is described as an implicit idea or topic that a group of repeating ideas has in common (Auerbach & Silverstein, 2003). During analysis, I organized repeating ideas and looked for similarities within the list of ideas. I then developed a theme idea that was found throughout all of the ideas. I continued with this process until new themes were not identified. Established themes were taken back to participants during the second interview for early member checking.

The fifth phase involved the organization of the themes into larger categories or constructs. It was during this phase that various themes were selected and compared to the literature frameworks of identity formation, power theories (including the bases of power and tactics of influence), as well as the situated and social cognitive learning theories and the ideas of espoused versus enacted beliefs. Prior to the second interview, I identified emergent themes from the data and added them to the interview guide for the second interview. This member checking assisted in affirming the early themes and allowed me to fill in data gaps

while forming a better understanding of the data collected.

Following second interviews, transcripts were analyzed according to the sequence described above. Themes identified from the first interview were selected and used during the process of coding the second interviews in an effort to uncover similar themes and those that were not found previously. Code exemplars were compared to those obtained during the first round of interviews in an effort to either corroborate or fill gaps in data. All new data were compared to the literature frameworks described in the previous section (Auerbach & Silverstein, 2003).

The sixth and seventh phases of the process involved organizing the data in constructs and interpretive narratives. The narratives summarize what has been learned about the research questions. This phase connects the research questions to the words of the participants, to their subjective experience. I completed this phase by creating narratives using the words of the participants while interspersing the constructs and themes as examples flowing through the story (Auerbach & Silverstein, 2003).

According to Patton (2002), the sixth phase is when significance is attached to what was found, sense is made of the findings, explanations are offered, conclusions drawn and order imposed. It is within this phase that the understanding of the experience of the novice occupational therapy assistant began to emerge; the unknown beginning to be made known.

Constructs and narrative creation were followed by the evaluation of the plausibility of the emerging meanings by exploring them through the data. This was accomplished through searching for evidence within the re-visited data to support the premises that are

being put forward. In addition, I looked for negative examples that negate the theoretical constructs and themes. These were combined, explored and explained. I reflected upon and question the plausibility of the assertions being put forth, and provide substantial evidence for their trustworthiness, built interrelationships between them and connected their significance to past and future research (Marshall & Rossman, 2006). This information appears in the discussion section of the final chapter of this study.

A data display is the method utilized to put forth the events, the people, their words and their actions in such a way that the reader can experience the world of the participants (Bloomberg & Volpe, 2008). The data passages obtained through interviews in this study were grouped in thematically connected categories and sub categories and displayed in narrative format. This method of presenting qualitative data is considered appropriate for a basic interpretive approach due to the flexibility inherent in the format (Bloomberg & Volpe, 2008).

Ensuring Validity and Reliability

Validity and reliability sometimes referred to as trustworthiness or credibility and dependability are important considerations in qualitative research. Regardless of the terminology used, the focus is upon how well the investigator provides evidence that the descriptions and analysis of the data reflect reality of the persons and situation studied (Bloomberg & Volpe, 2008). The outcomes of a valid and reliable study can be trusted and added to the existing literature with confidence. Several techniques to enhance validity and reliability are described throughout the literature. These techniques include triangulation,

bracketing, member checks, peer debriefing, clarification of biases, rich data, extended engagement with participants and negative case analysis (Creswell, 1998; Merriam & Associates, 2002, Patton, 1990).

Patton (1990) describes three issues that must be addressed when considering the credibility of a qualitative research study. These issues relate to (a) what methods and techniques were utilized to ensure the integrity, validity and accuracy of the analysis, (b) what does the investigator bring to the study in terms of qualifications, experience and perspective, and (c) what paradigm orientation and assumptions undergird the study (p. 461). These areas have each been addressed within this study as described below.

Methods and techniques. I used a technique described by Patton (1990) known as triangulation of qualitative data source. I compared interview data with data obtained during observations of the setting, and compared what was said by participants during the interview with what was said during different times, checked for consistency between both interview sessions, and compared information heard from treatment clients, other therapists and the critical incident report with what was said.

I also tested for rival explanations and themes when analyzing the data. I revisited the data to look for evidence that other ways exist for thinking about or presenting the themes that have been uncovered. As previously mentioned in data analysis, I looked for negative cases in the data because negative case identification may indicate that the experience of some participants was completely different from those experienced by others. Looking into these negative cases gives credibility to this study by demonstrating that the investigator is

willing to share all data and discuss possible explanations for phenomenon that does not match patterns (Patton, 1990). The thought process involved in differentiating positive and negative cases also adds more investigator insight into the decision-making process leading to theme identification, thus informing the analysis.

Through journaling, I conducted design checks through the creation of an audit to ensure that design and methodology choices are sound, are not negatively influenced by my prior knowledge and contributing positively to data gathering. Use of these strategies improved the reliability or reproducibility of my study and added to the trustworthiness (Ortlipp, 2008). I also had member checks, where subjects reviewed my initial narratives and findings to ensure that they are best representing their thoughts accurately. The second interview guide was created following the discovery of early themes from the first interviews, and captured information missing from previously collected data that could have impacted analysis and interpretation. Second interviews included member check feedback and addressed any points for clarification or gaps that I identified (Maxwell, 2005).

With regard to the number of available participants who meet the established criteria, it is understood that 10 is a sample size of relatively small breadth. To add to the depth of the collected data, approximately three hours were spent with each participant with additional time gained through informal observation of the work context. This provided approximately 27 hours of time in the field, hence expanding the depth albeit not the breadth of this study through long-term involvement (Maxwell, 2005). Time in field not only adds validity to my results through the extended opportunities to interact with and observe the participants, this

also adds to trust and comfort level during interviews which will add to trust and extend the richness of the gathered information.

Another methods challenge was the fact that the subjects were novice occupational therapy assistants with whom I had an academic relationship. These individuals may have felt a need to answer questions in a way that would please me, versus being honest to their own thoughts and beliefs. I dealt with this challenge, this reactivity, using several methods. This first method was to provide a very thorough explanation of the purpose of the interview and the study as well as a firm statement that this is a safe experience. The amount of time that I spent with participants assisted with the establishment of an atmosphere of trust where the participant felt free to express whatever sentiments they had. I assured them that I am aware of our history but would in no way be judgmental or utilize any type of power against them. I embraced their beliefs and embraced the opportunity to receive an honest appraisal of their current thinking in light of the teachings of the program from which they graduated; I asked for candor. I believe that the time and effort I expended to make clear the fact that I was bracketing my personal feelings about their thoughts minimized this validity threat. In addition, while analyzing the data I looked for alternate explanations, and analyzed negative cases that may stand out from a group of others (Patton, 1990). I also utilized the triangulation of qualitative data source method described previously to validate interview information.

Despite the possibility of redefining the purposeful sampling criterion that I had selected to include individuals with whom I did not have a history, I choose not to do this. In

other words, I did not interview individuals who are not graduates of the OTA program of southeastern NC, because I would not have a clear understanding of the paradigm that they were taught in the academic program. I embraced the fact that I share a common language and general knowledge of the profession with my participants. Additionally, although a potential threat to trustworthiness, I saw a plus in having a group that is homogenous with regard to their educational background; the study moved forward without concern for additional variables and the need to explore and interpret the focus of the educational program from which the participants graduated.

Investigator credentials. I have been an occupational therapist for over 26 years and have worked within several physical disabilities settings. I was a subscriber to the medical model paradigm while I worked in the field as a hand therapist, so am acutely aware of how this belief system can weaken the profession by creating practitioners who do not address all facets of client function which lead to enhanced quality of life. Since becoming an educator of OTAs, I have become a renaissance OT. I have re-visited the grounding tenets of the profession and have become a champion for the national paradigm change that was coincidentally called for at the time that I left clinical practice to become an educator.

I believe through my personal experiences that the viability of the profession is at risk due to the lack of a cogent professional paradigm and practice tradition. I believe that it is through the education of individuals learning about the profession for the first time, as well as through continuing education venues for seasoned practitioners, that the unique and sought after approach of this socially necessary discipline will be solidified. However, to this end, an

understanding of how meaning is made and professional beliefs are formed within the workplace context must be achieved in order to inform the creation of potentially effective educational activities. Planning without understanding the elements at play cannot be effective (Cervero & Wilson, 2006). Ultimately, I believe that adult education is the key to this professional problem.

I am an instrument in this qualitative study. I used my personal insight, my passion, my professional knowledge and my sensitivity of the topic to make a valuable contribution to the adult education and occupational therapy literature. My position as an insider assisted me in my ability to discover themes and central issues with enhanced trustworthiness. I was able to speak the language of the subjects, have a general understanding of the work challenges that they face and have an intimate understanding of the paradigm that they were taught and will therefore easily recognize changes to this early belief system. My past knowledge and expertise assisted me in my role as investigator, as an instrument of the process, thus adding a needed dimension to the qualitative approach.

Paradigm selection and assumptions. A social constructivist perspective that informs a basic interpretive qualitative approach was selected for this study. This approach is considered most appropriate for a study that sought to explore the meaning that novice OTA practitioners make of their profession, which ultimately inform their treatment choices in the clinical setting. Qualitative research is naturalistic, occurs in context, is inductive, relies on rich and thick descriptions and relies on the investigator as an instrument of the research

process (Merriam & Associates, 2002). These attributes are congruent with the type of information that this study sought to uncover.

According to Patton (1990), disagreements can exist between those who embrace quantitative versus those who embrace qualitative methodologies. The attention to method selection and investigator expertise described earlier will serve to add trustworthiness of this qualitative work.

Investigator Biases and Assumptions

I decided to explore the topic of the professional perspective and practice choices of the OTA because of a strong passion that I carry for the profession of occupational therapy and a desire to contribute to literature that will help the profession through a difficult time of paradigm change.

With regard to biases and assumptions, I feel that my status as an insider will likely be the largest. I bring an anecdotal awareness in addition to an empirically based belief that paradigm change in OT is occurring in the classroom, but is blocked from occurring in the field. Because no literature was found to explain how assistant therapists develop their professional perspective once in the clinical setting, I am embarked on this project. Since I am an educator of OTAs and an occupational therapist who believes strongly in the resurgence of the occupation-based treatment paradigm, I am interested in exploring the development of the novice practitioner with regard to their professional perspective and treatment methods choices post academic program.

Because of my insider status, I do have thoughts and beliefs as to why new OTAs may not choose the perspective that they were taught in school; I know that these prior beliefs create bias and had the potential to affect my objectivity. From a methods standpoint, I believe that this bias could have potentially skewed my approach when asking follow-up questions during semi-structured interviews; I may have asked questions that led and caused participants to answer in the way that I thought they should answer.

I bracketed these beliefs to the best of my ability while I interviewed participants so that they did not skew my results or negatively affect the trustworthiness of my study. I effectively bracketed previous beliefs through critical self-reflection regarding my assumptions, biases, and relationship to the topic. I believe that my personal biases were bracketed adequately due to the fact that I become quite surprised by the emergent themes that the data were revealing during the analysis phase. I likely did enter the process believing that anecdotal reports that explained why novice practitioners did not engage in occupation-based practice would prove true in a formal study. I was pleasantly surprised to see that I was able to see that this was not the case, to put aside pre-conceived notions and see the truths that emerged.

Additionally, I followed the lesson of Peshkin (1988) who recommended subjectivity audits to document the arousal of subjective feelings created by certain events or contexts. I added “I” categories to my researcher journal where specific examples of events were listed and then dealt with through reflection. For example, I created “I” statement categories that deal with my insider status such as: I the teacher, I the occupation-based therapist, and I the manager.

I also understood that choosing participants who are graduates of this particular program could have implications for personal bias. I may have had an unacknowledged desire to have them support my professional beliefs while they answered questions. This belief could have transferred to participants through my attitude and the questions I asked. The use of subjectivity audits also helped to avoid this potential bias, and were created in addition to reflective journaling and bracketing of potentially intrusive beliefs.

I understand that investigator assumptions and subjectivity will always exist in research (regardless of the use of quantitative or qualitative methods), and can influence the questions asked and the interpretations made of the data (Denzin & Lincoln, 2005; Ortlipp, 2008). I also understand that acknowledgement of one's subjectivity can minimize ill effects that it may have upon outcomes of the study while at the same time enhancing focus and perspective (Peshkin, 1988).

Chapter Summary

This chapter outlined the qualitative methodology and design of this study, which employed a basic interpretive approach. In addition, issues of selecting a purposeful sample were introduced as were the methods of data collection. The steps and procedures used for analyzing collected data and the methods employed to ensure reliability and validity as well as those to address issues of investigator biases and assumptions were discussed.

Outcomes of the study described in this chapter will be used to inform curricular content choices and potentially, work site policies, with regard to preparing novice practitioners to effectively create their professional beliefs and treatment methodology within the workplace context.

CHAPTER 4

Findings

The purpose of this chapter is to present the findings of the exploration into how novice occupational therapy assistants begin to understand their profession, form practice beliefs and subsequently the treatment methods and modalities that they apply to clients. The research questions that guided this study are as follows:

1. How do novice OTAs understand and describe the profession of OT?
2. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?
3. What environmental factors shape the practice choices of OTAs within the clinical setting?
4. How do novice occupational therapy assistants enact their professional belief within the clinical setting?

Ten occupational therapy assistants participated in this study. Each participant met sampling criteria established prior to data collection that included: graduation from the same southeastern North Carolina community college occupational therapy assistant program, graduation in either the year 2008 or 2009, currently employed by and working in a physical disabilities setting, and working in a physical disabilities setting for less than one year total time. Participants varied in work setting, age, gender and current geographical location.

This chapter is divided into two sections. Section one presents the profiles of the various participants and part two presents the interview findings.

Participant Profiles

This section presents the profiles of ten different individuals who participated of this study. Each profile includes the participant pseudonym, dates of interviews, and settings of interviews. In addition, basic demographic information that includes age and gender as well as reasons for entering the field of Occupational Therapy are also presented. The profiles provide a description of the educational and social backgrounds of the participants as well as other personal attributes.

The ten participants, eight women and two men, were interviewed for the first time between June 26 and September 22, 2009. The second interviews were conducted between August 22 and October 14, 2009. The time between the first and second interviews was determined by the time required for transcription and coding of the first set of interviews as well as the creation of a transcript summary that were reviewed by the participants prior to the second interview.

Interviews were conducted at the workplace of participants after their hours on duty, or held by telephone when the participant requested or when distance precluded face-to-face interaction. Each meeting, either by phone or in person lasted between one hour and fifteen minutes and two hours for a total of 27 hours of participant contact; a total of 18 interviews were conducted.

Six of the participants interviewed live and work in the state of North Carolina, the remaining participants are located as follows: one lives and works in New Jersey, one is located in New York City, one lives and works in South Carolina and the last lives in North

Carolina but works in South Carolina. All participants work in in-patient facilities with nine being employed by Skilled Nursing Facilities (SNF's) and one by a hospital where she works on an acute care unit. The length of employment varies from less than one month to approximately ten months with the average time of employment being approximately five months. According to initially established criteria, all participants are novice practitioners. The highest educational degree acquired by eight participants is an associates degree, two participants have baccalaureate degrees in unrelated fields that they obtained several years ago.

Participants work within facilities that employ additional OT practitioners; most have departments of two or three with one facility having five and one having 15 OT practitioners. All participants described the type of practice that they conduct as being occupation-based, all but one believe that the philosophy of their OT department in general is occupation-based.

When asked to state why they chose to enter the profession of occupational therapy, all participants responded that they did so because they enjoy the population that OTs work with, they wanted to help people and because they believe in the tenets of the profession. Eight out of ten participants reported that salary and job security also factored into their decision to choose OT. Seven out of ten identified benefits and work settings as contributing to their decision, only two and three respectively identified desire for an associates degree and proximity of program as reasons for their decision.

When asked to identify their reason for choosing to work in a physical disabilities setting, nine out of ten participants stated that the client population guided their decision; six

out of ten also cited good salary and the type of work that OTs do in the setting as reasons for their choice. Only two participants listed proximity of the work place to their home as reasons for choosing their work site; one identified benefits and one identified that it was the only job available as reasons. Participants were given the opportunity to provide multiple reasons for both their choice of profession and their choice of work site.

Table 4.1 summarizes basic demographical information about the participants and includes gender, age, time employed and year of graduation. The written profiles that follow provide additional detailed information about the participants.

Table 4.1

Participant Demographics

Name	Gender	Age	Time Employed	Year of Graduation
Casey	Female	23	6-8 months	2008
Jordan	Female	27	0-2 months	2009
Sage	Male	35	6-8 months	2008
Ashley	Female	22	8-10 months	2008
Jamie	Female	38	8-10 months	2008
Kelly	Female	23	2-4 months	2008
Logan	Male	38	8-10 months	2008
Rowan	Female	34	0-2 months	2009
Tracy	Female	22	0-2 months	2009
Hayden	Female	31	6-8 months	2008

Casey. Casey is a quiet yet affable 23-year-old woman who moved from Cary, NC to attend OTA school. A 2008 program graduate, Casey is now a resident of South Carolina

where she moved immediately following graduation in order to live near her boyfriend (now fiancé) who is completing his education in SC. Casey mentioned that once her 18-month contract is complete with this SC worksite and her fiancé completes school, she may move back to NC to be closer to her family. She states that she likes life in SC, but that it took some time to adjust to a busier tourist environment. Casey has been working at her current physical disabilities job for seven months.

Casey is a private person but was able to answer all interview questions without hesitation. She is mature and ethical; she did not joke or make any facetious comments during the interviews. Casey is a caring individual who stated concerned with the emotional well being of her clients as well as her responsibility to ensure this.

Interviews were conducted with Casey on both June 26, 2009 and August 22, 2009. The first interview was conducted at her place of employment in South Carolina. Our interview took place in the office of a speech-language pathologist and was located across the hall from the OT treatment area. The second interview with Casey was a telephone interview that took place on August 22, 2009. As with the first interview, Casey freely answered all questions. She stated that nothing had changed in her personal or professional life since the last time that we spoke.

During the interviews, Casey did not appear overtly concerned or make any comments about our past relationship when answering questions, yet did introduce me as her “teacher” (as opposed to former teacher) when introducing me to others. She was eager to show me around her work area and offered to take me on a tour of the entire facility and

introduce me to fellow therapists (OT, PT, SLP).

With regard to the setting in which Casey works, I observed a full bathroom with many pieces of large therapy equipment stored in bathtub. I also noted an upper extremity bike (also known as a restorator), pegs and pegboards, mats, weighted poles, nuts and bolts. No games or craft activities were observed, but I saw a cabinet with doors was seen in the office area where Casey reported that games were stored. A kitchen area was present and contained a microwave oven and coffee maker.

Logan. Logan is an extremely friendly and intelligent 38-year-old man who hails from Southeastern NC and is a 2008 OTA program graduate. He is married and expecting his first child with his wife, a nurse practitioner. Occupational Therapy is a second career for Logan who reports spending many years in sales. He was disillusioned with this career wishing instead to work with and helping people. At this time, Logan drives over one hour each way to and from work each day, but states that this is not a problem for him and is actually a good time to think and plan the day's activities or de-compress from a busy day.

Logan sustained a head injury while hiking in the Appalachian Mountains years ago when in a bachelors program at Appalachian State University. It is for this reason that he requires slightly extended time for problem solving and answering questions. He appeared somewhat nervous during the first interview on June 30, 2009, but did not state this. I observed him moving back and forth during the interview on a wheeled stool; he also manipulated a basketball that he held on his lap during the entire time. When he required additional time to think of an answer, his facial expressions indicated possible frustration.

Logan was verbal about his feelings about OT and what how it should be administered to clients. He also reported that he has at times had to compromise his beliefs when the needs of the client or the facility required such but truly has the best interests of clients in mind when at work, despite (per his report) working in a site that sometimes has concerns for productivity and 'bottom line' thinking.

The first interview conducted with Logan took place in a small room shared by occupational, physical and speech therapy. No residents were present at the time of the interview, but I was able to observe that the treatment area included a make-shift ADL space with no dedicated area for this purpose observed. A microwave oven and coffee maker reside in the staff office and are reportedly used for patient treatment if needed. A community bathroom is used for bathing and toileting.

The small dedicated treatment room, a converted patient room, contains a partial bathroom (sink and toilet) and a set of short stairs to be used for stair walking training. In addition, an over bed table, wall-mounted pull down mat, small shelving unit and one office chair were noted. A toy basketball hoop was observed over the bathroom door and the shelf stored several preparatory activities such as weights, weighted poles, cones, clothespins and some games (checkers, children books). A large basketball was in the room as well as upper extremity bike. Our second interview took place at a Dunkin Donuts on August 26, 2009 following Logan's day at work. He was much more self-assured and at ease in this setting than he had been during the first interview; he quickly and fully answered all questions with ease and conviction.

Hayden. Hayden was interviewed at a restaurant in southeastern NC on July 13, 2009. She chose the day and location of our meeting based on her desire to complete the interview following a late afternoon dental appointment. Although I was unable to see her worksite first hand on this day, I would be visiting it the following day while interviewing her co-worker Ashley, another study participant.

Hayden is a 33-year-old woman who graduated in 2008 from the OTA program. She is an attractive mother of two who lives approximately 45 minutes from Wilmington with her husband and two sons. Hayden presents herself as an affable and outgoing individual who is also quiet in her demeanor. She is agreeable, willing, and ready to help and lend support. Hayden is mature and open to new ideas; she does not appear to judge the decisions of others, but can always find a reason why another opinion or manner of doing is valid and valuable.

During the interview, Hayden answered all questions without hesitation. If she found a reason to disagree with something that exists in her professional or personal life, she did not make negative comments about co-workers of her work place unless she felt that their behavior is adversely affecting another, especially a weaker person. In general, she spoke highly of her co-workers and of her workplace. Hayden's very first OTA job was located in a veteran's nursing home over an hour from her home. She was offered her current position after less than a month of employment at that facility. She stated that she felt very bad about leaving the first site, but that her current position is a much better fit economically. Hayden is

kind and interested in helping people to live a quality life; she reported that she likes to try new things.

The facility in which Hayden works is an older skilled nursing facility. Many residents were observed in single rooms that appeared small with walls of cinder blocks. All rooms were somewhat dark and institutional in appearance and did appear clean. The therapy room was of medium size and housed an area for resident treatments and an office area for staff. Staff shared use of a table as a desk surface. Many large exercise machines were observed as were physical agent modalities and other enabling type upper extremity activities such as the upper extremity bike. A cabinet containing games and a box of craft items was observed.

The room is shared by OT/PT/SLP; some practitioners may choose to conduct treatments in the common day room or client room. A kitchen is reportedly available in the Activity Therapy room, but Hayden stated that OTs prefer not to use it due to belief that conflict exists with activities director. Hayden pointed out a stark courtyard area, mentioning that the OTAs had added bird feeders and sun catchers to visible resident windows.

The second interview with Hayden was conducted via telephone on September 21, 2009. According to Hayden, nothing of significance had changed in either her personal or professional life since the initial interview.

Ashley. Ashley, a co-worker and former classmate of Hayden, graduated from the OTA program in 2008. She was interviewed on July 14, 2009 at her place of employment, a

skilled nursing facility in southeastern NC. The second interview took place after work hours at a convenient local restaurant.

Ashley is a 22-year-old woman who grew up in Virginia, where her immediate family continues to live. She is currently living approximately one hour from her place of employment and commutes to work each day. Ashley lives in an apartment with a roommate and has a long-term boyfriend who lives in his own home in the same town.

Ashley had originally moved to the Charlotte area after OTA school and began working as an SNF there. Her boyfriend was attending a program at UNC-C. Unfortunately, the brother of her boyfriend was involved in a serious 2-story fall off a balcony earlier in the year and is now challenged by quadriplegia. Although he is currently in a rehabilitation facility, he will be returning to live with his brother, his only relative (both parents are deceased). Ashley returned to the area to support her boyfriend and his brother; her boyfriend has had to quit school but is able to take some classes at the local community college. Her willingness to support her boyfriend and his brother speaks to the strong character of Ashley, who is willing to help others in need even at her own expense.

Although she is working in a new facility, she is still working for the same rehabilitation company. The fact that the company was willing to transfer Ashley demonstrates their satisfaction with her work. If a company is not interested in keeping someone on board, they may not offer a transfer.

Ashley is a sweet young woman. She is quiet, but will quickly answer questions and initiate appropriate conversation. She reports being very happy working at her current facility

and appeared to have a positive working relationship with others, as noted by her interaction with nursing and social services when obtaining marketing materials for my study. Ashley appeared somewhat nervous at the beginning of the interview, perhaps concerned with how she would respond to the questions. Since Ashley works in the same facility as Hayden, the description of the facility appearing in Hayden's profile (see previous) is the same.

Tracy. Tracy is a 22-year-old woman who graduated in 2009 from the OTA program. She grew up in a small North Carolina town where her immediate family continues to live. At the time of the interview, she was living with her fiancé in a rented home approximately 20 minutes from her work place.

Tracy is a very affable and lively young woman who spent a great deal of her time as a child and teen in the pageant circuit; she was crowned princess of several local events. An attractive woman, she is very sociable and introduced me to all therapy staff, many nurses and administrators of the facility as well as several residents. In addition, she took time to chat with the residents, telling me something nice about them. The clients seemed quite taken with Tracy and were eager to chat; all had nice things to tell me about her when they learned that I had been her teacher. Tracy told me that I would always be her teacher when I mentioned that, since she had graduated from the program, we were now colleagues.

Tracy was interviewed at her place of work, a skilled nursing facility, on July 21, 2009. She was eager to begin the interview and had a small agenda of her own to discuss; she wanted advice on how to change the thinking of those she works with in order that they may engage in a more occupation-based approach to client care. This discussion did not occur as

part of the interaction for this study.

Tracy's mother works as the dietician at the skilled nursing facility, so we were able to use her office to conduct the interview. Tracy mentioned that she "grew up" in this facility; on days that school was closed, she would spend the day with her mother at work. That may explain Tracy's comfort level with all of the staff and clients and her willingness to share so much of her worksite. Tracy loves people and animals; these personal attributes were noted during her educational program and even more so today.

The therapy space in which Tracy works is comprised of one medium sized room, basically the equivalent of two client rooms. The room is filled with many items such as nautilus exercise equipment, a small kitchenette, shelves, tables, and counter surface used as clinician desks; the room is very cluttered. Typical preparatory activities such as physical agent modalities were observed as were the upper extremity bike, cones, pegboards, and weights. Tracy reports that they do have cabinets with assorted enabling activities and that she is able to purchase items for functional activities at local big lots store; I did not however observe these items.

The second interview with Tracy was conducted at a coffee house on Saturday, August 29, 2009. Tracy has had changes in both personal and professional aspects of her life. She is now single and living alone, no longer engaged to the young man that she mentioned at the time of the first interview. At work, there was a change in personnel and the OT that she had previously worked with is no longer at the facility, a new OT has joined the department.

Rowan. Rowan is a 32-year-old woman who graduated in 2009 from the OTA program. She grew up in North Carolina, where her immediate family continues to live, but has recently moved herself to the Bronx, New York City.

She reports moving to New York with the expectation of continuing a relationship with a long time boyfriend, but this did not worked out. She has stayed on in New York despite not having any family or friends close by. She is an individual who is self-assured and willing to live in an unfamiliar environment and to make new friends. Rowan has always presented herself as a free spirit who is a trained massage therapist, interested in health and wellness and a fan of Yoga. She is worldly in her thinking, and able to look at the bigger picture in her dealings with people and events. She is intelligent, attractive, single and in constant search of her career niche. Through our interview discussions, it was learned that Rowan feels that occupational therapy does match with her career and life goals. She is currently working at a skilled nursing facility as one of two occupational therapy practitioners

Our first interview was a telephone interview conducted on July 27, 2009. The second interview was also conducted via telephone during the early evening of September 3, 2009. Rowan reports that no major changes have occurred at her worksite between interviews, but she has started a new relationship.

Sage. Sage, a 35-year-old man who graduated from the OTA program in 2008, was interviewed in person on August 1, 2009 at a coffee house in Southeastern, NC. He asked to conduct the interview in this town as opposed to his new home town of Raleigh, NC for

reasons he did not discuss. Sage currently works as one of three OT practitioners at a skilled nursing facility, which is a 30-minute commute from his home. He brought several pictures of his facility and treatment area to the interview because he knew that I was interested in seeing where he works.

Sage is a very private individual who is very kind and sensitive to the needs of others; he is quiet in demeanor, yet very personable. Sage has remained friendly with several classmates and reported that he was to visit with one after the interview and will eat Sushi, a tradition for this friendly duo.

Sage spent time in the Marine Corps in the 1990's, but did not make this his career. He is originally from Texas and has not returned there to visit his family in several years. He can sometimes appear insecure with his skills and often referred to himself as a 'new graduate' during the interview, despite having worked in the field for nearly a year. Several times he remarked that he will ask clinical questions of fellow OT and PT practitioners while at work. Although a worthy trait that indicates an interest in learning, this is also seen as a bit of insecurity with his skills.

Sage reports that he often defers to the opinions of others and considers his participation in this research project as a way to 'give back' for the education that he received. He is very pleased with his current career; he reports that this is a positive for him as he tried the military but did not have a specific career goal until he was in his 30's.

This current position is Sage's second; his first job lasted only six weeks and was located in Raleigh. He reports that he feels as though he was taken advantage of because the

site had 100% productivity expectations, and despite their knowledge that he was a new graduate, they did not provide him with any orientation time or ramp up time for a caseload. He was actually "written up" for low productivity after only a couple of weeks of employment, which was very disconcerting to this ethical and hard working individual. Sage found that the turnover of therapists was very fast at this facility; he lost an OTR supervisor within a month and was told by a fellow worker that he needed to be careful since the facility would not likely hire another OTR. This lack of supervision would break NC licensure laws of having daily supervision for Sage as an OTA within his first year of practice. He was fortunate to find his current, much more satisfactory position, within just days.

Sage was interviewed for the second time via telephone on September 15, 2009. He reported that no changes have occurred in either his personal or professional life since the time of the first interview.

Jordan. Jordan was interviewed via telephone on September 22, 2009 and October 14, 2009. A 2009 graduate of the OTA program, Jordan has recently become employed by a community hospital in South Carolina. Despite her need to commute over one hour to work from her home in southeastern NC, Jordan has expressed enthusiasm with her new work place stating that she is already learning a lot and looks forward to learning more from the large OT staff at the facility.

Jordan is 27-years-old and resides with her husband of two years in their own home. She reports that OT is her second career and is pleased to have found a profession that she feels matches her personality and professional goals. Several of her long time friends are

previous graduates of the OTA program and encouraged her to explore the profession, believing that it is something she would enjoy.

Jordan described herself as a very organized and kind person who will do anything to help people. She has been observed being very sensitive when listening to stories describing challenges of others or when recalling situations herself in which individuals were hurt or otherwise victimized. She is a caring and compassionate person who is sometimes unsure of her abilities and skill, and stated this during the interview meeting.

Kelly. Kelly, a single 23-year-old woman living in New Jersey was interviewed one time via telephone during the afternoon of July 10, 2009. Kelly reports that she is in the process of buying her first house with her boyfriend with whom she has lived for the past year. She is currently working at her third job since graduating from the OTA program in 2008.

Kelly reportedly left her first job as a result of a significant personality conflict/difference in values with her employer and finally a car accident that put her on disability. When she was recuperated from having the car accident, she obtained her second job, but was let go when the facility learned that she was still officially on disability. She then connected with a contract agency that found her a job in April of 2009. She found this position to be a good fit, but reportedly erred by treating a client one day who was on isolation. Kelly developed a staph infection in both eyes and is now on worker's compensation. After being placed on workers comp and completing an incident report that cited her supervisor as incorrectly telling her to treat the client, Kelly was let go. She is to

return to serve out 2 weeks of work and will be placed in another facility, an outpatient hand therapy clinic, within in a couple of week through her contract agency.

Kelly is a very talkative young woman who left no stone unturned in her descriptions of her work since graduation. At times, I found her to be tangential in responding to interview questions and it was somewhat difficult to re-direct her thoughts. Although most questions dealt with Kelly's perception of OT, her responses often started with her thoughts about herself. Kelly often finds the actions of others to blame for her misfortunes. She does not seem certain as to why she has difficulty getting along at some facilities; she reports that criticisms of her in the past have hurt her feelings, but that she is much more secure in her abilities since her current site treated her respectfully, prior to letting her go.

Kelly entered the OTA program at after completing several OTA courses in Pennsylvania. She reports that she did not care for the program in Pennsylvania and wanted to relocate to NC with a boyfriend, so transferred into my program. She mentioned that she may have missed some information when switching schools, but described herself as a good learner who eventually picked up all of the skills needed and passed the certification test on her first attempt.

Kelly is interested in returning to school to become an OTR, but believes this to be a long-term future goal as she is very busy now with becoming a homeowner. She will likely stay in New Jersey, but mentioned several times that she misses North Carolina and the beaches.

Jamie. Jamie is a 38-year-old woman living in what she describes as a small, conservative Christian town in North Carolina. She was interviewed one time for this study on July 22, 2009, at her place of employment. Jamie has two adult children and is divorced with plans to marry her longtime boyfriend within the next month.

Jamie is a quiet and unassuming individual who is not one to gossip or speak about issues that do not concern her. She states that she prefers to keep her thoughts to herself unless she is asked a specific question. Even when asked, she will reserve judgment if an answer could be taken in a negative way. She is reluctant to say 'anything bad' about anyone else or any situation.

Becoming an OTA in 2008 was a second career for Jamie who was previously a day care provider. She stated that she did not think that she could love a population more than she loved working with children, but has found her work with elders in the skilled nursing facility to be very rewarding. One thing that she finds difficult about working with older folks is that on occasion, one of the residents of the facility will pass on. She became very sad when she mentioned this, stating that she has lost several of her patients due to their death. Conversely, she gleefully described her sense of happiness and accomplishment when her patients become well and are discharged from the facility able to function independently.

During the interview, Jamie stated several times that she was nervous about her responses. She felt that her responses were not correct and that she did not know how to put her thoughts into words. While walking to the OT treatment area, she introduced me to several work associates using my name; she did not refer to me as her teacher as so many

other participants have. She did not introduce me to residents although she did say hello to several folks who were sitting in the hallway

Observations of the facility indicated that there are two clinic areas on separate hallways. One space is established for Physical Therapy and the other for OT. According to Jamie, the equipment in PT area is used often by OT and is preparatory in nature. The activities include the arm arch activity, large colorful pegboard, standing table, UE bike, Nautilus machine and treatment table. The office of the clinic manager (a COTA) and PT's are contained within this relatively small space.

The OT area contained a treatment table, an UE bike, a table top surface, an adapted lounge chair, a small table that housed a few craft activities and other game-like activities. Office space also contained within the clinic area. A small adjoining room contained the desk of the Speech-Language Pathologist. This area also contained a large metal cabinet that Jamie mentioned contained many different games and activities. No kitchen or other ADL space was noted, but when asked, Jamie explained that they do have a hand held mixer and other appliances for table top cooking tasks that they occasionally do in the OT area.

Findings

This section details the findings of the study, outlining the experience of novice occupational therapy assistants as they create their professional beliefs and make practice choices while in the context of the work setting. Table 4.2 highlights findings as they relate to the four original research questions. The data will be presented in greater detail through the remainder of this chapter.

Defining and describing the profession of OT. The data display will begin with a discussion of the first research question that addresses how novice OTAs understand and describe the profession of occupational therapy. Participant interviews revealed that this group of novice practitioners creates strong beliefs about the profession while working and interacting with clients in the clinical setting. These beliefs contribute to the creation of the framework for intervention that ultimately guides treatment choices made by novice clinicians. Two categories emerged from the data that describe aspects of understanding the profession developed by the novices in practice. These categories include: (a) identifying OT interventions, (b) describing the unique attributes of the profession. Subcategories of the definition include identification of those interventions that OTAs are using in treatment as well as the purpose of those interventions. The description of attributes of the profession includes the subcategories of care and concern for clients, relationship building between the client and the therapist as a therapeutic tool, and the building of a sense of “community” within the facility and between clients.

Defining occupational therapy. Occupational therapy is a profession that struggles with presenting a cogent and consistent identity or definition to others in the health care arena and to consumers. As novice OTA Sage stated, “I find myself having to explain actually, to other departments in the building, what OT is.” Students and clinicians must therefore create their own personal description and understanding of the profession based upon their educational background and experiences. The definitions of the profession offered by novice OTAs are often distinct in their wording but share many similarities that

Table 4.2

Findings

-
- I. Defining and describing the profession of OT
 - A. Defining occupational therapy
 - 1. Identifying OT interventions
 - 2. Describing the purpose of OT interventions
 - B. Describing the attributes of the profession of OT
 - 1. Revealing care and concern for clients
 - 2. Engaging in relationship building as a therapeutic tool
 - 3. Recognizing community building as an outcome of intervention
 - II. Creating an understanding of occupational therapy while in the context of the clinical setting
 - A. Learning through interaction with clients
 - 1. Recognizing enhanced function of clients
 - 2. Recognizing changes in affect/emotion/motivation of clients
 - 3. Recognizing changes in client factors
 - B. Learning through formal venues
 - 1. Recalling lessons from academic program
 - 2. Recalling lessons from workshops
 - 3. Recalling lessons from books and periodicals
 - C. Learning through interactions and observations of peers
 - 1. Seeing positive examples
 - 2. Seeing negative examples
 - 3. Engaging in discussions with peers
 - III. Factors within the context of the clinical environment that contribute to shaping practice choices of OTAs
 - A. Being supported in practice choices by work facility
-

Table 4.2

(continued)

	<ol style="list-style-type: none">1. Recognizing administrators and supervisors as supports2. Recognizing financial supports within the work facility3. Recognizing mission and vision supports within work facility4. Recognizing physical environment supports within work facility
B.	Being challenged in practice choices by work facility
	<ol style="list-style-type: none">1. Recognizing administrators and supervisors as challenges2. Recognizing financial challenges within the work facility3. Recognizing physical environment space challenges
C.	Responding to requirements of third party payers
IV.	Enacting a personal understanding in practice
A.	Assuming a professional identity
B.	Enacting espoused beliefs
	<ol style="list-style-type: none">1. Engaging in occupation-based and purposeful activities2. Engaging in preparatory techniques and enabling activities

distinguish the profession from others. In this section, the actual descriptions of the profession will be presented in addition to the purpose of OT as described by research participants.

Identifying OT interventions. When asked to share her personal philosophy about occupational therapy, Ashley provided a multi-point perspective that outlines her thoughts and beliefs. Firstly, she stated, “occupational therapy is a skilled discipline that is much needed and used to help lives of many people who have great challenges in their lives and we

help them to become independent as far as they can go.” She goes on to say, “[For example], it’s the accomplishment of being able to pull your pants up.” She points out that as a profession, “we try to be functional based, as much as we can, occupation-based.”

Jamie demonstrated her enthusiasm for the profession as she described it as a means to getting client back to independence in life when she stated:

It is very meaningful and purposeful. I want my daughter to do it; I want everybody to know about OT because I did not know about OT until I started to school. I knew a little, not much, and then whenever I got in there and started learning how we could help people....It is just an absolute wonderful thing. I mean, I don’t know how to put it into words like I want to. Um, it, to get people back to their independent way of life. To be more independent as they can.

Kelly shares a philosophy and describes the profession in a similar fashion to Jamie. She is realistic in her description of client outcomes through OT in her facility. Always striving to help individuals safely return to home, she recognizes that some clients will remain in the skilled nursing facility, yet still have a right to as much independence as possible within that context:

We primarily focus on the patient...we focus primarily on activities of daily living, ADL’s, IADL’s, leisure is very important...it’s a holistic wellness approach to get the patient where they want to be, as good as they can go. Whether that be they can return home, which obviously is always my goal, to make sure they can return home, but sometimes that’s just not going to happen, but to get them to where they can be at the

highest level of function doing things they would do daily. You know, reading the newspaper, going to bingo, walking to the dining room.

Casey also describes facilitating independence in ADLs as a main function of occupational therapy:

We're a field and we're here to help you do things in your everyday life that you were once able to do but for some reason now you can't. And I would tell them whether it is dressing, bathing, going to the bathroom, you know cooking, brushing their teeth, brushing their hair. I would ask them of these things, what can you do and I would tell them you're here to regain those areas that you lost due to whatever your diagnosis is or whatever your problem may be. And... I mean we're just pretty much a big field, you know. Whatever they need help with pretty much as far as their daily living activities.

In her interview, Hayden reinforced the notion that OT is defined and described differently by different people when she said:

I think that each person has their idea and with OT being so... being so easy to kind of make your own. I mean, you do have guidelines but you have the flexibility to make it your own to an extent.

She goes on to say, from her perspective that:

My biggest thing is accepting the person as a whole. I see where, you know, the emotional or the spiritual part of a person, you know, it is all wrapped together with the physical and the mental status, and it really, I mean, it is one of the biggest parts of where I see OT from.

Jordan not only finds that practitioners define OT in several different ways, she also reinforces the notion that OT is conducted in different ways. Jordan describes OT as:

OT is practiced in many different ways. You can definitely tell a difference between an OT or a COTA who is, I don't want to say a new graduate, but maybe client centered, somebody who really wants it to be about the ADLs and about the function versus about just doing therapeutic exercises....my philosophy... That your practice has to be based on your client and their wants and needs and their goals versus goals that are set forth for them....It has to be relevant and mean something to them.

Sage also refers to the variations on beliefs and descriptions of the profession, "like OT, it's extremely diverse, very flexible. You know, it can, it does, it can do a lot of things. It is adaptive..." Rowan presents a more symbolic view of the profession what she states that, "OT, you just, it is like an empty canvas where you can create anything you want to reach that goal."

This group of descriptions of OT share several similarities such as the reports that OT is defined and practiced differently by different individuals, it is client-centered and is focused on the regaining of lost function in activities of daily living. The ideas that the profession considers all aspects of humans, including the mind, body and spirit and that practice can be creative are also described by participants.

Describing the purpose of OT interventions: In addition to describing what the profession is, the participants also reported what they have come to know as the purpose of the profession in the lives of clients and within the health care milieu.

Ashley, Casey, Jamie and Jordan described the focus on ADLs and returning clients to independent function as the primary purpose of the profession. Ashley stated, “We try to help them in any way that we can from positioning, functioning, from all the ADLs, any area of their life that we can help change for the better, that’s what we are here for.” Casey reinforced that belief by saying, “We are here to help them with their dressing, their bathing, their money management if need be, their home management, cooking, just everything that they do on a daily basis.” Independence was also the purpose of OT as described by Jamie, “to get people back to their independent way of life. To be as independent as they can.”

According to Jordan, the purpose of OT is the final outcome:

It’s just the end result, what are you trying to get that person to be able to do. Is it to, you know, maintain the grip on that walker so, you know, they are able to move functionally within their home. Okay, well then, let’s get some hand strengthening exercises by... we will play Yahtzee and I will make sure, you know, they have a good grip on that cup or that sort of thing.

In addition to ADL function as an expressed purpose of OT, novice OTAs report that the more esoteric side of the profession is also part of the overall purpose, that being the enhancement of quality of life through treatment. Hayden states, “to me, it is bringing back more than function, it is bringing back life within a person.” Ashley similarly states, “Just being able to help them in any way, like, help enhance their quality of life. I guess the wanting to enhance the qualities of other people’s lives.” Tracy shared her thoughts by reporting:

My philosophy is we work for the patients, for them to be as independent as they can possibly be. For them to live life to the fullest, if they are unable to do something we find a way for them do it. Nothing is impossible because of their disability or their age, or their level of strength.

Sage also reinforces the quality of life issue but also sees the lack of independence as a loss of power for the client and therefore views part of the purpose of OT as being a profession to enable individuals to regain power over their lives and choices. This philosophy is in keeping with the beliefs of the profession as put forth in the Occupational Therapy Practice Framework (AOTA, 2008):

I almost have to say just to make them functional. Try to get them as independent as possible; just to give them as much power as they can because sometimes, the people I see have so little power and control of their own lives. People dress them, feed them, change them and so, even if I can just give them where they can even assist some or even just feed themselves; just give them any kind of power. You know, some sort of control in their worlds.

The use of occupation-based and purposeful activities as tools for OT treatment were described by the participants as being a way to create a meaningful, relevant and client-centered experience. Ashley made the following statement about an occupation-based approach:

I think doing the function based helps the patient realize that what they are doing is going to carry over into their everyday lives. Whereas, them lifting a bar in the gym

may not make them realize that that's going to help them walk down the hall holding their walker or you know, wheeling themselves in the wheelchair. They may not put that all together, but actually doing something, maybe actually wheelchair training, or if they're going home, doing a cooking activity or laundry or anything that they need to learn how to do, doing it would help them be successful.

Hayden's observations of the effects of a treatment she conducted were similar:

I guess, uh, this one lady, she is like my favorite lady; I know you are not supposed to have favorites, but she is. Every day it's like, she won't work with too many people, but once I go in, and I kind of give her this extra added, you know, I guess its caring, you know, to an extent, and she knows that. So I go in and work with her, and she one day told me that she wanted some flowers, she had some pretty dead flowers in her room and we had continued to water those for a long period of time, and so I finally brought in my jade plant from school. I told her that she could have it, but we needed to repot it and everything, and she was just so thrilled. You could see that light in her again. And so, through OT and my practice, that is where I felt like just bringing that type of thing out of people. And so, she is so funny, but it was really good to see that come out of her again. And she had enjoyed it, and every day she is watering it. So, it's just something that we kind of were able to share and see a side of her.

Summary. Participants' describe the profession of OT as a client-centered approach to assisting individuals to regain lost functional abilities while tending to the entire person,

the mind, body and spirit. The purpose of the profession is described as being an empowering treatment that provides the service of re-training for lost function while ensuring that the individual experiences a life of quality during the actual process of treatment.

Describing the attributes of the profession. In addition to having a description and purpose, novice OTAs have identified certain attributes within OT that set it apart from other professions, making it unique in the healthcare environment. These attributes are: (a) the genuine care and concern that participant's report, (b) relationships formed between the therapists and the client, and (c) the community building within the context of the healthcare environment that OTAs have reported working toward as part of their treatment approach.

Revealing care and concern for clients. During interviews for this study, the concept that occupational therapy is a profession that demonstrates significant care and concern for clients was repeated time and again by novice OTA participants. OTAs recounted on several occasions their personal enthusiasm for working in the field and their concern for the well-being of their clients. As was so aptly stated by Ashley, "I love working with the patients. I try to do anything I can to motivate them to get better and as far as what they want to be able to accomplish in their lives."

Casey recounted two stories where she was touched by the positive response of her clients when she involved them in activities that they may not have otherwise experienced. She shared these stories as exemplars of significant moments in her career thus far; these client interactions did not occur during a treatment session per se. In the first story, she recalled providing a birthday party for an elderly gentleman that she was treating:

I just felt like it would be something special to him. You know, the guy is like 88 years old and he has never had a birthday party before and I felt kind of bad for him. I didn't know what his situation was growing up. Maybe his family didn't have money to have him a party or maybe, you know, maybe he didn't have a good family while he was growing up so you try to make the best of what can for what he has left, you know.

Casey later explained that the daughter of this man wrote her a note the following week to express her gratitude and to tell her how pleased her father was that he was given a birthday party. In her second story, Casey describes a fund raiser activity taking place at the nursing facility. She purchased paper hearts and put them on the door of a lady who tended to stay in her room:

So I went in and bought her some hearts and put them on her door and I went and told her what it was for and why the hearts were on her door. And she said, "oh my goodness, you little thing I don't know what I am going to do with you, you are just so sweet." She started smiling and started getting tears to her eyes. And I was like, okay, it's fine, and she asked if she had to pay me for them and I told her no. I told her the hearts she had she might win a prize. Just little things like that just makes her day, just to know that someone else is thinking about her.

Casey believes that the client is the most important individual in the therapeutic relationship:

The most important thing to me is putting the client first and, I mean, you know, if was someone in my family I would want them to be put first and just really do

whatever you can possibly do to try and help to try and help the patient regain whatever function they may have lost or regain it to the best ability they can to get back to their prior level if at all possible.

When asked to describe the traits that she feels are important for OTAs to have, Hayden described the following traits of a person that she considers a role model:

[She's] Just a people person, being able to sit down with people and not just always be about the minutes and be about the day...Sit down and just have conversations with people and that was carrying out a treatment as well, just in different, in another area. It was really nice to see her just relax and the patient's would respond to that a lot easier than, "Hey, get up out of the bed." I really admired that in her, because that is what I feel comfortable trying to apply as well.

She went on to describe traits that she feels are important for new graduates to have:

So, I think that that is the number one thing, just having patience and listening and just being able to hear them out and what their needs are instead of just trying to force things on them because people don't work like that. So, I'd say in order to be a successful therapist, that is the number one thing, is listening and then patience, huge patience because you never know what type of patient you are going to get and what type of ways come with those patients, their attitudes or they ways about them. I'd say, you've got to be able to sit down with them and learn who they are.

When asked for a metaphor that describes OT, Hayden said:

I would have to use the word life, I guess. Because I think the holistic view of the

spiritual, mental, and physical is life. I mean, and the spiritual part you can see it really shine through and I just think that OT just gives life. I just always felt that way, that is the reason I chose the profession.

Throughout her interview, Jamie shared similar thoughts and stated:

I think I am very caring. I want to say, I'm not passive, but I'm more for the other person. I don't know how to explain it. I think of the other person before I do myself. I listen to people. If they have a problem, whatever, I'm always there for that person, always. Colleagues, family, it doesn't matter.

We had a man that had Parkinson's and he was my favorite, I hate to pick favorites, but he, I just loved him. Gonna make me cry to talk about him... anyway, he had tremors so I gave him some weighted utensils and a weighted cup and it helped a lot. He was my baby doll. His wife had to come in every day to feed him, and it was more convenient to him to be able to do it himself. Because, he was a veteran from the army and so he was very independent from being in the army. I mean, he wanted to make his own bed, he didn't want the CNA's to make his bed; so I would help him make his bed. He didn't want me doing hardly anything, but he wanted to do everything himself, so when I got him those utensils and the cup where he could do it his self more so that made him, and it made me feel good, to know that he could do that independently and not have to rely on somebody else.

Jamie recounts another situation where she visited a bed ridden resident that was not on her treatment caseload. The client enjoyed having water to drink, but was unable to drink

it without assistance. Out of care and concern for the well being of this individual Jamie reveals:

I went to Wal-Mart and got her a cup this big with a straw because she is not very strong and she absolutely loved it. At first she hardly had the strength in her hand to lift that cup a lot, but then she finally, gradually she got used to using that cup.

Jamie states how she believes that her peers view her and how her personality impacts her relationships with clients:

Very professional, the clients, the patients love me to death and I love them. I'm all about the patient and their needs....when it comes to a meeting, a family meeting, sometimes I'll go because I know more about the patient then probably anybody because...I get more one on one with them while we are in treatment. I mean, sometimes they may be doing paperwork or something. I just get more, I mean, not personal but, it's like, my personality, they like to talk to me.

Kelly is able to distinguish the differences between the medical setting mandate to be productive and revenue producing, and her belief about OT as a caring profession:

I do not like fast-paced work environments because I feel that I have less time to really do what I need to do and its more of preparatory techniques, you know, just get the minutes in; I don't like that. I know it's a business and we have to make money, but at the same time, I really care about patient care and there has to be a happy medium. You have to really be a people person, empathetic.

Logan believes that it is important when practitioners are interested in, "Figuring out

where to get the richest experience for the individual.” He states about himself, “ I take time to learn about the individual and don’t just visualize it [treatment] as, you know, a time that I have to be somewhere. I visualize it as a person. It makes much more of a meaningful relationship.” He goes on to say:

Spend time with the individual; see if they begin to open up to you as we sit down and spend more time together. It is a challenge, the motivation to sit down and try to pull this relationship out when it is obvious that they are not, the motivation isn’t there, it is a challenge.

When asked how his practice demonstrates that he is an OTA who is concerned about the needs of the client, Logan stated:

I try to pay very close attention to what the patient needs throughout the session. If they need water, if they need to rest, if they need to stand up, if they need to go to the bathroom. If trying to go into the bathroom and practice toileting is too challenging that day, I won’t ask them to do it just because a [progress] note is due.

With regard to traits that a new OTA graduate should possess, Logan believes:

If you really love patient care, if you really want to work one on one with the patient and assist them then this is definitely the job for you. Don’t have, if you don’t have relationship or communication skills with other people then this is not the right place for you. You definitely have to be a team player and work with many different, many different people, aides, nurses, PTs, OTs, your boss, family members, the patients, you know, all those people are involved in treating one person so if you are not a

good communicator then you are going to be, you are going to isolate yourself and that's not good for the patient or you, or any of the people that you are going to work with.

Sage shares the sentiments of his peers when it comes to the attribute of care and concern for clients demonstrated by OT practitioners. He states, "you just don't want assembly line OT, just to get the productivity." He goes on to describe his personal approach:

I guess by the way I talk to my patients, the way I approach them. I mean, I try my best to give them all my attention. I try to let them know that they matter, you know, that they are not just a name on my board. You know, that I may not know what they are going through, but I try to understand; and I try to convey to them that even though this is not fun, because a lot of times they hate therapy, you know, that they need it, that it is going to give them some control, some sort of power.

Sage believes that, "patience and genuine concern for your resident" are two of the most important attributes of a successful OTA. Tracy shares this belief as evidenced when she states:

A good therapist that really cares about their client and that really cares about the well being of their client. I think you need a good-hearted person, I really do. And every OT that I have met, they just, deep down, they just seem like a really good character. So, I think that is very important.

To me, it's being good to the clients and giving the clients what they need. I think, I live like in the moment, I want them to enjoy that treatment right then and

with her, she is looking at the end result, you know, if she does this machine and does this and does this then this is what will happen, she will gain her strength up where she will be able to dress herself and bathe herself. So, I kind of live in the moment right there. What do they want to do, how can I make that activity meaningful to them?

This section has outlined the beliefs of novice OTAs with regard to the sub category of care and concern for clients. OTAs have stated that this should be a practice and personal trait of OT practitioners that they should demonstrate through sincere compassion in thought and action.

Engaging in relationship building as a therapeutic tool. In addition to demonstrating care and concern for clients, novice OTAs also describe the attribute of relationship building as being an integral part of the OT process; a phenomenon that facilitates communication between therapists and client and ultimately enhances motivation and sense of well being within the client. Tracy describes the pragmatics of the time spent in the workplace and the importance of establishing relationship with clients for the benefit of all parties:

Because, I mean, I spend more time with these people than I spend with my friends and family because I am with them every single day and this is where they live, this is their home. So, you know, I want them to feel comfortable with me and have a relationship with me and everything.

A similar philosophy is shared by Hayden who stated, “everything matters, it’s just that I think my biggest point would be building a relationship with the patient,” when asked

to identify one of the most important reasons that OT conduct the type of treatment that they do.

Ashley also sees the results of having a positive relationship with clients as it distinguishes her approach from other practitioners:

I'm a little different than some other people. Some people can be more pushy, "come on we're going to therapy", and I try to come in and start a conversation and build a good rapport with the patient. I need them to like me and I want them to, just using therapeutic uses in every way possible definitely benefits....you can laugh and joke and have a good time, but also be very productive and make progress while doing that.

Casey remarked about the importance of the therapeutic relationship in client and compares the response of clients when dealing with a practitioner who treats them well versus those that do not:

You know the patients definitely remember who you are and what you have them doing and they remember how you treat them, they remember how you talk to them and if you know give them attitude. I have three or four that refuse to be seen by one person...when they come over, they strictly ask for who they want to treat them because of the way some of the other OTs have been you know treating them or the way that they talk to them or they things that they give them to do.

Ashley goes on to describe the positive results of building the therapeutic relationship for both the client and the practitioner:

I see the patients and getting to know them, I feel like every day I find more and more what they need to work on, or, you know, I try to keep my eye out for what things they could improve upon, and, I guess, just getting to know them and developing that relationship with them inspires me to want to help them as much as I can with the time that I have with them.

Kelly explains how she begins building a relationship with clients, tying the relationship building into the client-centered approach that she espouses:

Initially I start right off the bat, I tell them my name, I tell them my profession, I tell them a little bit about myself so they feel a little comfortable, I'm not a complete stranger. Then, I go into, "this is what I believe..." Any point in time you want your progress notes, you want me to review how you are doing, we focus on things that you want, I can recommend things that I think are safe, but it's all about you. You are the customer, and a lot of patients, sometimes are like, "I feel bad, don't do this" and I tell them this is my job. This is what I want to do. I want to help you and I want to get you better.

Logan describes his belief regarding the positive effects that relationship building has on therapy and the willingness of the client to participate in, and benefit from intervention:

I think it creates confidence, you know, the patient has confidence in the time that we spend with each other, they don't just view it as a need to be here, they want to be here, they want to participate.

You can have the best therapist in the world, and the best book knowledge,

have all the x's and o's in place, but if they can't communicate with the staff, residents, etc., in a way that people are willing to participate with the course of action, it becomes a big problem.

Sage also describes the positive effects of relationship building with clients:

You have to connect with them on some kind of level so that they will work with you, they will trust you. Sometimes, if they are scared to stand, you will never get them out of a chair or never get them up on a walker if they don't have, if you don't have some sort of trust.

The concept of relationship building as an attribute of OT intervention is described as a means of facilitating a working relationship with clients and others in the rehabilitation milieu. Positive relationships based on respect, trust and positive emotions are motivating for all parties involved and can be recognized as a helpful entity when compared with situations in which such relationships are not established.

Recognizing community building as an outcome of intervention. Several novice OTA study participants described a direct outcome of treatment interventions that not only benefit the client, but benefit others within the milieu as well. This phenomenon, although not termed as such by participants, is describing a form of community building. Facilitating communication amongst staff and residents through creating a common history, a common activity and opportunity for common discussion is seen as a motivating entity for OT clients. Tracy uses events taking place throughout her facility to create meaningful engagements for her clients. When clients participate in facility, activities it gives them a greater sense of

belonging and contributing as well as linking them to others within the facility. Tracy relays the following story:

We had a yard sale in the dining room and it was to benefit the Alzheimer's walk and I just kind of took advantage of that and took one of my patients in short-term down there and had her do, walk around and, get the clothes out of the bags and fold the clothes and set up for the yard sale because she has housekeeping type goals whenever she goes home. So, I mean, different activities that go around the facility that influences some of my treatments. We are having a senior prom on Thursday and Monday I am going to have some patients help, like, with making the decorations and stuff like that. So, I mean, different activities that go around the facility influences a lot of my treatments too. IT makes it fun for the patient as well when I find like new, different, like helping out with the yard sale. And if you tell them "you're going to help with the yard sale", they're like "yeah" and all excited about it.

Ashley had a client wash dirty windows in the therapy room as a purposeful activity. He had goals that were addressed through the activity and received gratitude and attention from other clients who use the room:

One of my patients, he had two goals; one was to increase bilateral upper extremity coordination the other one was to increase standing tolerance. So, I got him to wash the windows in our therapy room, which were really dirty. He did it, and he enjoys being able to help us and it was working on both of his goals that he had and he ended up meeting both of his goals.

I knew that, he was tall and he could reach the windows at the top and I could see that it needed to be done and I was just trying to be creative and come up with something functional that he could do...., there was tape on one of the windows and I couldn't reach it and I was like, I know who could, and I was like, I might as well get him to do this and then I was like, why don't I just get him to wash all of the windows....And he enjoyed, he'd come down every day and we would do a window. I could feel that he had definitely a sense of accomplishment after finishing them. He could tell the difference between how much more clear that they were....Other people thanked him for cleaning and, you know, he was smiling and you could tell that he was appreciated for doing what he did.

Tracy recounts another situation where she was instrumental in bringing two ladies together as roommates who were otherwise becoming withdrawn and depressed. Despite the fact that this was not a treatment session per se, Tracy was able to recognize the impact of socialization upon the functional status of these ladies:

I have one patient who never wants to come down to therapy. She just, she makes comments like, "I wish the Lord would just take me" and stuff like that; and her roommate is non-mobile and she doesn't talk at all. Then I have another patient...and her roommate is the same way; doesn't talk, non-mobile and she [my client] loves to talk. She loves to come down to therapy because she knows that is where she can talk to other people; the treatment room is what she calls it. We always, the speech therapist always brings her down for breakfast and she just loves it, loves talking.

And, I'll get that other patient, Mrs. J and I wheel her down and I have to just push her. I have to not listen to what she says [that she does not want to leave her room] and just push her down there. And once she gets down there I always pair her up with this other lady and they just start talking and talking and they start doing stuff and they don't even complain or realize or anything. I always pair them up and do treatments with them together and their goals are similar. So, I went and talked to social services and I explained to her what the one lady was saying about the Lord just taking her because she just sits at her window and looks out the window. She doesn't talk to anybody, she is always in that room. Her only socialization is when she goes down to therapy and she is only three times a week, so I talked to her. And then the other lady, she is very sad because her cat is at home and she just came to the realization that she can't go home, the family doesn't want her to go home, it's not safe, so I talked to her about putting them in a room together because it is really like having somebody to talk to and having a friend in an environment like that is so important. It makes it better for them as well for us because it makes them want to come down. So I talked to social services and on Monday they are going to put them in a room together.

The novice OTAs interviewed for this study recognize the power in building community and including residents in activities that bring them in proximity to other residents. The resulting socialization enhances well being and motivation, two ingredients needed for successful treatment outcomes.

Summary. Research question one sets out to determine how novice OTAs describe the profession of occupational therapy after working in the field. In this section, participant commentary points to a belief that the profession of occupational therapy has several inherent features that create its motivational effect upon clients. When practiced well, the profession is described as being a facilitator of functional outcomes that is client-centered, occupation-based and concerned with the well-being of the individuals being treated. OT practitioners build relationships with clients as a way of enhancing motivation for treatment and ultimate independence, as well as to demonstrate care and concern. Community building between residents is also seen as an attribute of the profession and the professionals who work to create group experiences and opportunities for socialization and participation within the facility.

Creating an understanding of occupational therapy while in the context of the clinical setting. The next set of findings are those that relate to the second research question, how novice occupational therapy practitioners create their personal understanding of the profession of OT while in the clinical setting. Three key categories have emerged from the data that provide insight into how novice OTAs form their personal understanding of the profession. These concepts include, (a) learning through interaction with clients, (b) learning from formal educational programs, and (c) learning through observation of peers.

Learning through interaction with clients. Novice occupational therapy assistants who participated in this study consistently remarked on the importance of the observing client responses to their treatment selections as an indicator that they were being successful

practitioners in their respective settings. The success or failures of the treatments they provided offered new insights and validated their previously held beliefs about the profession. For this study, learning by doing is defined as the acquisition of knowledge gained through the observations of the effects of one's actions, and then using those observations to support change or continuation of the behavior. Ashley, a study participant stated, "the hands on experience, working with clients you learn more every day. And you also learn more from your coworkers, the people around you. Casey supported this idea through the following statement about learning through doing:

Like trial and error kind of thing. You know, you do something and see how the patients outcome is and then see how the patient, I guess really, how the patient feels about it and then, oh it worked for this person maybe it will work for another person or maybe not so great with another person. So I will try to change it and modify it for the next person.

In this study, participants reported observing changes in client function, affect, emotion and motivation, and with physical body client factors. These responses are reported to have occurred both during and following treatment sessions that were conducted by study participants themselves as well as other practitioners.

Recognizing enhanced function of clients. Functional gains are changes in the client's status that relate to improved ability to engage in desired areas of occupation. In the settings where study participants worked, most functional gains were in areas related to self-care, which includes dressing, grooming and bathing. Participants gauged the success of their

interventions based on direct observations or reports from clients and families that relate to enhanced function.

When asked to describe a situation in which she knew that she was successful as an OT practitioners, Hayden recounted the following:

We had a patient come down on Thursday...she came down and brought us some chocolate and she just started bawling because how much she was going to miss us, and she wasn't even from here. She was from upstate New York and she was just visiting and had a fall....Just the look in her face and how much she was going to miss us all, that just said it right there. Even the area manager said, you know, if that doesn't say it, nothing does. As far as feeling successful in what you've done, the, you know your therapy worked and it made her feel good, and she's even going to miss you.

Similarly, Jamie found the ability of a client to return to independent living a measure of her success as a clinician when she reported this about a resident:

We got her back to her independent way of living, she was able to go home, and start re-living her life as usual, and, well, her husband is here now and she comes to see him. So, now she is not a resident but a visitor.

Logan believes that success of OT lies in changes in interests and abilities that he noted while clients were still in residence at the facility.

If I see them up and about or see them engaging in activities after or during the time I am treating. They are out of the bed. That is a big goal for a lot of people. They are

not stuck in the same position all day, every day. They are interacting with the community at large, if they are on the front porch, if they are spending time with their family.

Rowan observes the effects that treatment has on the functional capabilities of her clients:

Now that I'm really in it and seeing it for what it is and seeing how four week or six weeks that a patient is doing OT and goes home and can do all these things. It hugely impacts their lives and makes them independent, most of them.

She states that perceptions of her clients regarding OT treatment, the direct feedback from them, shapes her thoughts and beliefs about how she should practice. "When they [residents] talk to me about what's important to them and how they, what they get out of our treatment sessions, that probably has influenced me the most in how I treat."

Tracy also finds the success with her efforts. "You see that you actually made a difference and you actually helped them and they can put their clothes on now. I have a lady who is driving. So, just seeing how the patient's progress has been the biggest influence." Tracy can see the links between the client's improvements and her skills as a clinician:

When a goal is met, or they accomplish something that they couldn't the day before or the week before; just like my patient who was driving to church. You know, she is living at home by herself now. Just seeing the progression, seeing, they were not able to do that, or looking back in the notes and them saying *max assist* ... and now it's

saying *standby*. I say, wow, I must be doing my job.

Recognizing changes in affect/emotion/motivation of clients. Changes in affect, emotion and motivation are another area of observations made by participants and are typically described as facial expression, emotional displays or motivational levels of the client. Affect and mood are not typically recorded as OT treatment goals for clients in the long-term care or rehabilitation setting, but were consistently reported by the participants as being very important outcomes of daily treatment encounters. Several participants reported positive changes in client motivation and affect as factors that influence the way they think about and understand the profession.

Casey finds that her approach is effective for enhancing the enjoyment that client have during treatment:

I think it's just the patients, just you know, like when we see the smile on their face. You know giving them something different to do. A lot of them used to play sports you know, when they were younger so it probably relates back to when they were younger or they are "oh my grandson plays basketball" or something like that. Just seeing their reaction on them and just seeing how much fun they are having doing is really what keeps me going out buying new things.

Hayden also reports the response from therapeutic interactions as an influence in how she understands the profession.

I think the response that I get from the patients and the interaction that I do have with them as far as building a relationship. I believe the response that I get from that is what I feel like influences me.

In this same vein, Hayden describes a personal experience that she had with her grandmother who was undergoing occupational therapy treatment in a skilled nursing facility several years ago. This experience, according to Hayden prompted her to become an OTA. “With my grandmother, just basically watching her for an entire six months, you know, and just basically, just going, and then when I saw her come to, with this big light in her face, it was through OT.”

Jordan saw the effects of occupational therapy intervention on client motivation first hand, as she relates in the following about a client that was receiving a reductionist form of OT. When Jordan provided a more occupation-based paradigm perspective, she observed significant changes which reinforced her ideas about that form of intervention:

When I sat her up in front of the mirror with her makeup laid out in front of her and the response was totally different, you know it was something that drove her, it was something she wanted to do. Did it make her better, instantly? No, but within two weeks...she's like turned into assisted living, she made the bedside to the bathroom test while I was there.

Rowan concurs, “...makes me think that this is the OT that we learned about in school, you know, this is the OT that we should be doing. It is what the patient gets excited about and motivates them.”

Logan draws his understanding for and excitement about OT from the successes of his clients when they are engaged in meaningful activities and occupations:

I think success from my patients. You know, to see them move forward at some level,

be it something as simple as complete a shaving activity or something as dynamic as building a model that they are interested in. That is always a huge motivating factor for me to get back in and sort of explore those rich opportunities that exist. It's just a matter of pulling them out.

Conversely, Casey sees a lack of motivation on the part of clients to participate as representing a less than optimal treatment session. "I guess just not having patients wanting to participate in therapy would be not a good day." Logan supports these observations illustrating how lack of motivation creates an obstacle to treatment for the client. "...their motivation is not there to begin with so, you know, we are working with unmotivated people at some point, so that is probably the biggest hindrance as well."

Rowan has experienced the effects of both engagement in meaningful activities and the use of preparatory methods on the motivational levels of her clients:

A good OT day is a day that I am doing activities with the patients and they are very excited about doing what you ask them, they are excited because it is something that they want to do, a goal that they want to accomplish. A not so good OT is a day when you are doing a lot of preparatory activities; they are not that into it.

She goes on to support the importance of an occupation-based approach to treatment versus a reductionist approach when she states:

Well, it's just, I think what motivates the client to perform, you know. If you are just asking someone to do something like some rote upper arm bike and there is no attachment to where am I going to be, how is this going to affect me when I go home?

If there is no attachment there, then there is no motivation to really perform well and they are just going through the motions of.... It's almost like you are seeing somebody and they, if they are doing something like that,...I think about colors, they are a kind of grey and dark, they are very neutral. But if they are doing something that, say they are standing in front of the sink and they are washing dishes and putting them away and that's what they really want to do because that is what they do every day at home. Then they are red and orange and purple, you know, colors that make them feel alive.

Recognizing changes in client factors. In the profession of occupational therapy, client factors are defined as those components of the body or mind that must be present at least in part for an individual to engage in functional activities and occupations (AOTA, 2008). In the settings used for this study, common client factors addressed by OT included strength, endurance, joint integrity, range of motion and the cognitive factors of memory and problem solving. Novice OTAs report the effects of their treatments on client factors and their role as OT practitioner. In some instances, participants were able to see that treatments focusing only on client factors were not in the best interest of the client. They found that a more occupation-based approach led to the overall improvement of mind, body and spirit, creating change in physical factors as well as other important facets such as motivation and cognition. Cases in which participants reported learning through seeing negative effects of a reductionist approach are considered learning through negative or non-example.

Jamie saw factor improvements through the use of an enabling activities to address the client factor of hand grasp; she values addressing the hand as a precursor to function. In the following excerpt, Jamie explains a modification to upgrade an activity that she made after seeing his successes with a more simplistic version:

I had a man that had a CVA and he couldn't grasp things and so I used a foam ball for him to, you know, start picking up. So, he got that part good, he had conquered that, but I wanted to make it more difficult for him. So I got, you know the Velcro thing that the balls stick to? I got that, so the ball would stick so he would have to pull it, so he would have to have muscle grip to pull it off...

Ashley described her observations of clients receiving treatment that focuses on factors versus a more occupation-based approach to care in the following statement:

A lot of times the patients don't seem to make as much progress in my eyes as they would if they were doing the more functioned based. Usually [that means] in the room kind of stuff [ADL's], things that they should be getting used to doing on a regular basis.

In the case of another client, Ashley ties motivation and a reductionist approach together when she comments "he probably would have been bored with that [UE exercises], more or less. Um, you know, he probably would have done it, but it wouldn't have been, like, as meaningful to him as washing the windows was."

Casey has found that when addressing client factors in isolation, there is a potential for not meeting client needs in terms of pain and tolerance for the activity. She has learned

that you can take the lead from the client and modify enabling activities to make them as client-centered as possible:

You would just have to understand [the client]...their needs and what they are able to do as far as when you start doing treatments. You need to think ...for example, if you give them something to do and they say “awe I can’t do this, this hurts my arm,” or you know, something is hurting.

In this excerpt, Casey also remarks on the differences between her interpersonal approach toward her client and that of other therapists who do not share her philosophy. I know some of the other OTs push them to do it—“you can do it, just keep doing it,” and with me, I would decrease it [the weight] and be like, “that’s fine we’ll build up to what you can do. You know we’ll build up your tolerance and stuff.” Relationship building and interpersonal communication with clients is a recurring theme in this study that will be described later in this chapter.

Summary. This section has provided data examples of how novice OTAs make meaning of their profession through actual interactions with clients within the workplace. When engaged with clients, the participants were able to see the positive effects of an occupation-based approach to care, as well as positive outcomes from more focused, preparatory treatments. Additionally, they were also able to see the less than optimal effects that occurred when OTs were not using an occupation-based or client-centered approach to care.

Learning through formal venues. In addition to forming their understanding of the

profession through observing the effects of treatments upon clients, participants also reported learning through additional venues. These venues include their academic OTA program, participation in in-services and workshops since graduation from the OTA program and reading textbooks, magazine and journal articles or visiting internet sites.

Recalling lessons from academic program. Study participants often remarked on lessons learned through their academic program when asked how they decide on certain treatment approaches or how they have come to know their profession. The following data illustrates beliefs of the participants concerning their current and evolving understanding of occupational therapy.

Casey describes her thoughts about academic learning when she states: “I think mainly what has influenced me has been what I learned from school and going and applying what I learned in the field of working.” She goes on to remark about occupation-based and client-centered treatment specifically, “I think just really what I was taught in school, what I learned from you guys, you know, to be occupation-based, and to be client-centered.”

Kelly remarks similarly when she replies to a question that asks what she feels has influenced her most in practice, “A little bit of school, you know, of course. Your teaching and T’s teaching about, you know, client-centered approached and all that good stuff...” Jordan also finds that she is using lessons learned in school as she practices as a new graduate:

I mean I’m very new to the practice but I really do feel like everything I am using now as I practice, I learned in school....right now, I mean,...just the classes and case

studies and that sort of thing that is what I am pulling from.

Some participants, such as Logan believe that the approach that they are seeing in the field is not the approach that was learned in school and is therefore not the approach that they would like to use in practice. Logan uses his academic experience to guide his beliefs at this point in his career:

I try to focus back to my classroom experience because so much of what I see in the field is not the direction I want to take my practice. I try to focus on what I learned in class and sort of keep that in more of a focus than into what some of the goals that some other people have set or what other practitioners are doing.

Logan believes that keeping with the lessons about OT from the classroom setting helps to maintain his grounding in the type of treatment he espouses. “To do effective OT, you know, which is a challenge some days, it’s got to be looking to the class room experience and the conversations we had in school for the probably the easiest way to stay on target.”

Rowan further exemplifies the fact that the type of OT taught during the academic program continues to influence new graduates. “Makes me think that this is the OT that we learned about in school, you know, this is the OT that we should be doing. It is what the patient gets excited about and motivates them.” She again notes the effect of her choice of treatment approach upon the affect and motivation of the clients with whom she works.

Sage is also of this mindset and goes on to describe his way of knowing the profession is grounded in what he learned in school:

I think that is what I was taught in school is really at the core of what I do now and if

it was different then I don't think I would be a good therapist or I don't think the things I work with would be [for] functional purposes.

According to Tracy, her greatest influence has also been school, "that's what you are taught. I just always think about the person first. So, I guess that is where it comes from, I always think about that person. I don't think about them as a patient."

Recalling lessons from workshops. Workshops offer novices an additional venue for learning about OT when in the field. Workshops are defined in this study as educational events that occur either at the workplace, in the form of a formal workshop or in the form of in-services presented by peers or equipment vendors. Workshops can be held off the worksite, be provided via the internet or in reading/written format.

OTAs interviewed in this study, described participating in very few educational workshops since becoming employed as OTAs. This is not unexpected since new practitioners are not required to participate in continuing education for licensure purposes until the second year post graduation. Those experiences that OTAs have had to date were often geared toward all allied health professionals or facility staff. Despite not being tailored specifically to OT, the participants do describe learning from these venues, and are able to articulate their belief regarding the relevance to practice.

Ashley was able to link her inservice on documentation to the possibility of receiving denials for payment of services. She has learned that specific styles of documentation will lesson this possibility, a reality of a profession that is a billed for service.

We recently had an in-service on documentation and just how to give more evidence

of why a patient requires this much assistance, and explain it in more detail so that if someone were to review it they could know exactly how the therapy was going, and it would decrease your chance of denial.

Casey also participated in an inservice that was not geared toward OT specifically, but was information that creates a safer nursing home environment for clients.

We've had some in-services at work that is not directly related to occupational therapy, it's more for the facility. We had one today, actually, it was a Fall Fair. The main focus right now at the facility as a whole is to help prevent falls. They had different work stations on what can cause falls and how to prevent falls, and then at each station there was a quiz that we had to take.

Casey has also participated in on-line educational opportunities sponsored by her place of employment. Despite the fact that these learning modules were not created specifically for OT, Casey did try to make the experience relevant to her understanding of the profession by choosing specific topics for the choices provided. "I did some. I tried to base it on what [clients] we have a lot of. I did one on strokes. I did one on diabetes, I did a lot."

Hayden also participated in a positioning workshop that was geared to all staff, she reports gaining a good deal of knowledge from this experience:

Seating and positioning techniques and, you know, just the way the body itself is positioned and the effect. You know, subluxation or all different kinds of body mechanics that are bad posture and things like that that people tend to carry, so, I felt like I learned a lot from that one.

Logan shared his recent educational experience: “We had an in-service on working with dementia patients.” He reported that the focus of the event was “just a refresher talking about scheduling tasks, when to work with the individual, what times and how long it should be, how long a treatment should be to be effective.” He found the information presented to be helpful because the population experiencing dementia in his facility is, “probably the biggest thing we have to deal with.” He described additional things that he learned including:

Simplification of tasks, speaking clearly, looking directly into the eye of the person you are working with; keeping tasks very concrete. Yeah, lots of things that I’ve probably been sort of just glazed over or been sort of poetic or talk too much, just keep it very direct. So, yeah, I saw a lot of opportunity for that.

During our interview, Tracy excitedly spoke about an educational workshop that she would be attending the following month:

We have been given the opportunity in September I’m going to what they call *OT Boot Camp*. It’s a whole Saturday and I can count it as continuing ed hours and it is just OT and long term care, so I have those opportunities to learn. It’s great, my company supports that, they send people, ACP people come out and teach us about in-services about new stuff, about modalities, what have you. So, if there is something I’m not sure about, let’s say, I went to my district manager and said “you know, there is a lot of people here that are amputees, I am not comfortable with amputees. Is there a resource or anything you can give me to help me?” They will find somebody or somewhere for me to get that...I’m so excited about it because I

think it's going to teach me a lot and give me a little more experience.

Jordan recently attended a documentation inservice and learned how to care for a tracheotomy in the case of a client in the intensive care unit. She states that tracheotomy care is not something that she has an immediate reason to know, but believes that the learning is interesting:

There were two in-services, one was just for the facility billing so that was always helpful...I also went to a tracheotomy in-service. That is something that I have not had to deal with so I felt if it were put in front of me right now I would probably still be clueless. It was a low priority in-service but it was very interesting and a little intimidating at the same time.

The data collected for this project contains only one participant reference to participation in an educational events that was specifically geared toward the OT practitioner. However, even in this case the topics did not address the occupation-based or client-centered perspective of the profession. Study participants report making the lessons learned relevant to their practice; using the information to inform their understanding of treatment approaches and general client needs.

Recalling lessons from books and periodicals. Information gained through books and periodicals is another avenue for learning utilized by novice OTAs. Books are textbooks that deal with topics related to practice that OTAs are able to access. Some books are those that were used as part of the OTA educational program and others have either been purchased or borrowed by practitioners since graduation. Periodicals are OT related peer reviewed or trade

journals that participants report using to further their knowledge base.

Jordan and Ashley both state that they have “read a few articles in *Advance* and brushed up on some different topics in [the] phys dys book.” When asked what she learned through that venue, Ashley stated, “I reviewed some on traumatic brain injuries and I was reviewing the level of cognitive functions going through the different levels from non-responsive all the way up.”

For Casey, the book known as “OT study cards in a box” have been beneficial. She goes on to say that cards in a box and a physical dysfunction book:

Have really come in handy especially when we have people, you know, with shoulder fractures or wrist, or where we have to range them and then get the measurements.

They come in really handy cause there’s been sometimes you know that I can’t remember exactly where to put the goniometer.

Kelly finds the use of trade journals and textbooks very important to her practice and states that:

I still refer to all of the textbooks, well not all, but the ones that fit my setting. Even my anatomy book sometimes when I need to look up something, and I have the quick reference to OT, the little book, I always carry that with me. I also have the magazine *Advance*.

Rowan revealed that she uses “OT cards in a box,” admitting that they “are in my desk and my quick reference is in my desk. I look at both of those every day.” She also uses her physical dysfunction book from school and adds:

I use a lot of the books here [workplace], just like the physical therapists have all of these textbooks because one of them was a clinical instructor for a couple of years so she has a lot of books that just kind of help me out because I need to be aware of the anatomy and things and that was just not my strong point, so I refer to a lot to them and the internet.

Summary. Much like the use of workshops and past classroom experiences, textbooks and periodicals are employed by participants as contributors to professional meaning making. Of interest is that the novices report using books, periodicals and other non-classroom learning when they need to brush up on client factor issues or treatment methods that are not typical of an occupation-based approach and sometimes not typical of OT treatments at all. Most participants reported school based learning to be the strongest influence on their understanding of the profession, with additional learning about general practice areas and issues from other sources, an important component.

Learning through interaction with and observation of peers. Study participants make numerous references to how other clinicians conduct OT practice within the work setting. Participants such as Ashley report, “I know I learn from observing other people.” Novice OTAs state that they observe the interactions of other, typically more seasoned clinicians, and clients to gain insight into the therapy process. Descriptions of observations, and how the participants understand what they have seen, fall into two separate categories-- positive examples and negative examples. Positive examples are those observed behaviors that match what the participant thinks and believes about the OT profession at that time. Negative examples provide a perspective that is not shared by the participants but can

reinforce their beliefs and promote meaning making through display of results obtained using a different approach and perspective. Participants also learn through asking specific questions or advice from peers. As with information from observations, the information obtained through discussions with others, enters into the understanding that novice participants are gaining about their profession.

Seeing positive examples. Casey describes observations that she has made of the OTR that supervises her and how the observations impact her choices as a clinician:

When she does treat...I see different things she's doing with patients. You know I pick up on it...oh yeah, this is something else that I can start doing with the patients or this is something I can, you know, try to start.

Jamie describes her observations of others and attributes her desire to do this to being a novice practitioner:

I watch everyone because, you know. I'm a new grad, but I've been in it for eight months now, but I watch everybody as far as, I don't have one specific role model because, well, we're all a team. So, I watch what J does with someone with her treatments and different activities she uses and different ways. And the OT and how she does things with people, like a stroke, someone who has had a stroke.

Jamie's words indicates that she values what she sees as the knowledge and wisdom of experienced clinicians:

I wish I had their years of experience because they can pop stuff off the top of their head at any time.... I mean, they can look at a patient and they know the way,

like if someone's crooked or leaning and just everything. Just how they lean them in the wheelchair, and what they need, and if the footrest on the wheelchair is not right, they know we need to change that and set it a different way. With their hands, if they need a splint. It's everything, their note writing, just everything.

In addition to observing peers in the clinical setting, Jordan also describes others that she has learned from, "I am lucky enough to have several friends who are in the field and I have had a lot of people to kind of pull from and bounce ideas off of." She also describes others from the perspective of having more experience than she and therefore having knowledge that she does not possess:

Other co-workers who I kind of look to for answers because they have been practicing longer; and that's I mean, co-workers, I also have friends in the field that I call on and pick their brains for certain things.

Jordan also appreciates being observed by others who can give her feedback if required, and using them as role models of techniques. She chooses to treat clients in a large gym area versus a smaller more private room for this reason:

I really feel like I am learning more, I'm there in front of other people, I'm able to see and take in things and if I am doing something incorrectly or maybe there is a better way to do it, there is someone to tell me versus in the other gym or in the solariums or the patients room it is more of an individual, like one on one contact...I think that hands on and being able to see other people practice and the learning through feedback is really the only way that I've done it so far.

Kelly describes similar experiences:

You know, when I started...I was so scared to transfer a CVA patient; I learned so much about transferring...just through the girls I work with, they are so knowledgeable; they have years of experience and are willing to share. I mean, altogether, I feel like I have learned to be a better practitioner.

Sage observed a specific technique for positioning a client in a wheelchair that he now uses all of the time:

I saw a positioning thing, there was this one resident, she was always sliding down in her wheelchair...I was always trying to get her to scoot back and I saw a technique where they, where one therapist told a resident to lean forward and she put her knees against the residents knees and just pushed on the knees and the hips and everything went back and it was just that quick and that easy...I use that all the time now.

Tracy learns from clinicians of other professions as well as her OT associates, “the speech therapist and the physical therapist, they influence me, they just teach me a lot of different stuff.” Since she currently works with a graduate of the same OTA program, Tracy also describes her experience with someone who shares her developing understanding of OT:

We were taught the same thing; we both have the same understanding of what occupational therapy is, what it is supposed to be, how it’s supposed to be done, and so she has been a really great influence and she has helped me out a lot.

Seeing negative examples. Jordan recounts an experience that she had during a level II fieldwork. She observed a client who was not improving while being treated by other

clinicians. Jordan was given a opportunity to try her approach with the client; using techniques that were very different than what she observed of the initial OTs:

The OT was treating her at the time but it was one of those things after about two weeks of no gains with her, she was like all right, well Jordan, you take her, and I just ask her daughter what drives her, what will get her motivated, what matters to her. They said well she was a beautician; she is about the hair and about the makeup and that was it. Okay, then why aren't we doing that with her, why are we not doing grooming with her? I sat this woman in front of the mirror and it was amazing the difference. I mean, forget function, like they were hooking e-stim up, they were doing stroke recovery program which is necessary, but if you are not following it up with meaningful occupations and activities what's the point if she's just not motivated to do the restorator or to do, you know, the weight bearing on that side.

Casey has observed other therapists engaging in behaviors that do not match her values or beliefs about the profession. She realized from these observations that there are ways to interact with clients that she does not agree with:

It kind of makes you a little angry, I guess a little upset for the way that they are treating the patients. You know we had like one lady we were trying work on standing and the lady couldn't hear good at all. She just kept saying, she kept trying to get her to stand and the woman would come off the wall and say, like the patient would say something completely out of the ballpark and not even close to what the OT asked her to do, and the OT would be like "if you would listen to me, if you

would hush and just listen to me.” But she just kept rambling on cause she could not hear herself talk so she was loud to start with and she [therapist] just kept on “if you would just listen to me.” You know just that type of thing. I mean you can’t do that. She doesn’t communicate very well with her patients and you just can’t do that type of thing.

Hayden sees the use of many reductionist activities in the clinic. She is somewhat surprised by this fact, but indicates that she is adding the concept into her understanding of OT:

In the field, I see a lot of um, I guess, preparatory activities, things like hand bikes, and things like that that just prepare you for strengthening so that you are able to later put that strength to use in other areas. But I see a lot of that, and I guess I expect it to be a perfect world, where it is completely functional. But I guess they do need to do strengthening as well to apply to everyday activities. So, I guess that kind of surprised me to see so much of it.

Hayden further describes her interest in wanting the world of OT to be as she envisioned, but is coming to terms with creating her understanding of the profession in the reality of the clinical setting:

I guess, just seeing that perfect world of OT. You know, you get it in your head and you want it, then you go out there and you’ve got to kind of conform to what it is going on to a certain extent and then make it your own.

Logan has also observed manners of treatment that do not match his evolving ideal of

the profession, but has also decided to revert to his academic educational experiences to guide his choices versus internalizing what he sees in the field:

I think it makes more sense. Especially the way the practice of OT is trying to go to. I think it, you know, look toward the future not towards what people are doing that, you know, they define as OT but might miss the mark. I think to begin with you, a lot of times you are just going with the flow of the other providers there, you know, it is so easy to get caught up in just the preparatory activity, you know, cone stacking, upper extremity bike, you know, running a rainbow [arc activity] around, working with the basic activities and it is just brainless. You just push a button and they do it, set the timer and it's over.

With regard to following the lead of others, Logan goes on to state:

I think you want to be, you have to be strong willed to stand for what we should have learned in school, and if you don't have a passion or confidence, or are willing to sort of go out on a limb, you can do nothing. You can do what everyone else is doing.

When asked why he thought that some clinicians simply follow the crowd he stated, "A lack of confidence, lack of understanding of, you know they a – maybe the light hasn't come one yet, they haven't seen the bigger picture; and just going with it because it is easy. Just to do simple activities."

Rowan shared an experience on which she learned how *not* to work with a client:

My director, she is an OT and a PTA. When she gets stressed, I think patient care lacks a little bit...she had the patient down and she [patient] was just

really out of it, she couldn't keep her eyes open, she couldn't really speak, and; she was just, the OT was pushing her way too hard. You know, you can tell that something was seriously wrong with her, like she needed to go to the hospital. And she was yelling and very abrasive, you know, and loud and in her face and I just thought, and I told her that she couldn't stand that she needed to go to the hospital. And she did that day, she went to the hospital. One of the nurses who I talked to later, she said, I called down here and told her that she could not get out of bed, she was really sick, blah, blah. It just made me think, I hope I never get to the point that you are not even aware of how your patient is doing because of your own agenda.

Engaging in discussions with peers. In addition to observing treatments and interactions of other therapists with their clients, participants reported experiences that they have had when asking for assistance or feedback from others. This is a common behavior for Rowan who stated "I really, I use the PTs and OTs a lot, we talk a lot." Jordan recounts asking the advice of her rehab director:

I went to my RD [rehab director] and said, gosh, I really feel like I'm doing the same 15 to 20 treatments just kind of over and between dressing and bathing and making sure their kitchen safety is where it needs to be in their home safety and that sort of thing; is that normal? And so she sent me to a few of the OTs just to kind of pull ideas from and, yes, reaffirm that because I am seeing a lot of the hips and knees diagnoses, that it is going to be similar training, it is going to be a lot of adaptive equipment and I was feeling a normal way that I should be feeling.

Ashley was also comfortable asking questions of other OTs and described her interaction with her rehab manager, “My last manager was like straight to the book, very, very good manager. Any questions I had, she would be more than happy to, if she didn’t know the answer, she find it out.” In addition to her rehab manager, Ashley often gains insight into the profession through discussions with other clinicians:

I ask a lot of questions to people that have been in the field, and I just try to, you know, squeeze about everything I can of their knowledge....We talk about patients. They are very willing to help me with any questions I have. Um, more than willing to help me with, like, treatments, or any questions I have, they’ve been really good about. They’ve all been pretty easy to work with and, you know, try to keep everything in order.

Jamie shares a similar experience with watching other clinicians and asking for feedback:

I watch everyone and they all will help me. If I have a question about a treatment, on how to treat this patient and, what’s a good activity I can do with them, they always come back with something wonderful.

Sage explicitly describes the connection that he makes between consultations with his supervising OT and his developing understanding of the profession. “I always consult with my OTR and I do see the results of the things she tells me to do and every time that works, I get more confident in the profession.” In addition, he shares his comfort with learning from others in the workplace:

I have no problem going across the hall and I’ll ask PT, how are we doing with

transfers. I mean, I'll talk to them so I'm always eager to hear what they are doing. I even seek a PTs advice sometimes because I know if they have had someone longer than... I think they would describe me also as inexperienced, you know, because I'm new. Sometimes they will come over and say, it's better if you do it this way or it's easier.

In a similar fashion, Tracy finds that discussing techniques used in the profession with someone who graduated from the same academic program has been very helpful to her:

We were taught the same thing, we both have the same understanding of what occupational therapy is, what it is supposed to be, how it's supposed to be done, and so she has been a really great influence and she has helped me out a lot.

Summary. Research question one sets out to determine how novice OTAs create their personal understanding of the profession of OT while in the clinical setting. Data from participant interviews has pointed to three distinct ways in which novice practitioners gain insight into the profession of OT while in the workplace, insight which informs their understanding. These three ways include: learning through doing; client responses to treatment; use of materials and lessons from educational venues and; observation of peers conducting treatments.

Participants remarked on the beliefs they formed through seeing the effects of their treatments on clients in terms of functional gains, body factor gains and motivation. They described information gained through the educational program, books and periodicals and workshops in addition to insight in the form of both positive and negative examples

through observation of, and interaction with, other practitioners.

Factors within the context of the clinical environment that contribute to shaping practice choices of OTAs. The next research question to be addressed will involve descriptions of the environmental, or contextual factors, that contribute to the shaping the practice choices of OTAs within the clinical setting. Three categories have emerged in the data that support the notion that contextual factors do have a role in the manner in which practitioners practice the profession. These categories include facility-based supports for practice, facility-based challenges to practice and requirements of third party payers. These three categories are divided into seven sub categories that include administrative supports and financial supports within facilities that assist OTAs, mission and vision of work facilities that support OT practice, and physical environment supports such as space and equipment that support OT practice. Administrative, financial and physical space challenges are also outlined by participants.

Being supported in practice choices by work facility. Participants of this study identified four entities, that support the choices of OTAs when treating clients that each deal with the facility itself. Many skilled nursing facilities or hospitals are part of larger networks or organizations, and although seemingly independent to make all business decisions, they often must operate under local and corporate management. Participants in the study were able to describe factors at both levels, those that appear to exist at the higher organizational level and at their actual worksite. Participants described policies, philosophies, finances, people and physical space as being the mechanisms through which their practice is influenced. This

section will address the four thematic areas of administrators and supervisors of facility as support, vision and mission supports, financial supports and physical supports.

Recognizing administrators and supervisors as supports. OTAs are typically under the supervision of at least one individual, an OTR, who oversees their care of clients. In some cases, this OT also serves as the manager of the rehabilitation department or there may be an additional individual of a different professional background who oversees the work of both the OT and the OTA. An additional level of authority is that of the facility administrator and/or corporate administrator who has authority over all who work with the facility. In the cases highlighted below, participants spoke of the clinical support and professionally supportive relationships that they have with these individuals with authority.

As Logan stated when asked about the relationship that he shares with his direct OT supervisor:

My supervisor and I get along very well, good working relationship, open communication. You know, very willing to assist if I come up with ideas, encourage. He wants us to pace ourselves, not just take on huge caseloads and he wants to spread the work out. We get along very well.

With regard to his rehabilitation manager, he also reports a positive relationship that promotes his skills as a therapy assistant when he states the following:

She is open to anything I want to try to do or accomplish. She is very willing to let us explore whatever we think is a good outlet for an individual. There is always encouragement, she appreciates creativity and likes it....You know, in spite of all the

pressures they have, they are still, you know, they are always willing to let us be as creative as we want to be

Ashley also finds that the OTs she works with to be supportive of her treatment choices and her autonomy. They will also give her ideas or make suggestions for treatments if she asks and in some cases if she does not. As an OTA, Ashley may take the suggestions of the OT without question, even if the suggestion does not fit her personal treatment philosophy. During the interview, when making the comment that appears below, Ashley was speaking in a upbeat and positive manner about the relationships that she shares with her OTs:

I think that, as far as the OTs that I work with, they've given me a lot of freedom as far as the treatment interventions go. They may suggest, "hey, so and so may need a hot pack prior to their treatment", and I say ok. If I have any questions, if it is a difficult client, then they will throw suggestions at me and I will try those, but no, if I don't have any questions, or I have a general idea, I can go in there and try to figure out the most creative way to help that person in my way. As far as treatment intervention goes, I definitely feel like I have control over that.

In addition to good communication with the OTs in her facility, Ashley considers her supervisor to be her role model, possessing the qualities that she herself strives to achieve. Ashley reports her supervisors skills as being related to both the practice of OT and the management knowledge the she displays:

Definitely seeing how she does her thing and seeing her success and progress with people and patients and her knowledge of OT, is something I want to strive for,

knowing that much not only about occupational therapy, but the billing part too, just the whole process of the whole occupational therapy as far as it goes. It's what I want to strive for.

In similar fashion, Hayden speaks to the relationships that she and other OTs have with the managers and administrators at the nursing facility where she and Ashley work together:

The manager is always in after the morning meet, and we all discuss patient and where we think they need to be and what discipline needs to be carrying them, and what our main focus is, whether they are going to go home or what. I can't complain about a single one of them as far as relationship wise.... The administrator has even come down and she is very therapy oriented. So, that's a good thing.

Kelly describes the support that the entire rehabilitation department gets from the rehabilitation director who also happens to be a physical therapist:

We actually just got a new gym to expand so my director of physical therapy is working hard to make sure that we have enough space to do what we need to do, we have a kitchen, we have all the material utilized, she is very good about asking for more money for budget, all that kind of stuff.

Rowan also finds the rehabilitation manger to be a support, and is adamant to make the point that it is her rehab director, not a facility or corporate administrator, to whom she is referring. "The director, she is very supportive...Rehab, not the entire facility at all, definitely rehab."

Sage also finds his manager to be a support; he embraces her management approach, her team building and her organizational skills:

She is very professional. She does a good job at keeping everybody as a team and being friendly, being your friend at the same time. She is also good at being the administrator when she has to be. You know, she can crack down and say, you know, we're not doing this, we have to do this, you know; she inspires teamwork and cohesion, you know, we are a small rehab department but she is very organized, I mean, everything is by the number, almost like the military, just very strategic, nothing happens randomly, everything has got a date, is planned out, very little surprises happen there.

Recognizing financial supports within the work facility: The profession of occupational therapy, by design, utilizes various tools as modalities with which to treat clients. These tools can include positioning equipment and various non-expendable exercise and daily living items. When done from an occupation-based paradigm perspective, additional supplies and equipment may also be required, many of which are expendable and must be refurbished from time to time. Occupational therapists require the financial support of their facility to provide all OT treatment, but even more so to provide service from the occupation-based paradigm perspective. The following comments from study participants provide insight into how they see their facility concerning the financial support for treatments.

When asked to identify supports for her treatment ideas through her facility, Jordan

first described the financial support that the entire rehabilitation department at her acute care setting receives:

I think the financial portion definitely. Like I said before, I have a lot at my fingertips to use, and I think that if the financial portion of our facility wasn't there, that wouldn't be the case. So that is definitely important.

Logan also finds that his facility supports the purchase of equipment that he finds that he needs. The decision to order supplies is also supported by his rehab manager:

We have, you know, if we need to order things from catalogs and so forth, that's never been an issue. We've always had the products we need without a lot of questions. The rehab manager really supports creativity, and I think that is an important part of it; the flexibility, the creativity and, you know, success. I mean, a lot of things get in the way, but she always says; any creativity you bring into the job is good.

The facility that Ashley and Hayden work for are interested in having the occupational therapists use "function kits" when treating clients. These boxes are themed as various daily activity tasks or leisure activities and should contain all of the equipment and supplies needed for a client to complete a purposeful activity. The facility will reimburse staff for purchasing items to create these kits. Ashley stated:

I will go on my own and pick out things that I feel like I can use that will help motivate the clients and then I will bring a receipt and highlight how much it costs and do an expense report for that, and they will reimburse you for that. As long as it is

a functional kit, and that is what they have been encouraging us to do, so, I'm all for it....Maybe without the reimbursement from the company it could be more difficult to get all the supplies for functional kits.

Hayden also recognizes the financial support that she sees from the facility:

I think they do give us a fair amount... I mean, it has to be because you have to have things. I think they are pretty open with things that we need or if we have activities that we want to carry out once a week; we try to do groups and things like that, I think that they contribute to that well and reimburse with that. And that is a good thing because not everybody always has money to fork out. Um, I think that if we need equipment and things like that we have a certain budget a month that they are able to give us what we need. Of course, there are bigger things that we would all love to get, you know, but we've basically, we get the things that we need as far as materials and once in a while we will get a new item to work with, whether it is OT or PT.

Sage reports that his facility is well equipped with equipment and physical agent modalities such as electrical stimulation units and diathermy use in preparation for OT. "I can definitely say that, [they] provide all the modalities that we need." The facility also purchases adaptive equipment and clinic equipment, but when it comes to some smaller supplies he would like to use, it is easier to purchase the items himself than to submit requests for a purchase order:

It is just easier to just go and get it then to go and to submit a request and wait for it.

It is just easier to go get it yourself and it is not that expensive....It doesn't cost but a

few bucks and my facility is really good about whatever we need, like any sort of adaptive equipment, chairs or anything like that they are like, if the resident needs it, order it. So, that's good too.

The facility in which Tracy works is similar, they provide equipment for treatment and will reimburse a therapists who purchases supplies even though Tracy does not always ask for reimbursement:

The one thing I cannot ever complain about is equipment and means of stuff, we have so much stuff, the company I work for is a contract company, but they, I mean, they supply us with so many different machines, anything we need we just call them and we have it. The funds are great.

Everything, the means are available, even if I want to do some kind of craft or what have you. The activity department is awesome and it's available. And then *Big Lots* is right across the street, and that's available too! I can just run to *Big Lots* if I need something and come back....They would probably reimburse, they reimbursed me for my license, but I don't care. I just do it on my own. I also bring stuff from home.

Financial supports for services are paramount for the ability of practitioners to provide quality service. Several study participants experience an adequate amount of financial support for the treatments that they wish to provide.

Recognizing mission and vision supports within the work facility: Underlying the willingness of a facility to support rehabilitation programs are the philosophies, mission and

vision of the facility and their commitment to provide quality services for their clients. Review of the marketing materials of the workplaces of Ashley, Hayden, Tracy, Rowan, Sage and Logan indicate that all offer and promote rehabilitation programs for residents. Most mention the physical, occupational and speech therapy, but none describes particular methods or modalities used in OT.

Participants recall examples of how the philosophy of their facility supports their practice. Ashley mentions the functional kits as an example of how her facility demonstrates its mission to enhancing function of residents:

I guess, the facility and the company they are all one and their belief is that, it seems more like now they are leaning towards doing the functional kits and improving through activities, not only to increase their business but also to just have proof and evidence that by doing these activities our clients are making progress and getting better and they have proof and evidence of that that they can show other facilities.

Jordan describes the client centered approach that she has observed in many department within her facility:

I think that they try really hard as an organization to make everything individualized and that goes right down to... we have an 'at-your-request' menu service that is literally like a menu from a restaurant...they really, even just from down to the dining try to make it very individualized. They, gosh, as far as, I mean, part of the hall as long as they are open rooms they get those kind of options. I really, I mean, down from the admissions portion to the therapy part, I mean, I really feel like the facility

does a great job of trying to make it about the client.

Sage reports that in his facility, rehabilitation services in general are given priority over other types of resident activities. Even though Sage, as an OTA, recognizes the importance of allowing clients to engage in other activities that bring them some form of meaning, he also sees that his facility does value rehabilitation:

Rehab interrupts almost every other activity. I mean, I hate to pull them out of bingo or whatever activity or services or whatever, but, you know, if there is anything else going on and if it conflicts with rehab, rehab always takes priority. That is always at our discretion, if we want to pull them out. I don't like to pull them out of church services.

He goes on to describe the facility rule that physical agent modalities can only be used when they are in preparation for purposeful activities:

Yeah, we all have to start with a modality and then...because at our facility you can only do modalities if they are preparatory for some sort of purposeful activity so they would have to follow. So, it would be structured the same, modality, then something functional afterwards.

Sage was the only participant to mention that his facility has a rule that preparatory modalities must be used only in preparation for purposeful activities. This facility philosophy is congruent with regard to the use of physical agent modalities found in the OTPF (AOTA, 2008). The OTPF is clear that any treatment that does not actively involve a client, but is provided to them by the clinician can only be used in a preparatory manner. Participants in

this study have enthusiastically described the facility policies and philosophies that they feel support their personal approach to practice.

Recognizing physical environment support within work facility: In addition to facility philosophies, financial and administrative supports, the physical environment and available equipment must also support occupational therapy and its unique approach to enhancing daily living skills. Bedrooms, bathrooms, kitchens and well-supplied clinic settings can add or detract from the ability of the practitioner to create their personal vision of practice.

Jordan describes many of the positive physical attributes of her facility that she believes support her approach:

The two floors each have their own gym, which is where OT and PT practice. They are also other, I guess, sub-areas. There is a dining room, which sometimes is used for groups. There is a kitchen that is used for groups. Both OT and PT share the space....there is a kitchen and it is set up just for the disabled... lower counter tops, everything is accessible as far as the stove, the refrigerator. There is also, there is a shower in each patients room set up with a shower bench, the modified commode, bedside commode, raised toilet seat, there are bars of course. And then also a full size bathroom so if it was a situation where your patient had a bath at home versus a walk-in shower, there is an area to simulate that and then there is also a transitional living apartment that before discharge, 24 – 48 hours prior to going home, it is available for patients so that is also, you could use that as a practice area if you needed to. It is not just for discharged patients.

Jordan goes on to explain how the physical environment supports her treatments:

[I] think the fact that the patients rooms are all individual, private rooms so as far as being able to do ADL review, very client centered treatment especially when we are talking like, you know, that morning ADL routine it is really nice that you are not sharing a room with another patient which I have experienced. It definitely makes it a lot easier to have those individualized rooms.

When asked how the physical environment of their work place supported OT treatments, Sage and Kelly both spoke about the availability of kitchen space. According to Sage, “we can always, there are kitchens upstairs and we can always go upstairs and do a cooking activity or just practice home making. They have an elevated garden outside that they also provide for us.” Kelly stated:

We actually just got a new gym to expand, so my director of physical therapy is working hard to make sure that we have enough space to do what we need to do, we have a kitchen, we have all the material utilized...

Tracy and Hayden are also well satisfied with the space and equipment provided by their workplace. With regard to the amount of equipment available, Tracy said:

The one thing I cannot ever complain about is equipment and amount of stuff, we have so much stuff, the company I work for is a contract company, but they, I mean, they supply us with so many different machines, anything we need we just call them and we have it. The funds are great.

Hayden compares her current workplace space to the lack of space that she saw in other facilities:

The space that we are given, you know, the amount of space as far as a therapy room. Some places are small and it is hard to get more than one patient or hard to co-treat or even do groups. We have available space, so I'd say that is two. Three... the... I mean, I guess just them supporting what we do. They are very supportive of our therapy department and pretty much any idea that we run across them as far as whether it is an activity or something that we need for the facility, they support us completely.

Summary. This section has offered insight through the voices of novice OTAs with regard to supports found within the physical disabilities workplace that support the OTA as they form their understanding and practice habits of occupational therapy. The next section will describe the entities that they find less than supportive in the workplace.

Being challenged in practice choices by work facility. Novice OTAs who are forming their practice habits and understanding of the profession are faced not only with facility supports, but also with facility based challenges. A challenge is an entity that a study participant believes blocks their ability to engage in the manner of OT that they would prefer. When challenges arise, OTAs may need to change the way that they conduct treatments in order to get the work done. Facility based challenges are found in the areas of administrators and supervisors as challenges, financial challenges, documentation and billing practices and physical environments challenges.

Recognizing administrators and supervisors as challenges. In the preceding section, administrators and supervisors, representing the authority found within hierarchical

organizations, were described as supports to study participants. In this section, several participants describe instances when they do not feel supported by authority figures in their quest to conduct treatments.

Logan speaks to the fact that there are occasions where one level of authority has to yield to the forces coming from above. “Their [supervisors] pressure is coming from above; they want to have, you know, people on case loads that for whatever reason are trying to accommodate the higher ups and my philosophy of OT, it is hard to blend.”

He goes on to say:

Higher ups are always making demands on how, what productivity levels should be at and who should be where and how many people we should have at each level, so.

You know, I feel like my direct supervisor, my rehab manager, she is sort of a cog in the wheel of the bigger picture. She is having to turn what the higher people are saying.

Rowan also sees the hierarchy of authority in her facility and how it impacts her practice:

I think she is very influenced by the director, of course, because this director’s name is thrown around a lot, you know, this director is not going to be happy if we have too many discharges on this day, you know, there will be three discharges on Wednesday so we need to get the beds filled, so....

Kelly paints a darker picture of authority figures as being uncaring of clients and workers, and being more concerned with money and productivity. “They didn’t care, all they

care about was money and RUGS [Resource Utilization Group reimbursement system]. They didn't care about the individual or the coworkers." She relates the challenge of authority figures to her own ability to conduct treatments, "you know, I can't do what I want to do with these patients because I don't have time or the RUGS are inappropriate, my boss won't listen to me..."

Tracy describes the influence of authority figures that oversee her practice and the higher authorities to whom they are accountable. She describes this influence and its connection to productivity and the push to pick up certain types of well-funded clients. This increase in number of clients and billing categories ultimately translates into revenue for the company:

Our manager now, she is so stuck on our productivity and our meeting RUG levels and our how many part Bs do you have, increase your part Bs. I'm like, seriously, these people are getting what they need, it shouldn't matter what the productivity is, it shouldn't matter how many part Bs. People who need therapy right now in the facility are getting therapy. I don't want to go pick up somebody who doesn't need or want therapy just so we can increase our part B census.

Tracy believes the reason for her area manager's focus on revenue is due to her lack of client contact and need to answer to higher authority:

I think she has lost sight of it because she is not treating the patients. She is not one-on-one to patient, she is up there with the whole business aspect of things and she has people above her telling her what to do. So, I think that if she were to go back to her

treating patients and everything I think that might change because I met her and I have a pretty good read on people and I could tell that she is a good person, but she has people telling her what to do as well....what she is seeing right now is the numbers, that's all she has is the numbers. She is not there, she doesn't see the human beings. She just sees the numbers.

Recognizing financial challenges within the work facility. As we have seen in the preceding sections of this chapter, several study participants identified financial supports that they believe are in place and that influence their client treatments. In addition to supports however, there are also reports of finance-based situations that participants described as obstacles. Challenges appear to come in the form of productivity requirements, lack of adequate funding for supplies and documentation and billing concerns that interfere with reimbursement and productivity, ultimately affecting the bottom line. As is the case with supports, challenges have the potential to influence practice choices made by novice practitioners.

Sage spoke at length about productivity requirements at his worksite and how he must try to strike a balance when providing quality care while simultaneously ensuring that revenue is brought into the organization:

Well, I know one thing...trying to balance, where I work, it is all about productivity, trying to balance, trying to be functional and give quality care; but still be productive. You know, not that, we are on a clock, but you have to just find a good balance of doing the work and seeing everybody and getting the time in and at the same time not

everybody is just a number or a name on a board; giving them that care and the attention. And I find that takes a lot of work and I see a lot of therapists do it, you know, they are really good at it. That is something that I'm still working with.

At my facility, they require 85% productivity and we have a form, you fill it out and at the end of the day, they pick like an average during the week and it goes in the system and it goes up, I guess, to the corporate office of the company you work with and then it will go to an area rehab director (ARD), like the district manager and then, you know, sometimes when productivity drops they know that the case load is low, but if it stays that way then they will go to the rehab manager or maybe even the person in charge of the building and want to know why aren't your therapists being productive? It goes way up to the corporate folks. I mean they really push productivity.

Ashley makes a similar point when describing her workplace requirements and how treatment must go on, even if the client is not interested completing the designated amount of time:

A lot of it is a business, as far as getting the minutes and the billing can be a little tricky to work around. People [clients] who have their days where they may not feel up to giving their 55 minutes, but you're pushed to try to reach that, which is understandable. To stay in business, you have to meet certain requirements. That can be challenging. There is a lot of paperwork.

Logan describes the productivity requirements at his workplace and how he sees these

requirements influencing his treatment choices. He reports that there is a push for therapists to maximize the amount of time that clients spend in treatment even when many are not able to tolerate that level or are not expected to make progress:

Productivity and allotted time with individuals. I mean, there are lots of things pushing you away from occupation-based therapy; you know, client centered, really rich experiences. I mean, everything is pushing you the opposite direction almost....I'd say RUG levels, where we have to have individuals operating at levels that I don't feel as productive. You know, they are too high; their expectations are higher than their potential ever will be. The productivity expectation is always a challenge because some of the individuals' time expected in is so much more than what they need or are able to participate actively in.

Logan also mentions the productivity requirements placed upon support staff such as nursing assistants who must ensure that all residents on their caseloads are properly cared for in a given amount of time. Despite the fact that supporting OT by allowing the clients to practice their own self care to become proficient, nursing assistants will continue to do the work for the resident, hence limiting their ability to be rehabilitated or maintain function:

And sometimes, the support staff from within, like a CNA, are so busy trying to take care of their people that they are not willing to let us sort of try to support independence and in turn reduce the job of a CNA.

Casey describes budgetary constraints and some creative ways that these are overcome in her facility, including therapists purchasing supplies without an ability to be reimbursed:

Each year they give us a budget and we have to go you know once out with what's in that budget and also what comes out of that budget is like if we order chair cushions for patients, we have a budget and nursing has a budget. A lot of times we try to order it out of nursing's budget just because it's so much bigger but sometimes it does have to be pulled out of our budget depending on what it is. And you know a lot of these little things I pick up are not but a couple of bucks and its not really, its not that big of a deal to me....They won't supply money for anything. Everything I have bought here has been out of pocket for the patients.

Casey also describes paperwork requirements of her facility. The scope of this task, which typically does not get reimbursed and not part of productivity can be appreciated through Casey's description:

I am usually one of the first ones here. I usually get here about 7:30 or so. Each day we make a list for what patients we have at what hour and if they have minutes, we put their minutes beside their name, we put their room number beside their name and then if they have a note. We do weekly notes for each patient. If they have a note we'll put whatever number of note it is. When I was telling you before, they usually do a reference note every 12 weeks and each note is like 1,2,3,4,5 you know for like each week they're here and like every other note is a two page note which means that the OT has to do a second page to it so like note 2, 4, 6, 8, 10, 12, is a two page note. So usually the two page note, we try to give it to the OT just because it is a good way for her to see how the patient is coming along, you know because often she is not able

to treat. So we write that out the day before. I come in about 7:30 or so, I make copies and give all the OTs one.... I pull out all of the notes that we have for that day and the ones I have been treating the most, I pull them out and get started on their notes you know writing everything out.

Hayden also described documentation requirements at her place of work and how she strives to stay on top of the task:

I try to be on top of the documentation and paperwork and things like that, I try to be on top of it. It is probably one of my weaker points, but I do know that it is huge, it is important and it is, so I'd say that is a big part in, as well as doing the therapy. Uh, and then just trying to carry out the functional therapy in a good amount of time. The time limit that we are given, it is hard to keep up with that time with everything without the minute. But, I just try to stay right on top of my game with all of that, there are so many different factors.

Jordan also finds the paperwork levels to be significant at her facility, but does not feel that this inhibits her treatments per se:

We have to document that is just part of being a practitioner. And I wouldn't say it is inhibiting my treatments, but that is one thing that is really a downfall. The fact that our treatments are so close together, they are back to back every 45 minutes from the time you walk in the door. There is an hour at lunch to do half an hour of documentation and half an hour for food, but it is just... there is not that down time so if somebody does run over or I have someone who needs to use the restroom if there

is not a tech to take them, I'm obviously going to take them and I am sometimes late for my next appointment. So that time constraints because everybody in our facility is receiving at least three hours of treatment a day and then if they are on speech or if they with the recreational therapist there is no additional time so it is really very fast paced...

Kelly does not embrace the fast-paced work environment found in many facilities and does find that the productivity and numbers do affect how she chooses to practice:

I do not like fast-paced work environments because I feel that I have less time to really do what I need to do and its more of preparatory techniques, you know, just get the minutes in; I don't like that. I know it's a business and we have to make money, but at the same time, I really care about patient care and there has to be a happy medium.

Rowan does not feel that her facility provides enough funds for supplies that she feels would support her treatment choices:

Not a lot, no. Not a lot of supplies. That is definitely lacking. Money, well, there's not a lot of. There is no extra money for supplies like crafty things. There is one, we have this one patient who is an artist and he loves to draw. We have, literally, a mechanical pencil and computer paper for him to draw with. And he is totally find with it, we tape it on the wall and he stands there and he has an issue with balance, so he works on balance and drawing. It's great and he loves it, he gets the biggest kick out of it. He drew a picture of me and the other OT and the OTR in the therapy room and

himself in a wheelchair. It was so incredible. And he does it with a mechanical pencil, he is a true artist. But, it would be nice to be able to have some real drawing pencils and paper, some paints, just something, an easel; but we don't have any and I don't see us getting of that stuff anytime soon.

Summary. Novice OTAs participating in this study were able to identify financial challenges of their workplaces that reportedly influence the way that they are able to practice occupational therapy.

Recognizing physical environment space challenges. As with other sub-categories of entities that influence practice, participants have described both supports and challenges of the physical space and equipment available to them at their place of work.

Hayden finds the space in which she works to be adequate in size, but does not feel that the layout is conducive to her approach as the large ADL areas such as the kitchen are in a different place. My observations of her work confirmed that she is able to work in an adequately sized room, but that equipment unique to OT was not easy to get to. In addition, the room was well equipped with preparatory and enabling activities, but only a few purposeful activities were observed:

Work space is really good, it's just, if we could put certain things in that work space. Um, in order to go and do the activities that we would like to do, we have to go over to the unit, and it's kind of hard to get patients in and around. So, I'd say that would hinder some treatments when you could just have it all in the same room and everyone together versus, going here and there....It's such a big room and it's got

such nice space. But, it would be so nice if there were more functional things. If you had a bathroom, or if you had a kitchen, that way we could get them out of their rooms. I think they would enjoy coming down to the rehab room, but when walk into that room and they see all that exercise equipment, you're talking about 80-year-old people here. They do not want to touch that equipment, and I don't blame them.

Hayden also believes that the limitations in the size and appointments of the resident rooms at her worksite influence the types of treatments that she is comfortably able to conduct:

I guess I would just say privacy overall for the patients. In their room, a lot of them, you know, there are two to a room and there is not a lot of space in the personal, the their own personal rooms as far as doing toilet transfers and things like that so the neighbor, you know... and I guess that plays another part with the financial; but I would just say privacy.

Tracy does not find the general therapy room to be conducive to all client treatments. She finds that privacy of clients is compromised in this room and that she has to change the setting for client treatments in order to accommodate their needs:

Personally, I try to not do a lot of treatments in there [therapy room] just because they're so many people in there and it's uncomfortable to the patient sometimes if you get them in at a busy time. It's uncomfortable for some patients to be doing certain things in front of other people. Like I have one patient, for example, I'm working on her with feeding and she refuses to eat in the dining room or in

the therapy room because of, her finger opposition is not good and she can't, she will spill her food so I've been working with her with a built up handle and she is doing great and I've just recently integrated her into the dining room. But that's just an example of how they are very self conscious, so I try to do treatments in their room because is where they are comfortable at, and also, outside.

This section has highlighted, through the voices of research participants the challenges of the workplace environment that influence the way the novice OTAs conduct OT practice.

Responding to requirements of third party payers. In addition to supports and challenges originating in the workplace or work organization, third party reimbursement entities, who pay the organization for the services provided by the OTA can also influence the manner in which they understand the profession and work with clients. There are many various payment sources that cover OT services for both younger and older individuals; some have very specific rules and guidelines for which treatments are reimbursable and which are not. The primary third party payer influencing those who work in skilled nursing is Medicare, which includes both plans A and B. As all participants described third party payers as influencing their practice in very similar ways, there are no sub-categories that have emerged from this category. Therefore, the data that follows describes general influence as opposed to a specific type of influence on practice choices.

Ashley describes the treatment frequency requirements set by the Medicare system and the effects that they may have on the productivity requirements of her workplace:

Well, we have bases of clients that we usually work with, but we just make sure that each person is going to get seen, make sure that the “three day a weekers” are seen. I’ll plan my minutes as far as how much time I need to spend with each person for Medicaid, I mean Medicare A, and um, to make sure that I can reach my 85% productivity.

Tracy also expresses frustration with the pressure that is put on a clinician to ensure Medicare reimbursement is maximized:

You know, pressure from Medicare, and not having ample time to actually do your treatment, do all of your treatment. I mean, if you work six hours and you have eight or nine patients and they are each in assessment and they need 60-70 minutes, you know, you’re not going to be able to do that. So, you kind of try to fly through the cracks and find, kind of convince yourself, that’s what I’m seeing.

The choices that OTAs make with regard to treating clients in groups or to provide individual treatments are often determined by Medicare requirements. Despite the fact that a practitioner may feel it in the best interest of a client to treat them with others, for example in a cooking group, they may not be able to due to rules and regulations of third party payers. Sage has experienced this frustration:

Well I know that the policies, one of the biggest is just the way that we see people or group people. Like, you can’t do groups of A’s and B’s together, like mid A’s and Med B’s. Sometimes you may have a resident who is a Med A and a couple who are Med B’s that could be a really good group is you could get them together, but you can’t do groups of A’s and B’s together.

Sage also finds frustration in the formulas used by organizations to ensure that clients are maximizing their reimbursable therapy time. When reimbursement and third party payer restrictions must be considered, the manner in which OT is conducted can be influenced:

Yeah, for whatever unit they decide that they are trying to get and I don't understand... you know, and some days it is like they are 32 minutes all week and the next thing you know, you turn around and they are at 80 or something high and you're like, wow...I would like to see it not be so restricted by billing. Just to be able to whatever you wanted to do and not have to worry about Med A's and Med B's and overlapping and duck tailing and codes and groups, you know...

Jamie feels limited as well, if she has spent time with a client during the morning routine time, she is not able to do activities that are time consuming in the afternoon, even if such a treatment session may be of benefit.

We have a time limit that we can spend, so, you know, when I bring them down some of their time has already been spent doing the ADL's so we'll come down and do a little short activity and I'll take them back. So, it's, like I said, the more independent ones, they come on down and I spend more time with them in the therapy room.

Jordan is frustrated by the time that Medicare documentation takes to complete as it can affect her productivity. "The documentation is very detailed, intense and takes... it is very time consuming."

Tracy becomes frustrated with the reimbursement system and gives this advice to

future practitioners, “just make sure that your treatments are to benefit... you are giving the care that this patient needs not what Medicare needs.” When asked what forces influence her approach to treatment, Rowan responded, “the financial God.”

Summary. The second research question that addresses how factors in the work environment influence the treatment choices of novice OTAs has been the topic of this section. As we have seen, the data has revealed several categories and sub-categories that support the notion that factors do exist and that those factors do exert various influences upon practice. The categories identified have been those of supports and challenges in the workplace including administrators and supervisors, finances, philosophy of the workplace and physical space. An additional category is the effect of third party payer rules and regulations upon practice decisions.

Enacting a personal understanding in practice. The fourth research question addresses how the understanding of the profession that the novice OTA gains is enacted in practice. The categories that have emerged through the data that relate to this question are *professional identity* and *enacted beliefs*. Enacted beliefs, the actual treatment choices made by the practitioner, are divided into activity level sub-categories of occupation-based/ purposeful activities and preparatory techniques and enabling activities. Professional identity refers to the way that the clinician sees and understands themselves as an OT practitioner. The theories of action or espoused beliefs that an individual hold comprise their professional identity.

Assuming a professional identity. Defined in this study as the way that the novice

understands him or herself as a professional, what they have come to believe about their role within the profession; those aspects that contribute to their sense of how the profession should be practice and upon which they base treatment choices. In the case of the occupational therapy assistant, participants often remarked on why they are in the profession, what it means to them, and what they believe about themselves in relation to the profession. Understanding how participants view themselves professionally will assist in the understanding of how actual treatment choices are made.

The interview data of this study revealed several commonalities amongst participants in the way that they view themselves as people and professionals and with which attributes they feel are important for OT practitioners in general. In the following excerpts, Ashley, Jamie, Hayden, Casey and Tracy describe their personality characteristics and those they consider positive in others in others. Ashley considers herself, “a hard worker, I love working with the patients, treatment is my favorite. I try to do anything I can to motivate them to get better. I’m honest, I try to be as ethical as possible and everything.” With more specific reference to the profession, Ashley also commented, “I wanted to help people and I liked the way occupational therapy involved occupation into their lives and helps motivates them to get better.” Casey states, “ you have to be nice to the patients to start with and you have to have patience with them...I treat them the way I would want to be treated.” Hayden believes that “patience and listening” are the key, “[it is] huge because you never know what type of patient you are going to get...just having patience and listening and just being able to

hear them out and what their needs are.” Sage believes that patience and concern are the keys to OT: “Patience, a lot of patience. And I think you have to have a genuine concern for the residents.”

Kelly echoes the categories of care, concern and patience when she mentions how her role model with give clients her undivided attention no matter what. “She gives every patient her 24/7 attention. Even though she may be slammed that day.” Similarly, Tracy states, “I really care about the patients I work with. I’m always happy, even if I have some kind of issue, I don’t bring it to work because, to me, the patient’s need, they need that enthusiasm, they need it.” Jordan also sees herself as “a great people person” and Rowan states that in order to be successful you must, “really love patient care.” She warns, “if you don’t have relationship or communication skills with other people then this is not the right place for you. You definitely have to be a team player and work with many different people.” She believes herself to be “professional, down to earth, easy to communicate with, motivated, hard worker who take pride in her job.” Tracy supports this premise with her statement about how she sees herself as a person, “I think its personality. For me, I mean, I think its personality. I have a very good personality and I care about others.”

Jordan also mentions the client centered beliefs that she embodies, that each person should be treated as an individual, otherwise it is not OT. “Each individual person having their needs, their wants, their desires that it is so personalized, it is that client centered approach. Without that and with the difference in PT, it would feel as if were just nursing.”

Logan and Jordan also mention professional characteristics that are skill based,

extending their natural personality style. They both believe that these attributes are part of who they are and contribute to their ability to be successful OT practitioners. According to Jordan:

I am really good with time management, I am organized.... I'm pleasant to work with, I take my job seriously and I am driven; I want to know everything about everything and the why's and how's and the what's... I am receptive to learning and hearing new ideas and new things.

She believes that the following attributes are also important: "Time management and organization. You have to be motivated, and I think that's not even just as an OTA, but in general in a rehab setting; and forward thinking."

With regard to being practitioner willing to make change, Logan states:

You have to be strong willed to stand for what we should have learned in school, and if you don't have a passion or confidence, or are willing to sort of go out on a limb, you can do nothing....Don't give into the system at large. Try to create success through what you learned in school. Don't just fall into the trap of the other OTs, you know, how it is done so much now. Be willing to learn.

To this group of novice OTA practitioners, being a clinician who is client-centered embodies honesty, ethics, patience, optimism and sincere care and concern for others are qualities that describe who they are as OTs. In addition, most espouse management, organizational skills and a willingness to learn as necessary characteristics. Logan also voices his belief that novice OTAs should be willing to practice their beliefs and not practice a

certain way just because others in your context do; this refers to a sense of ethics and belief in occupational justice.

Enacting espoused beliefs. Enacted beliefs are the actual treatment choices made by the novice OTA. For the purpose of this study, the practice choices have been divided into a more occupation-based paradigm perspective that includes selection and use of occupation-based and purposeful activities, and into a less occupation-based paradigm perspective that includes selection of preparatory techniques and enabling activities.

Engaging in occupation-based and purposeful activities. In this section, participant comments that reference their use of purposeful and occupation-based activities as treatment will be highlighted. Occupation-based activities are those that involve engagement in actual daily activities, such as completing the morning routine (including bathing, grooming and dressing), or completing a meal preparation activity (involving planning, cooking and serving a meal). Purposeful activities are similar to occupation-based, but only include parts of the occupation. For example, the act of bathing alone, or making a cup of coffee; these are meaningful and relevant engagements, but do not equate to a complete occupation, they are parts. Both of these levels of activities are in keeping with the current occupation-based philosophy of OT.

Ashley believes that “activities” should be incorporated into every treatment, she states: “We try to be functional based, as much as we can, occupation-based.” She reports her commitment to providing interesting engagements for clients that address their functional goals:

As far as, like on Fridays, we try to do the fun, an activity or craft, and try to make it, incorporate it into their goals if they're trying to increase their endurance or increase their standing tolerance, and try to get them to stand up and do their activity; or add weight, or even coordination, make things challenging or more graded for each person based on their goals.

Ashley indicates her belief in the necessity of an occupation-based focus when she states, "to be a successful COTA, that would definitely require incorporating occupation-based activities into your treatments to help motivate the client, you know, to make progress and to see them be successful." Casey shares a similar perspective, "I hardly, ever if ever, use the upper extremity bikes or the cones or anything like that. I try to incorporate more occupation-based activities, things that the people like to do." She is able to see direct benefits of an occupation or purposeful approach to treatment:

It's very rewarding to see patients come in you know that can't dress themselves, that can't bathe themselves, that can't toilet and then when they leave here they're able to do, to know things that you've taught them and it's good to know that you were the one that made that happen.

Hayden believes that, "you always want to make it functional." This is a very important feature of the profession to her. "That is my key thing.. Every day I go in and I feel that ADL's ... just simple things, just getting up in the morning and being able to get yourself prepared in the morning, those things are important." With regard to the facility in which she works, Hayden would like to see a more occupation-based culture, but also sees

the importance of the belief of the practitioner:

The facility itself, like I said, is not as occupation- based as I would like it to be, but, we do groups once a week, and we usually will bring in something and put it all together, whether it's a meal or something like that, or even make a craft or something like that just to incorporate, for individual goals, they all have their own goals.

Jordan is able to distinguish a difference between the type of treatment that she believes in, a more occupation-based approach, and the reductionist approach of others when she states:

OT is practiced in many different ways. You can definitely tell a difference between an OT or a COTA who is, I don't want to say a new graduate, but maybe client centered, somebody who really wants it to be about the ADLs and about the function versus about just doing therapeutic exercises....[I am] very occupation-based. I have not used a single modality. This caseload that I have now, they are all 90 minute and broken into the two times a day for the 45 and it is all... doing an ADL, in the shower that morning or we are doing a standing activity this afternoon and we are going to be up in the kitchen making banana pudding; like we really, the hospital is very... make it ADLs if you can. I mean that is why these people are here. They want to be able to go home and do things by themselves, so let's get them to that point. I really feel very fortunate in that aspect, it is not, you know, set them up on e-stim for 30 minutes and for the next 15 do active range of motions, nothing like that...

Kelly is a strong believer in the use of an occupation-based approach that she will take less pay in order to work in a facility that also embraces this belief. “I would rather take a lower pay, honestly, and work with better people, better OT care...you know, a more holistic approach because that’s what I am about.” She goes on to further describe her beliefs:

We primarily focus on the patient, I personally, do client center focus, I don’t believe in, you know, doing something that isn’t, that the client doesn’t want to do. If they don’t want to take a bath or shower, then they want to sponge bath, then why try a shower transfer. We focus primarily on activities of daily living, ADL’s. It is the client you are doing it for, always make sure it is client centered.

Logan provides examples of activities that he has done with clients that represent his beliefs about the use of purposeful activities and how they address client factors as well as client motivation:

I was in the back yard one afternoon, we have a nice backyard, with one of the residents and all he talks about is fishing and while we didn’t have time to go fishing, I was able to bring a fishing rod in and we were practicing casting. It was very engaging, it worked a lot of fine motor, a lot of gross motor....Easter eggs, we decorated Easter eggs. The population I work with is a lot of elderly, very Christian, women so they enjoyed spending time in Easter eggs and telling stories. Everybody spent time around the table working on those. There have been several different opportunities, all the holidays, Easter, Christmas, Thanksgiving, we were all very,

you know, grouped around the table working together. It was neat.

Rowan shares her beliefs in practice through her description of a *good* versus *bad* OT day:

A good OT is a day that I am doing activities with the patients and they are very excited about doing what you ask them, they are excited because it is something that they want to do, a goal that they want to accomplish. A not so good OT is a day when you are doing a lot of preparatory activities; they are not that into it.

She goes on to more specifically describe her approach:

Well, the kind of OT practice. I guess, like I said before, client-centered. We focus a lot on ADL's; a lot on, I do a lot of transfer with them, a lot of toileting, a lot of upper body strengthening. Sometimes I'll get them on the mat and do some bed mobility stuff, especially if they stay, have trouble turning over in bed; like I have one patient that has trouble with the covers, they feel heavy and the patient can't maneuver in bed very easily so we work on that.

Sage points to differences in facilities that he has worked at, those that espouse a more reductionist approach and those that are more function or occupation-based, such as the one where he now works:

I've worked at two separate facilities and I've noticed that every facility is different. I mean, some facilities, it is very, you know, work them out, get them strong, you know, weights, arm bikes; and then in other facilities they really emphasize function, you know, ADL's, make it purposeful, meaningful....In my setting we always have

ADL goals, always. ...Outside we have a big, huge standing box with dirt in it and we do gardening outside, we have an upstairs activity room that has tables and we actually do cooking activities in cooking groups.

Tracy also describes her belief in the use of an occupation-based or purposeful activity approach as she recounts ideas that she has for client treatments:

The practice is very, I try my best to be occupation-based, I try my best to do meaningful stuff with them. I always ask them before I do it, I'm not going to say, get on this bike and ride it. I'm going to say, would you like to do this?...I think seeing the progress of the patients, that supports it. You know, just, I mean, I was doing an activity last week with a blow up baseball and bat and just seeing the... for the people around me to see how much the patient enjoys it and see that I've got 4 lb weights on their wrists, you know, that is building that muscle there and they're playing a game of baseball, and this patient used to play so they thought this was perfect.

Presented data suggests that participants vary with how they describe their belief about occupation-based and purposeful activities, but all embrace the concept of the use of this level of activities with their clients.

Engaging in preparatory techniques and enabling activities. Preparatory and enabling activities are treatments that are either done *to* a client without their active participation or are activities that are created to address factors such as strength and movement, but are not based on actual occupations, they have no inherent meaning. Both levels of activities are allowed in OT practice (AOTA, 2008) as long as they are being used in preparation for an

occupation-based activity—that should directly follow. The use of preparatory/enabling activities does not represent the base philosophy of OT. As the data will illustrate, novice practitioners have divergent ideas and uses for these approaches. As we will see, some practitioner use them freely as preparations, others consider them poor OT practice and will not use them at all. Still others use them and consider them to be on even keel with occupation-based and purposeful activities with regard to client value.

Logan, perhaps one of the most vocal pro-occupation-based approach participants stated the following about his use of preparatory activities:

Preparatory, you know, it's probably 33%, you know, 33, 33, 33. I try to keep it as rich as I can, but five days, working with some clients five days a week and without the motivation they have, without the excitement they bring, and I, whatever I try to do I can't get that excitement out of them. You know, you begin to lose motivation to create rich experiences too, so that's probably, that pushes me back towards the preparatory.

Ashley takes an equally pragmatic approach and appears to uncharacteristically consider occupation-based activities as a means to evaluate which preparatory activities should be completed:

I just feel like you definitely have to do the occupation-based because that is what all the preparatory exercises tie into with me, I mean, if you are going to improve your ADLs, then you may need to increase your strength, your coordination, but you have to do the function based activities to see where your weaknesses are, where your

strengths are to know what you need to work on.

Depending on the patient, depending on what their needs are for their goals; I try to aim the activities to increase their skills so that they can be able to that. So, I guess I learn how, what kinds of things they need to work on by doing a functional activity. Well, if they have trouble doing the buttons on their shirt, then they need to focus on increasing their pinch skills so they may need to do some clothes pins for a while to increase their strength. Or, do some range of motion and stretching if they are having trouble brushing the back of their head or putting their shirt on. So just based on their different needs, focusing on what they can improve upon. That's how I pick from preparatory or occupation-based.

Understanding that the use of preparatory activities do not match function for many clients, Ashley commented on what she will say to attempt to reconcile the two ideas for the client:

Sometimes I feel like they might wonder why they are doing all these exercises and I try, if we are doing an exercise because I see that they need it, then I try to re-emphasize that they are doing this exercise so that they can increase their independence with whichever activity daily living we are focusing on.

Rowan describes a sense of excitement that she experienced when a co-worker created an enabling activity to simulate hanging clothes on a clothesline as opposed to a more purposeful approach to the same activity:

We do have theraband, we have a deck of cards and we had some clothes pins until this past week, but we will have... this girl, this other OT we had, she had the

residents pin the cards onto the theraband line so they were practicing their core strength and balance and all this stuff and I thought oh my, it's something that is different, something that they could actually be doing at home, hanging their clothes on the clothes line.

Hayden also describes preparatory activities as being a necessary part of the treatment process when she states, "But, I like... I mean, of course, we have to work up to it with the preparatory thing, so we may strengthen or do some range of motion and then do it an activity that is maybe more purposeful for them." She also reports, "a lot of my treatments... they may start out with preparatory activities and then evolve into a purposeful activity." When asked if this was the manner in which she believes that all treatments should be conducted, Hayden seemed to change her thinking to some degree and stated:

Well, I don't think that each one has to, that's why I say I probably shouldn't have stated it that way, because I don't believe each one is like that. I mean, it depends on the level of the patient. If I go in and the patient is highly functional, more so than another, then I may just work on an occupation-based activity versus a person that needs more strengthening or needs more range to be able to use that to incorporate into the occupational based activity. So, that's what I see where I would have to use preparatory, is to increase the functional part of it.

In similar fashion, Casey reports using preparatory techniques and states that she will try to follow it up with occupation-based or purposeful activity:

I do some preparatory techniques and then I might try to follow it up with an occupation-based or purposeful activity. I mean, I feel like what I do is purposeful and meaningful. Like, I don't just go in and put a heat pack on somebody or an ice pack on somebody and call that treatment. I would, if that was needed, I would do it and after that I would follow up with some type of activity. Like if it was shoulder pain or something that needed heat on it and then do an activity to range it or, you know, just treat whatever the need to be.

In a second excerpt, Casey describes exercised, which are preparatory, that she does with clients. She adds that she will give clients distractions to work on during the exercise and believes that those will increase the interest of the client.

I don't know exactly what it is called but it is like the pulley thing that you put onto a door and you do it. I don't know what it is called but you can lean different ways to help strengthen the sides of the trunk uh. We do a lot of mat exercises such as push-ups. Um. Putting people on balls and going back and forth to help strengthen the trunk muscles and then there are some times that we do just use the weights and the thera-band or like I put weight on their arms and we'll do activities, you know standing to help build their endurance and it's also strengthening their arms. But I try to incorporate little things so they don't realize what they are doing but it's really, you know, exercise--that they are really strengthening, right?

In a seeming reversal of beliefs about preparatory activities, Casey then states:

In the field, I see a lot of um, I guess, preparatory activities, things like hand bikes,

and things like that that just prepare you for strengthening so that you are able to later put that strength to use in other areas. But I see a lot of that, and I guess I expect it to be a perfect world, where it is completely functional. But I guess they do need to do strengthening as well to apply to everyday activities. So, I guess that kind of surprised me to see so much of it.

In the following account of a client outcome, Jamie reports the satisfaction that she and a client have taken in the clients improved ability to lean forward in and propel a wheelchair and to play with pegs and towels; no mention is made of occupation-based or purposeful activities or functional outcomes beyond wheelchair propulsion:

I had this lady, she is very, very overweight and she has to be gotten out of bed with a Hoyer lift. When she first came to the facility she couldn't do anything on her hands, arms, or anything when she first got here. As a matter of fact, a lady in activities is her mom. And she, we started working with her, she could not lean forward in her wheelchair to even put the pegs in or anything because she is so obese. Now, she can roll her wheelchair, she couldn't do that, actually one reason why was because she didn't have enough strength to roll her weight in the chair, but she has enough strength in her arms now. She can put the pegs in, she can actually take a towel and roll it out and bring it back, so she's getting, her core is stronger now where she can pull herself backwards and forwards. That's a lot, that's a lot for this lady if you were to meet her. It is so much, especially rolling her wheelchair. She is so proud of herself, every time I see her in the hall she has to show me how much further

she can go. It just makes me feel good to know that I worked with her enough to where she's gotten to that point.

Jordan has a less than favorable opinion of preparatory techniques that are not followed immediately by functional activities:

I mean, forget function, like they were hooking e-stim up, they were doing stroke recovery program, which is necessary, but if you are not following it up with meaningful occupations and activities what's the point if she's just not motivated to do the restorator or to do, you know, the weight bearing on that side.

Jordan is able to articulate the various levels of activity that are used by practitioners and to describe the appropriate use of occupations following passive preparatory techniques.

Logan, like Jordan, has a less than optimistic view of a preparatory-only approach to treatment when asked how others at his facility may conduct a treatment session.

I'd say the more of a preparatory type world where they are not really developing anything at the end. It's just, you know, the strength building for strength building sake or range of motion for range of motion sake or just sort of not as a rich of experience, I hope, as to what I would see if I were doing the activity.

Logan shares his belief that he has learned, being a post 1998 OTA student, to be more holistic in his approach, not relying on preparatory techniques as many of his more experienced peers do:

I can definitely see that having gone to school when I did, I can definitely see a shift in focus from how some aspects of OT assistants practice and how I approach. I think

it's, I guess it would be sort of like an pre 1998 and post 1998 is probably the way I visualize it. You now, having got taught within more a medical model you know within more reductionist, for use of a better term, instead of looking at the whole person, just looking at the body mechanics.

Rowan sees that preparatory and enabling activities can improve underlying factors of clients, but she can see that they miss the mark on being holistic, as the profession of occupational therapy is meant to be:

Yeah, I mean. Sure they reached the goal, but I don't feel good about myself to have a very, ... um... preparatory day or just like a rote activity kind of day, I don't feel good about myself because I think it is very boring for the patient. It is boring for me; it's not that it's boring for me, it's that my day was crazy and that's why... You know, sometimes, not a lot of times, but sometimes we have a lot of, our skilled nursing home is in a predominantly Italian neighborhood and sometimes we get Italian men. Not to stereotype all Italian older men, but a lot of these men I've worked with, they do not want to do occupation-based activities that I have given them and, even dressing. They don't want to mess with dressing, so if I put them in front of a bike, an upper arm bike, that seems to occupy when someone is refusing therapy, I don't want to do this, that's, I'm not interested, and I say, okay, getting them to do this then at least they are participating in therapy. So sometimes I resort to that if I need it and I don't feel bad about that in the least.

Logan, enacts his belief against a reductionist approach through the advice that he

gives the next generation of OTA graduates. Interestingly, as was described earlier in this section, Logan does report the use of a more reductionist approach himself when faced with a difficult client:

It is easy to fall into the trap. I mean, you can just go through the motions of the day, and just do whatever, and fill time. But, you know, it takes a conscious effort to actually spend time and, you know, try to formulate activities that engage the individual. Because, it is a challenge, I mean, it's a big challenge to find, to meet the goals of the company and find the client engaged.

Don't give into the system at large. Try to create success through what you learned in school. Don't just fall into the trap of the other OTs, you know, how it is done so much now. Be willing to learn, don't just, you know, I'm in a rural community, I, we could just sit here and do the same thing all day, every day. Be willing to learn. I think that we should come away with, a good framework, but be willing to educate yourself.

The participants of this study identify with occupational therapy as a client-centered profession where care, concern, and compassion for the mind, body and spirit of the client are valued and addressed through treatment. Participants report conducting practice in a manner that is congruent with this professional stance. In addition however, the use of a more reductionist approach using preparatory techniques and enabling activities is described and reported by most as an appropriate and useful approach to treatment. The concepts are not mutually exclusive in the daily treatment approach of these novice practitioners; for these

individuals, occupational therapy is found in the relationship and concern for the client more than in the choice of treatment methods.

Chapter Summary

The purpose of this chapter was to provide profiles of the study participants and to display the narrative data obtained through semi-structured interviews. The ten participants interviewed were all graduates from the same occupational therapy assistant program located in southeastern North Carolina. Seven were from the class of 2008 and three were from the class of 2009. At the time of their interviews, all participants were employed for less than one year. All participants currently work in skilled nursing facilities except for one who works in an acute care hospital setting. Each participant was interviewed twice for this study with the exception of two individuals who were each interviewed once; a total of eighteen interviews were conducted.

Coded findings were displayed as they related to each of the four original research questions. Categories and sub-categories that emerged from the data were reported in narrative form. The data obtained and displayed provides insight into the overarching purpose of this study which was to explore how novice occupational therapy assistants create their understanding of the profession and how this understanding ultimately impacts their treatment choices when working with clients.

When compared to the original research questions, the findings indicate that novice OTAs define the profession of occupational therapy as a profession with the primary objective of bringing *quality* and *meaning* to the lives of clients through the enhancement of self-care abilities and engagement in activities that bring pleasure such as crafts, pet care and

simulated engagements such as fishing. This personal understanding is created while in the social context of the treatment environment through observing the positive responses of clients to particular interventions. In addition, formal learning as occurred in the classroom, and facility based in-service training offered opportunities for professional growth. Novice OTAs also report learning that occurs through observation of peers as they conduct and suggest treatments in the context of the work setting; lessons gleaned can be through positive or negative example.

Work place environmental factors that contribute to shaping practice choices include facility supports and challenges, both overt and covert, and the requirements of third party payers. These factors are in the form of power relationships, equipment and supplies available to the clinician, and productivity requirements that limit time spent with clients.

Novice OTAs have been found to enact the beliefs that they hold, with a partial breakdown occurring between the congruence of their beliefs about the profession and the occupation-based approach being espoused by the AOTA and taught in the OTA curriculum. OTAs did not describe consistent use of reflexive practice to self-judge the congruence of their espoused versus enacted beliefs, but were able to identify this lack of congruence in their peers. Chapter five will discuss these findings and their relationship to the relevant literature. Implications for these findings and recommendations for future research will also be discussed.

CHAPTER 5

Summary, Conclusions, Implications and Recommendations

This chapter contains five sections. The first section will provide a brief summary of the study; the second will provide a summary of the findings including both categories and sub categories that have emerged from the data. The third section will provide a discussion of the four conclusions drawn from the findings and the fourth section will provide implications for education, theory and the practice of OT. The fifth section will offer recommendations for further study.

Summary

The purpose of this qualitative study was to explore how novice occupational therapy assistants begin to understand their profession; to form practice beliefs that inform their selection of, and engagement in, specific treatment methods and modalities with clients. The four research questions that guided this study are:

1. How do novice OTAs understand and describe the profession of OT?
2. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?
3. What environmental factors shape the practice choices of OTAs within the clinical setting?
4. How do novice occupational therapy assistants enact their professional belief within the clinical setting?

A basic interpretive qualitative research design was used to explore these questions;

primary data were analyzed inductively using the constant comparative method (Bogdan & Biklen, 2002; Charmaz, 2006; Glaser & Strauss, 1967) of 18 initial and second interviews conducted with ten participants totaling approximately 27 hours in the field. The participants were purposively selected and included eight woman and two men, who all graduated from the same OTA program in Southeastern North Carolina. Participants were all novice clinicians, three graduated in 2009, seven graduated in 2008. Participants ranged in age from 23 to 38 years and had spent between 0-2 months and 8-10 months employed within the field of OT. They are all employed within the physical disabilities practice area.

In addition to interviews, secondary data were analyzed from participant critical incident essays, participant observations, worksite observations and workplace documents. Several steps were taken to ensure trustworthiness of the conclusions including triangulation, investigator bracketing, journaling, and member checks.

The findings that emerged from the study were displayed as categories and sub-categories of the original four research questions. The data provide insight into the overarching purpose of this study which was to explore how novice occupational therapy assistants create their understanding of the profession and how this understanding ultimately impacts their treatment choices when working with clients.

For research question one, two categories and five subcategories emerged from the data that illustrate how OTAs define and describe the profession of occupational therapy. Category one relates to *defining occupational therapy* and contains the subcategories of (a) identifying OT interventions, and (b) describing the purposes of OT interventions.

The second category relates to *describing the profession of OT* and contains the subcategories (a) revealing care and concern for the client, (b) engaging in relationship building as a therapeutic tool and, (c) recognizing community building as an outcome of intervention.

For research question two, three primary categories and nine subcategories emerged. The first category is *learning through interaction with others*. Subcategories are (a) recognizing enhanced function of clients, (b) recognizing changes in affect, emotion and motivation of clients, and (c) recognizing changes in client factors. The second category, *learning through formal venues* includes the subcategories of (a) recalling lessons from academic program, (b) recalling lessons from workshops, and (c) recalling lessons from books and periodicals. The third emergent category, *learning through interactions and observations of peers* includes the subcategories of (a) making positive example observations, (b) making negative example observations, and (c) engaging in discussions with peers.

From research question three, three categories and seven subcategories emerged. The first category involves *being supported in practice choices by the workplace itself*. Subcategories emergent from this category include (a) recognizing administrators and supervisors as supports; (b) recognizing financial supports within the work facility; (c) recognizing mission and vision supports with the work facility, and (d) recognizing physical environment supports within the work facility. The second category is *work facility based challenges to practice* and includes the subcategories of (a) recognizing administrators and

supervisors as challenges, (b) recognizing financial challenges with the work facility, and (c) recognizing physical environment space challenges. The third category has no subcategories and relates to *responding to requirements of third party payers*.

The fourth and final research question pertains to enacting a personal understanding in practice. There are two categories and two subcategories associated with this question. The first category is *assuming a professional identity* and has no subcategories. The second category is *enacting espoused beliefs*; the two subcategories are (a) engaging in occupation-based and purposeful activities, the second is (b) engaging in preparatory and enabling activities.

Conclusions

Three major conclusions regarding how novice OTAs understand the profession and select treatment interventions can be drawn from the findings of this study. These conclusions are (a) OTAs define and describe the profession as embodying practitioners who have great care and concern for clients and use relationship building as a therapeutic tool, (b) novice OTAs engage the process of OT in a linear and hierarchical manner that is not in keeping with the tenets of the profession, addressing client factors (e.g. strength, motion and endurance) prior to engaging clients in functional tasks, (c) the practice of OT by novice OTAs is impacted by hegemonic environmental factors such as direct management, the organization and third party payers.

Conclusion one: A model of divergent identities. The first conclusion to be drawn from this qualitative study is represented by figure 5.1. Novice OTAs possess, yet do not

describe an awareness of, two divergent professional identities that impact their espoused and enacted practice beliefs. In other words, OTAs, while in the context of the workplace actually construct more than one professional identity and belief in the profession. Two identities are held simultaneously by the novice OTA, each identity embodying a part of practice, but neither containing the full range of beliefs described by the AOTA. The creation of these identities, and the practice conducted as a result, are supported in the literature through (a) identity theory, (b) social cognitive theory and the (c) concepts of theories in use versus theories of action.

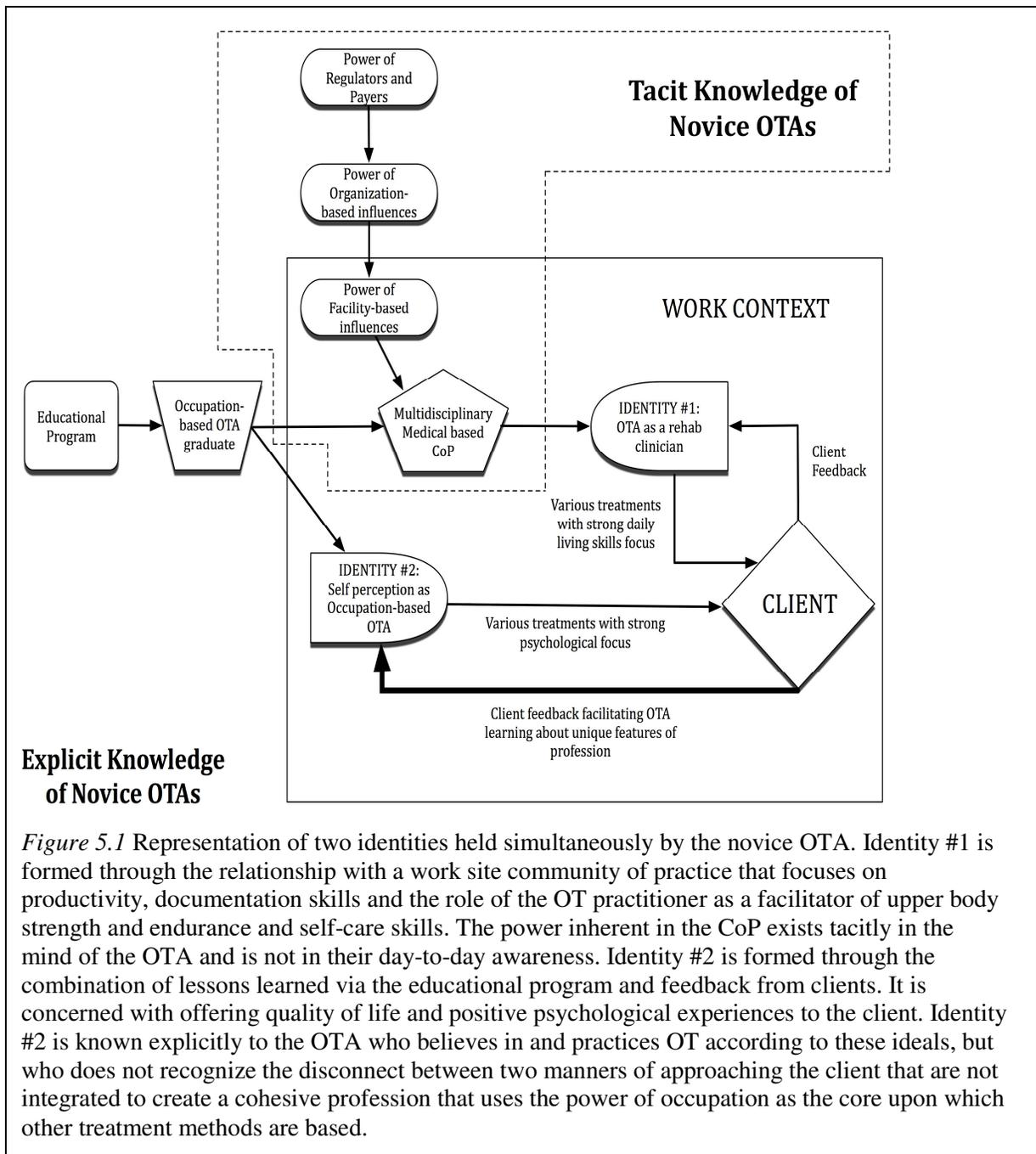
As illustrated in figure 5.1, identity one is formed through the relationship with a work site community of practice. The significance of this CoP will be explored in conclusion two. Through their involvement with the CoP, the novice OTA forms their identity as a rehabilitation therapist, a practitioner who works with clients on body function and structure and then assists them to acquire self-care skills. The knowledge of how this identity came to be and the shortcomings of the practice belief it holds, exist tacitly in the mind of the OTA; the OTA is not overtly aware of the development of their reductionist identity or that they are in any way practicing reductionist care.

Identity two is formed through the combination of lessons learned via the educational program and feedback from clients. This identity is concerned with OT practice that offers quality of life and positive psychological experiences to the client. This approach may or may not include engagement in occupations but nonetheless is seen as a unique to the practice of OT. Identity two is known explicitly to the OTA who believes in and practices

OT according to these ideals and self identifies as an occupation-based OT practitioner. However, the OTA does not recognize that they conduct treatments through two disconnected practitioner identities, nor do they recognized that the two sets of beliefs guiding client interactions are not integrated to create a cohesive profession that uses the power of occupation as the core upon which other treatment methods are based.

The concepts of identity and identity formation have been posited by Hitlin, Wenger, Fenwick and Ibarra; and help us to understand how a clinician can have two professional identities simultaneously. According to Fenwick (2008), individuals can maintain several identities and are able to fit within several contexts simultaneously. She considers the individuals' sense of their own knowledge of work and the value held by the group within which they belong as strong elements in identity formation. In other words, the OTA will strive to fit into the workplace CoP through their identity as a rehabilitation professional who is knowledgeable about the rules, regulation and culture of the workplace, but will maintain their previously formed identity as an occupation-based clinician since this identity is not challenged or negated by the former.

This idea is supported by Hitlin (2003) who also posits that personal values drive the decisions that individuals make regarding their identities and cause them to chose certain groups and roles; novice OTAs are able to maintain their personal beliefs about the profession of OT even when their work CoP identity in the workplace causes them to approach practice from a more reductionist perspective. Daley's beliefs support the thinking that novice OTAs have two work identities by pointing out that novices are not in a position



to assert their beliefs about a profession and therefore must rely on others in context to model behaviors (1999). In other words, to be successful within the workplace at this early stage in

their career and simultaneously maintain the ideals acquired during the academic program, they must adopt the second set of values and beliefs of the CoP, which unfortunately do not match those of the profession of OT.

The theories of identity theory and social identity theory are confirmed by the findings of this study. Both describe the individual as organizing the behaviors of their identity into meaningful units. These units are either described by roles (identity theory) or norms, stereotypes and prototypes (social identity); both espousing the notion that multiple self-identities are interrelated in various important ways (Hogg et al., 1995). This is the case for the novice OTA who practices occupational therapy from the perspective of two interrelated identities. Additionally, identity theory posits that identities define the self. This is seen in the findings of this study where novice OTAs identify themselves as occupation-based practitioners, according to Hogg, et al (1995) this is consistent with identity theory where one names themselves as a member of a social category or commitment; in this case a group of allied health professionals has identified themselves with a perspective of their profession by calling themselves occupation-based practitioners. Interestingly, when describing identity one (figure 5.1), as a practitioner within the facility, OTAs refer to themselves as OT practitioners or OTs, they do not use the title associated with a sub-grouping when describing themselves to others in the CoP. This finding expands the social identity theory through offering a perspective on how professionals self-identify with others in the field or in their worksite.

The second part of this conclusion is illustrated in figure 5.1 and relates to the novice

OTAs believe that their unique role in the treatment setting is to enhance the quality of life and motivation of clients. When asked to describe the heart of the profession of OT, novices are strong in their belief that OT is unique in its focus on happiness, quality of life and engagement in occupations that hold meaning; the psychological aspect of the profession. The interaction leading to improved motivation and engagement is known by OTs as the *therapeutic use of self*, which is a way of engaging the client through the use of the personality traits of the therapist such as kindness, verbal and physical attending and the ability to engage in conversation relevant to the client. These traits can be used to assist the client with building and maintaining their self-efficacy (Bandura, 1978), which is so important for motivation and quality living. The traits of therapeutic use of self assist the client to visualizing the promise of the future and empowers them to take control of their current situation and move forward in life with optimism.

OTAs proudly identified their personality skills as being part of their occupation-based clinician identity and often described the subsequent client motivation as the distinct contribution of OT. Novice OTAs report that they come to understand the effects of their positive personality traits through therapeutic interactions with the clients and at times, their families. They describe a phenomenon in keeping with social cognitive theory, specifically reciprocal determinism as described by Bandura (1986). Reciprocal determinism is the manner in which individuals learn through experiences occurring in the context of the environment.

According to Bandura, there are three key components that must be present together

for learning of this type to occur. These three concepts are described as the interplay of cognition, affect and biology with behavior and the environment. Novice OTAs create their work identity as occupation-based clinicians who excel in the use of their personality through the feedback received through client interactions that meet criteria for reciprocal determinism. In other words, clinicians use personality traits such as optimism, positive talk, body language such as direct eye and listening skills. The feedback of motivation and engagement that the clinician receives from the client is reflected upon and is determined to be resultant from the use of self skills. The clinician sees that the continued therapeutic use of the self creates a treatment milieu that is positive and uplifting; a contagious culture of optimism is created that transcends a single treatment session to facilitate client interest in participation in living. In this way, the novice OTA has gained self-efficacy, the belief that they have that ability to affect their environment. Self-efficacy is at the core of social cognitive theory and serves as master motivation for the activities in which individuals engage. OTAs have seen the positive outcomes of their actions in the responses of the client, they internalize their effectiveness as occupational therapy practitioners.

However, despite the fact that OTAs operationalize their constructed identity as an occupation-based practitioner through their demonstration of the therapeutic use of self; it is simply not the full professional paradigm. OT is not defined by the psychological aspects of practice alone, or by the use of exercise to remedy weakened body parts. OT is also not concerned solely with the client's ability to engage in self-care activities. The profession is so much more. The social learning occurring in the workplace through CoPs and client feedback

leading to enhanced self-efficacy reinforces a fragmented picture of practice; the two professional identities are supported. This incomplete picture soon becomes reality and this reality turns into practice.

The theory of social learning is confirmed through the findings that (a) OTAs have high levels of self-efficacy which are reinforced through mastery experience when positive outcomes are achieved with clients, and (b) OTAs learn through vicarious experience and the modeling of others as they engage clients in the workplace. The theory of social learning is expanded through the phenomenon that individuals engaging in the treatment of others may receive supportive feedback but may not be practicing their craft to the standards of the profession. Bandura (1986) describes the potential for faulty thinking where an individual believes their interpretation of facts to be correct when they are not, yet they are supported in this belief by the environment. The way for a person to correct this errant thinking is through reflection and consideration of alternatives; both propositions may prove difficult for OT practitioners working in isolation of other practitioners or with others who practice in the same way.

The espoused and enacted beliefs of novice OTAs with regard to the profession of occupational therapy are congruent. The OTAs participating in this study commented multiple times that they believe themselves to be occupation-based occupational therapy practitioners. However, observations of their respective work sites and their own descriptions of the practice that they conduct and beliefs they have about the profession are not congruent with the documented tenets of the profession, the professional paradigm espoused by the

American Occupational Therapy Association. There are some facets of their beliefs and practice habits that approach occupation-based ideals, but these are not consistently stated nor consistently executed. For example, the novice will state that treatment must be designed to remediate deficient client factors prior to client engagement in occupational activities. This belief leads to the use of preparatory and other reductionist techniques in treatment. Another belief is that the uniqueness of OT is found primarily in the use of self as a motivational tool. Although it is part of an occupation-based approach to treatment, therapeutic use of self does not define the profession. At times, novice OTAs will underplay the importance of relevant and meaningful occupations that they do provide, believing the positive outcome they observe are due to the power of their personality as care providers.

According to Argyris and Schön, congruency should exist between what the professional espouses, or believes and how they execute what they believe (theories in use). The beliefs or theories of action that novice OTAs acquire while in practice do translate into their theories in use, the manner in which they conduct their treatments. Therefore, there is congruence between espoused and enacted beliefs. Unfortunately however, the beliefs and subsequent treatment approaches do not represent the current paradigm of OT espoused by both the profession and the educational program that the novice attended.

As stated previously, the data have revealed several reasons for this phenomenon including the non-OT learning occurring in non-OT CoPs, the power inherent in the organization through managers to keep learning focused on that which will assist with organizational goals, and the feedback received from clients that suggest happiness and

positive outlook are linked to therapist personality traits. These phenomena provide examples as to why the novice is constructing a skewed understanding of OT and therefore are not practicing in a manner consistent with new OT paradigm.

It is also possible that an information gap has occurred in which the practitioner does possess the tacit knowledge, but is unable to verbalize it (Argyris & Schön, 1974). However, if this were indeed the case, I would expect to see the consistent use of an occupation-based approach in actual practice, but do not. Argyris and Schön also state that a professional may hold a belief and have the capacity to execute the belief but are not able to due to outside forces. This may also be an explanation for the behavior of the novice OTA, but does not seem likely because the novices interviewed are unable to consistently articulate an accurate description of occupation-based practice despite their self described identity.

In order for any professional to create consistency between their theories of action and theories in use when it does not exist, they must first experience a sense of unpleasantness that creates a call for action. They will enter a process of reflection and reflective action in order to bring congruence between that which is espoused and that which is enacted. In the case of novice OTAs who believe that what they espouse is accurate and therefore what they enact is correct, the change required is in their understanding of the profession. In order to bring congruence between that which they know and that which is espoused by the profession, recognition of the incongruence must first be achieved (Wenger, 1998).

This conclusion confirms and expands the literature of espoused and enacted beliefs

as put forth by Argyris and Schön (1974). The literature supports the premise that one can hold and practice beliefs, but that the belief may be misguided. Such is the case with the novice OTAs within this study. They have beliefs about OT and are practicing to those beliefs. Unfortunately, the belief system is skewed. This fact does not bode well for an allied health profession in the midst of change. If practitioners do not see incongruence between what they believe and what they do and if they are not motivated to compare what they do to the new paradigm, change will not be prompted. For the advancement of the profession of OT and the clients that are served through this profession, the concepts of espoused and enacted beliefs must be applied to allied health practice with a plan for imitating change of the paradigm incongruence.

Conclusion two: OTAs engage the process of OT in an overly simplified and linear manner. The second conclusion to be drawn through this study is that novice OTAs engage the process of OT in a linear and hierarchical manner that is not in keeping with the tenets of the profession; they hold and verbalize a belief that client factors must be addressed specifically, often in isolation of and prior to engaging the individual in functional tasks. The linear or attention to client factors-first is in keeping with a positivist, medical model approach embraced by the scientifically based, western civilization, health care community.

According to the tenets of practice described in the Occupational Therapy Practice Framework (AOTA, 2008), occupational therapy is a non-hierarchical approach to client care that does not rank order the return of function or place client factor functioning as a necessary prerequisite for engagement in activities. A transactional relationship is said to

exist between the various client factors (strength, motion), performance skills (planning, organizing) areas of occupation (i.e. work, leisure, activities of daily living), and the process of treatment. Client motivation and enhanced client factor functions are addressed simultaneously when activities are chosen that are relevant and meaningful to the client. A linear, or reductionist approach holds that client factors must be addressed via preparatory techniques (physical agent modalities, rote exercise and non-contextual, non-meaningful activities).

The novice, as a learner in context, established these reductionist beliefs based upon their interactions with others in the setting. The phenomenon of learning through interaction with others and the development of a professional identity, have been described by several theorists including Ajjawi and Higgs, Bandura, Tryssenaar and Perkins, Lave and Wenger, and Wenger, McDermott and Snyder. The experiences and learning of participants of this study are best described through the lenses of Communities of Practice (CoP) and identity formation.

CoPs are defined as groups of people who share a concern, set of problems and passion about a topic and who deepen their knowledge and expertise by interacting on an ongoing basis (Wenger et al., 2002). The existence of organically formed CoPs within the worksites of study participants can explain the conditions under which these novices refined and modified their belief about their profession while interacting within a group of like-minded individuals. The following points highlight the relationship of conclusion two to the CoP literature: (a) Groups of co-workers that meet criteria for being CoPs are present in

worksites of OTA study participants; (b) the CoPs that exist in the physical disabilities workplace are comprised of multiple practitioners from various discipline, they are not exclusively comprised of OT practitioners; (c) the shared meaning, goals and identity of these CoPs represent general rehabilitation ideals and are not concerned with OT practice issues and; (d) novice OTAs consistently refer to their relationship to others in the work place that in most cases are considered growth promoting and offer learning on a wide variety of general rehabilitation topics; and (e) novices who participate rehabilitation worksite CoPs learn how to conduct treatments using artifacts from the context that that are espoused by medical based; artifacts are not unique to the OT profession.

According to Wenger et al. (2002), the criteria for a community of practice includes group meaning making, sharing historical and social resources and frameworks, having a sense of community, and a common understanding of how learning modifies identity. These attributes are present in the workplace CoPs of which novice OTAs are members. However, the majority of CoPs described by participants are not exclusively a community of occupational therapy practitioners, and may be comprised of only one or two OTs in addition to individuals from several other disciplines. In general, these CoPs do not represent the thinking of the profession of OT alone so therefore do not support any particular type of OT practice. These CoPs are rehabilitation communities, where the shared meaning is the common goal of enhancing function of clients, through the use of shared supplies and treatment space; where each profession understands and is responsible for its own contribution. Professionals learn together through in-service and other continuing education

venues, often provided by the workplace organization, the lessons important for success as a member of the rehabilitation team.

Rehabilitation professional CoPs are not focused on the success or promotion of one particular profession and therefore do not share or work to enhance the common philosophy of novice OTAs. Those entering these CoPs as new comers seek to become old-timers through gaining the abilities that they find desirable in clinic managers and others identified as role models (who may or may not be OT professionals), the desired attributes reported include (a) having extensive knowledge about the business end of rehabilitation, (b) having strong documentation and people skills and, (c) having extensive clinical knowledge with regard to general rehabilitation techniques and understanding of pathologies. Therefore, the discourse that drives the learning through the community includes philosophies and treatment methods employed by others, such as physical therapy, a historically biomechanical based profession and speech-language pathology. Wenger (1998) posits that the mutual engagement of individuals within the CoP leads to shared meaning making over time. In the case of the novice OTAs, this mutual engagement impacts their developing identity as rehabilitation professionals.

CoPs rely on all members to bring ideas and reflections for growth and change, but there is no specific time frame as to when this change must occur. Therefore, it is possible that an OTA could impact a CoP at some future time by bringing occupational therapy beliefs and artifacts from their academic learning. This conclusion brings to light the fact that OTAs have not constructed a strong post educational program understanding of the

profession of OT. OTAs will role model non-OT practitioners, without realization that they are not engaging in or enhancing their understanding of holistic and occupation-based OT.

This conclusion both confirms and expands the theories of Communities of Practice and the theory of social learning. It is through the social interaction with others within the workplace that novice practitioners come to understand their context and their place and task within it. Novices may become active members or peripheral members of the CoP; both levels of which learn from other members, particularly the old timers who served as leaders of the community. As per CoP theory, new members seek to assimilate into the CoP, to become one of the group. For the novice OTA, this includes choosing practice beliefs and methods that are embraced by the CoP; novice clinicians do not have formal or informal power within the group, although this may change with time.

This conclusion also expands the theory of Communities of Practice and social learning by offering an example of what can occur in a context where the learning occurring with the CoP is actually incorrect learning. According to Salomon and Perkins (1998) people who are apprenticed in particular ways may pick up undesirable forms of practice, wrong values, or strategies. Novice OTAs who work within a small physical disabilities rehabilitation setting comprised of practitioners of various rehabilitation disciplines, will learn the values and treatment philosophies of the collective group. When these values and philosophies either negate the OT paradigm or simply do not consider it as part of general practice, the novice will adopt this manner of thinking. This incorrect learning stifles holistic and occupation-based practice and reinforces a linear and biomechanical approach to

treatment. This reinforces the notion that incorrect learning can and does occur through CoPs in the workplace.

Conclusion three: The hegemony within physical disabilities practice. The practice of occupational therapy by novice OTAs is impacted by the hegemonic power held by the management of the rehabilitation department, the organization (interested in issues of profitability), and third party payers (who hold the purse strings and create rules regarding reimbursable services). These three entities each equate to a social power influence that impacts the meaning making about the profession of OT and the types of treatments administered by the OTA (figure 5.1). Study participants report awareness that third party payers, organizations and direct department managers potentially hold some type of power over their treatment decisions but they often report being able to complete their desired types of practice regardless of this power; they learn to work within the system and to “walk the line.” What is not understood by clinicians is that the power held by these entities can be covertly transmitted and that despite their belief that practice choices are their own, they are not (Contu & Willmott, 2003; Fenwick, 2008; Hogan, 2002).

Power held by the direct manger is the first I will discuss. Managers of rehabilitation departments may have backgrounds in one of several rehabilitation disciplines. These individuals are in charge of their departments and as per study participant reports, are sought after for work related advice and information. Rehab managers typically have their desk in the same office as staff clinicians or in very close proximity. They may be responsible for client care in addition to their managerial duties and are therefore seen as a core member,

possibly the leader, of the rehabilitation community of practice. Participants often consider these managers to be *one of the group*, to be individuals who are themselves directed by others and have very little formal power. The power that they do possess in the minds of the clinician is *personal power* as described by French and Raven (1959). Both expert and referent power describe the power believed to be held by the department manager. Expert power is belief that the manager has greater knowledge than the employees; referent power refers to the personality traits that they possess. Both are reported by study participants as characteristics to role model, which leads to the conclusion that clinicians will follow the lead of the manager even when that means practicing OT in a reductionist manner; the boss knows best.

Very few study participants mention their awareness that managers possess formal power that controls the rehabilitation department through methods such as coercion, reward, legitimate power, information power and ecological power (French & Raven, 1959). If a clinician does not believe that their manager has power over their practice, it is likely due to an underestimation of the ability that they hold to control things like information and the work setting itself. Ecological power is used to control the community of practice and hence the practice habits of the clinician through social learning and management of the culture of the community. Informational power is the ability of the manager to transmit from the organization to the clinician only those messages that they believe to be necessary.

Information power and ecological power offers the manager, the leader of the CoP, control through influence tactics such as rational persuasion, apprising and legitimating

tactics. These tactics gently lead the clinician to internalized compliance where they believe that behaving according to group norms is in keeping with their own personal value system, regardless if it is or is not (Yukl, 2009).

Through vision and mission, the goal of the organization is to make a profit for those who own the entity; public entities also carry an agenda for financial solvency in order to maintain viability. Therefore the organization, through its higher ranking managers, holds formal power over the rehabilitation manger. This power is overt in the mind of the manager, but since it is not directly experienced by the clinicians, they do not recognize how this power ultimately affects their professional choices and beliefs. Participants will however report that they are aware that their manager must answer to the organizational managers; they speak of this as an unfortunate circumstance for their friend, the rehabilitation manager.

Participants view the control held by the organization over the rehabilitation manager as being either coercive, where fear of job loss leads to compliance, or through a reward system where compliance is created with pay incentives and possible promotion (Yukl, 2009). The participants are not as verbal in their understanding that the messages and mandates taken from the organizational leaders by the clinic managers are applied to their departments through the control methods previously described within the context of the rehabilitation CoP.

In addition to power over clinicians through the behaviors of the manger, the organization can directly control the formal learning of staff clinicians by offering mandatory in-house education or offering a choice of free venues that encourage clinician attendance

due to the cost savings over choosing a different venue. Hence, the information being transmitted is controlled by the organization.

At this time, the profession of OT is a billable service provided to those who experience deficits in their abilities to engage in life functions, primarily activities of daily living functions such as eating, dressing, bathing and personal care. Within skilled nursing organizations, Medicare is the primary payer for services of the various rehabilitation therapies. As a third party payer whose monetary reimbursement to the organization can either make or break the viability of that organization, the third party payer holds considerable formal power exercised by financial rewards. Informational power is also held by third party payers; organizations, to ensure that they are in compliance with rules and regulations, will provide them with whatever information is required to ensure reimbursement for services. This information is taken in part from the rehabilitation therapies whose practice habits are overseen by the clinic manager. When a new mandate is put forth by the third party payer, the organization will instruct the manager who will ensure follow through of the clinician in either documenting or practicing in a particular way.

To reiterate, in this study, participants referred to the third party payer and the organization as being concerned with money, but did not see this as the concern of their direct manager. In this manner, they are comfortable in their belief that they are members of a CoP that has their best interests and those of the client in mind. If this was not the case, and the clinician was focused on the financial gain of the facility, they may not be interested in working for that entity. The control of the environment and information held by the clinic

manager, although not overt to the clinician, maintains a hegemonic order in the rehabilitation department.

It is a reality of the current healthcare system that quality of life and motivation are not considered functional outcomes, and that the manner in which functional gains are made are not of significance. The paradigm of OT being provided is of no consequence to managers, organizations or payers-assuming it is not outside the legalities of professional practice acts. As a matter of fact, using physical agent modalities such as deep heat and ultrasound, in addition to other reductionist methods that can be administered and billed for quickly with minimal clinician time involvement, are encouraged. Organization control over treatment choices is also seen through the statements of participants who report that their organization supports the rehabilitation department through provision of *function kits*; individual boxes containing all supplies needed to engage a client in a functional activity (e.g. a feeding box would contain flatware, drinking cups, plates, bowls, napkins and non-perishable food items that allow the client to practice self feeding skills). Although seemingly promoting occupation-based practice, these kits also allow for a healthier bottom line by saving the clinician preparation time during treatment and keeping the focus on reimbursable function.

When acknowledged, this power hierarchy is generally accepted, is of benefit to third party payers (wishing to pay only for certain services yielding measurable outcomes), to organizations (wishing to remain solvent), and to the rehabilitation managers (who are in leadership positions and earn equivalent wages). However, it can also be detrimental to the

profession of OT. Occupational therapy is not a profession that is only interested in outcomes. As described previously, OT is also a profession concerned with the healing power of the process of occupational engagement. This concept is not important to any power sources and is therefore not a mandated way of practice for OT clinicians. The lack of OT specific communities of practice and OT managers interested in the tenets of the profession, keep the focus of novice OTAs on the feedback they receive from their clients for the use of therapeutic use of self and instruction in self-care; they are not prompted to question their reductionist definition of occupation-based practice. It is in this way that third party entities (existing far outside the organization), the organization itself and the rehabilitation manager actually control the type of OT and understanding of the profession experienced by the novice OTA.

According to Yukl (2009), the way for individuals to take back control is to first recognize the forces of power that exist around them and to then reflect on how to create a compromise with regard to continuing to meet the mandates of management but at the same time be true to the profession. This can only occur through reflection upon the basic beliefs of OT and reflexive practice to ensure that those ideals that are espoused match the methods and activities being carried out in treatment sessions.

This conclusion confirms theories of social power, and the existence of both personal and formal power within the workplace organization. As described above, the workplace organization in which the novice OTA works has power influences at three levels, the rehabilitation manager, the healthcare organization or facility and the third party payers who

pay for services rendered with the healthcare organization. The use of influence tactics within these levels of power, in most cases, keep the OTA from believing that power from above is informing their practice beliefs and treatment decisions. The participants do not recognize the hegemony that is part of their work context. Novice OTAs believe that they are side-stepping power influences that could impair their ability to complete the type of OT that they espouse; they are not aware of the use of influence tactics, particularly those used by their direct manager. Novices do not see that those holding power are indeed able to direct their beliefs and the manner in which they practice.

Implications for Theory and Practice

The findings of this study offer implications for research, adult learning and identity theories, the profession of occupational therapy, and for OT educators, clinicians and students. These implications are consistent with the original purpose of the study, which was to determine how novice OTAs create their understanding of the profession while in the workplace and how this understanding informs practice choices.

To my knowledge, this study is among the first to describe the negative consequences to an allied health profession, of incorrect learning occurring through a community of practice. It is also among the first to describe the dual professional identities of novice OTAs as they practice from both a reductionist perspective and psychological perspective, never fully integrating the facets of new paradigm OT.

Implications for theory. Implications for three adult education theories emerged from the findings of this study. The first implication involves the finding that incorrect

learning can and does occur within allied health communities of practice. Communities of practice offer social learning within a group that shares similar beliefs, values and professional understanding. When the CoP is general in nature and the profession that a new clinician is learning about is not understood by the community, incorrect learning can occur. In the case of the OT profession, this incorrect learning can lead to less than optimal treatment being administered or place the profession in danger of being misunderstood by those in positions of power. Incorrect learning must be identified and then modified to ensure that learning is in keeping with the beliefs of the external organization; in this case AOTA. At this juncture, realization of incorrect learning has not been described by study participants.

Implications for espoused versus enacted beliefs and social cognitive theory have also emerged from this study; in both cases, incorrect learning has occurred. According to these theories, the learner is responsible for the accuracy of their own knowledge acquisition. Social cognitive theory requires the individual to reflect upon their new knowledge and to make choices to modify it if needed based upon the context and the environment. The learner must choose from alternative behaviors if needed. Espoused versus enacted beliefs can also involve incorrect learning, the individual may believe that what they espouse is correct, and continue to enact those beliefs in practice. In order to change this behavior, the individual must also reflect upon that which they know and that which should be known according (in this case) to the profession of OT. Despite the theoretical realization of incorrect learning, the realization had not occurred at the time of the participant interviews.

Implications for identity theories have also emerged from study findings. Novice OTAs have been discovered to conduct OT practice through two divergent identities while in physical disabilities practice. Identity one involves a linear and reductionist approach to treatment that is condoned by the rehabilitation community of practice to which the OTA belongs. The second identity is that of an occupation-based practitioner that is unfortunately very specific in the belief of what constitutes good OT practice. Although multiple identities are described in the literature as existing simultaneously (Fenwick, 2008) both OTA identities in this case are based in incorrect learning and can perpetuate incorrect practice and belief systems within the environments to which they belong. Each identity is supported in some way, so the impetus to change and expand the knowledge base of the profession is nonexistent.

Implications for research. While surveying the literature for studies that describe the construction of professional beliefs and practice choices of OTAs, it was discovered that very little qualitative literature exists that explores the process through which OT professionals create knowledge and make practice decisions. This fact and the fact the qualitative studies are rare in U.S. literature has been recognized by proponents of qualitative inquiry (Dickie, 2003). This study uncovered richness in the experience of novice practitioners whose voice was found through semi-structured interviews, therefore adding to evidence that this form of research is significant for a profession that seeks to understand the constructed reality of practitioners and ultimately clients.

Implications for practice. The changing of a paradigm of a profession can be a challenging task and seemingly beyond the scope of education when the manner in which clinicians learn in practice is not known. This study has revealed that incorrect learning and identity formation through social interaction, without self-reflection to recognize the disconnect, can lead to treatment beliefs and behaviors that perpetuate out dated ideas. Therefore, this study offers practical implications for the occupational therapy assistant educators, creators of continuing education curricula, practicing clinicians and students

Implications for students. OTA students are typically individuals who are returning to academia to earn their first college degree. Graduates must embrace the notion that learning does not stop in the classroom and must continually refine their knowledge about the profession while in the field; occupation-based OT must be reinforced daily as they begin to practice in a challenging healthcare environment. Continuation of the disconnect between that which *is* known and that which *should* be known will continue to be a source of confusion for OTA students who are taught an occupation-based paradigm but who see a very different picture of the profession when interning and ultimately working in the field. Educational programs must equip the OTA student with a greater level of understanding of the forces at play in the workplace that can potentially influence their understanding of the profession and treatment choices. This education must include strategies for resilience and fostering of the OT paradigm. As learners, OTA students must strive to become reflective and reflexive individuals despite the fact that these skills may seem foreign and difficult to master. The process of becoming reflective practitioners who are able to objectively assess

their own effectiveness and that of the type of treatment they are providing must begin in the classroom.

Students must be learn the dynamics of communities of practice and how the community can reinforce incorrect learning; students must understand the need to reconcile multiple professional identities in order to become an occupation-based clinician who practices according to the AOTA espoused paradigm. Students must be willing to learn and practice the new paradigm for more widespread change to occur in the field.

Implications for clinicians. Communities of practice that are not exclusively OT communities may enhance knowledge of aspects of care that are not distinctly OT, but they can also provide incorrect learning for novice clinicians who are still forming their practice beliefs and professional identities. Occupational therapy communities will offer social based learning that matches OT practice.

Current practice is not marked by reflective and reflexive practice. This leads to the perpetuation of dated ideas or incorrect learning of new ideas. Those who are willing to look closely at their beliefs and behaviors are able to change them as needed for the greater good; the espoused and enacted beliefs of the professional must match those of the professional organization.

Implications for OT educators. The recognition of the power of communities of practice to influence knowledge construction, particularly amongst novice practitioners will influence curriculum design that fosters creation of OT CoPs in the workplace. In addition, the recognition that social power and the use of influence tactics exists in the workplace at

several levels and that practitioners do not always recognize the influence that these power holders have over their beliefs and practice decisions, can inform instructional activities that foster understanding of the influences of power in the workplace.

Educators of OTAs must seek to engage learners in activities that will develop their skills to reflect upon and critically evaluate their own professional beliefs and practices. Since the community of OT in practice does not readily reinforce and occupation-based practice paradigm, individual practitioners must rely on their own knowledge and skills learned in the classroom. Feedback that is non-existent in the clinic must come from the self through self-observation and a willingness to put forth effort to make recognized and needed changes.

Many individuals consider disagreement with a particular entity or belief system to be a sign of disrespect and will therefore believe whatever they are told or practice in a manner that matches what other, more experienced, clinicians do. Becoming a critical individual who can look outside of an issue, to weigh the true pros and cons and then make an informed decision to agree in whole or in part with the entity, is a skill and way of thinking that requires practice and a deep understanding of its importance before learners will embrace the concept. Educators must foster the creation of this knowledge and offer activities that provide valuable yet safe lessons until the skills are well learned.

Educators, through their personal and professional mission, may foster a community of practice within their town or city to provide practitioners with a group of individual with whom they can discuss issues surrounding the changes in practice and offer assistance to one

another. Communities of practice must develop through legitimate participation of all individuals, although they may take upon differing roles within the community. Practitioners must have a sincere interest in and commitment to the group. This commitment cannot be created by an outside entity but the group can be nurtured through creating an initial meeting, providing space for meetings and providing resources and materials until the group becomes self-supporting.

If face to face meetings are not embraced by practitioners or if the community of practice is to involve individuals who are geographically at a great distance from each other, other methods of communication may be utilized. For example, a CoP can take place through real-time or asynchronous internet meetings or through postings on a listserv to which all have access.

Implications for the profession of OT. The full value of the profession of OT will not be realized by others in society, particularly those who fund federal insurance programs, if practitioners continue to provide reductionist interventions that only address basic self care of those within physical disabilities settings through the use of preparatory techniques. The professional organization must recognize that a disconnect does exist in the field between the beliefs of what occupation-based practice is and what it is not. This disconnect will continue to exist if it is not acknowledged and the underlying reasons addressed (lack of OT CoP for social learning, a lack of critical reflection on the part of the practitioners). The profession must ensure the third party payers, especially those of the federal government, recognize the uniqueness of the profession and gain an understanding of the effects of occupation-based

intervention upon the individual with regard to both physical and psychological functioning. Payers must recognize that OT interventions can facilitate client outcomes that negate the need for expenditures in other areas such as home care support and extended nursing home stays. If payers are not limiting reimbursement, the organizational focus on productivity may diminish and therefore allow OTs the creativity they require.

Occupational therapy has been in existence for nearly 100 years and has always struggled to fit in to a society that is more concerned with statistical analysis focusing upon body factor functioning than upon those entities that drive a person to maintain or restore independent function. These entities are motivation, self-efficacy and hope. The profession, through strong membership support and through funding via the OT foundation, must encourage research that measures these facets of the human and the outcomes that ensue when they are addressed by OT practitioners. Qualitative inquiry must therefore become a strong focus of the national organization.

Recommendations

In order to address the possible negative consequence of the implications that the study conclusions have for theory, research and the profession and practice of occupational therapy, the following recommendations are made: (a) through the use of a qualitative research design, the practice habits of OTAs and OTs in settings other than physical disabilities should be investigated to determine if the practice beliefs and habits are similar or different from those found through this study. Identify values, domain of interest, created identities, power dynamics and communities of practice within these settings; (b) academic

education should be enhanced to provide for a more explicit understanding of the power inherent in CoPs in addition to knowledge regarding the use of personal power possessed by practitioners that can be utilized to change limits placed on OT practice; (c) academic curricula and continuing education venues should be designed to teach, encourage and support reflective and reflexive practice. Enhanced knowledge of how to become a reflective practitioner will enable clinicians to recognize the disconnect between clinician espoused practice, association espoused practice and enacted practice and then take action to remedy this gap; (d) the number of continuing education venues being offered through the national association, academic programs and private companies that review the paradigm of OT and provide insight into how this paradigm can easily and correctly applied in practice should be increased. These learning experiences must be easily accessible and not cost prohibitive as the clinician themselves will likely be choosing these venues and paying for them independently; (e) educational venues that instruct practitioners in the formation and use of communities of practice should be created. The creation of OT based communities in the workplace where all members espouse the new OT paradigm will facilitate a better understanding of and use of this paradigm in practice amongst all OT practitioners who are members; (f) professional organization must seek monetary support as it continues to educate government agencies, insurance companies, rehabilitation facilities, other professions and the public about the unique and necessary role of OT as a holistic entity offering occupational engagement and the accompanying enhancement of quality of life for all clients; (g) The association and professional foundation should support OT scholars as they create and

execute a research agenda that includes quantitative and qualitative investigation of outcomes related to the new OT paradigm; (h) investigation into negative learning in healthcare environments that can occur during social interactions and within CoPs should be undertaken to determine how this learning is constructed and the effects upon practice.

Chapter Summary

The purpose of this study was to explore how novice occupational therapy assistants being to understand their profession and then use this knowledge to inform treatment method selection while in the context of the work environment. The phenomenon of knowledge acquisition and use in the workplace by the novice OTA was investigated in an effort to enhance understanding of the original research problem that states: A disconnect exists between the new, occupation-based paradigm being taught within educational programs and actual practice being conducted by those in the field who are trained in the new paradigm.

This final chapter has offered a detail overview of the data derived from the semi-structured interviews conducted with ten study participants. The findings were divided into ten categories and twenty-three sub-categories that provide insight into the professional understanding and treatment choices of the novice OTA.

A brief overview of the methodology used to complete this basic interpretive study was then provided in addition to review of the study questions. Three conclusions that were drawn from the data were then presented and include: (a) novice OTAs possess, yet are unaware of, two divergent professional identities that impact their espoused and enacted practice beliefs; (b) novice OTAs engage the process of OT in a linear and hierarchical

manner that is not in keeping with the tenets of the profession, addressing client factors (e.g. strength, motion and endurance) prior to engaging clients in functional tasks; (c) the practice of OT by novice OTAs is impacted by hegemonic environmental factors such as direct management, the organization and third party payers.

A discussion of these conclusions and their relationship to social learning, communities of practice, power dynamics, identity theories and espoused versus enacted belief theories was provided. Following this discussion the implications for both the theory and practice of occupational therapy were highlighted as were the recommendations for educational and national organizational activities to promote a consistent understanding and practice of the new paradigm of occupational therapy for future viability of the profession in the midst of this time of growth and change.

REFERENCES

- Accreditation Council for Occupational Therapy Education. (2006). *Standards for an accredited educational program for the occupational therapy assistant*. Retrieved February 9, 2009, from ACOTE Standards Interpretive Guide.
<http://www.aota.org/nonmembers/area13/docs/acotestandgd.doc>.
- Airasian, P. & Walsh, M. (1997). Constructivist cautions. *Phi Delta Kappan*, 78(6), 444-450.
- Ajjawi, R. & Higgs, J. (2008). Learning to reason: A journey of professional socialization. *Advances in Health Science Education*, 13, 133-150.
- Anderson, J. R., Reder, L. M., & Simon, H. A. (1996). Situated learning and education. *Educational Researcher*, 25(4), 5-11.
- American Occupational Therapy Association. (2004a). *Definition of occupational therapy practice for the AOTA Model Practice Act*. Bethesda, MD: Author.
- American Occupational Therapy Association. (2004b). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 58, 663-667.
- American Occupational Therapy Association. (2005). Standards of practice for occupational therapy. *The American Journal of Occupational Therapy*, 59(6), 663-665.
- American Occupational Therapy Association. (2006). Policy 1.44: Categories of occupational therapy personnel. In *Policy Manual* (2007 ed., pp. 33-34). Bethesda, MD: Author.

- American Occupational Therapy Association (AOTA). (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *The American Journal of Occupational Therapy*, 62(6), 625-683.
- Argyris, C. & Schön, D. (1974). *Theory in Practice: Increasing Professional Effectiveness*. San Francisco, CA: Jossey-Bass Publishers.
- Bandura, A. (1977a). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Bandura, A. (1977b). *Social learning theory*. Upper Saddle River, NJ: Prentice Hall.
- Bandura, A. (1978). The self-system in reciprocal determinism, *American Psychologist*, 33, 344-358.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1989). Social cognitive theory. In R. Vasta (Ed.), *Annals of child development. Vol. 6. Six theories of child development* (pp. 1-60). Greenwich, CT: JAI Press.
- Baum, C. (2000, January 3). Occupation-based practice: Reinventing ourselves for the new millennium. *OT Practice Online*. Retrieved January 30, 2009, from <http://www.aota.org/Pubs/OTP/1997-2007/Features/2000/f-010300.aspx?css>
- Bloomberg, L. & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. Thousand Oaks, CA: Sage Publications.

- Bogdan, R. & Biklen, S. (2002). *Qualitative research for education: An introduction to theories and methods* (4th ed.). Upper Saddle River, NJ: Pearson.
- Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2008-09 Edition*, Retrieved April 19, 2010, from <http://www.bls.gov/ocos078.htm>
- Burke, P. (1991). Identity processes and social stress. *American Sociological Review*, 56, 836-849.
- Butler, E. (2001). The power of discourse: Work-related learning in the “learning age.” In R. Cervero and A. Wilson (Eds.). *Power in Practice* (pp. 60-82). San Francisco, CA: Jossey-Bass.
- Carandang, R., Seshadri, S., Beiser, A., Kelly-Hayes, M., Kase, C., Kannel, W. & Wolf, P. (2005). Trends in incidence, lifetime risk, severity, and 30-day mortality of stroke over the past 50 years. *Journal of the American Medical Association*, 296(24), 2939-46.
- Carter, K., Cushing, K., Sabers, D., Stein, P. & Berliner, D. (1988). Expert-Novice differences in perceiving and processing visual classroom information. *Journal of Teacher Education*, 39(25), 25-33.
- Cervero, R. & Wilson, A. (2006). *Working the planning table: Negotiating democratically for adult, continuing and workplace education*. San Francisco, CA: Jossey-Bass.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.

- Christiansen, C., Baum, C. & Haugan, J. (Eds.). (2005). *Occupational Therapy: Performance, Participation, and Well-Being*, Thorofare, NJ: Slack.
- Christiansen, C. & Townsend, E. (2009). *Introduction to Occupation: The art and science of living* (2nd Ed.). Upper Saddle River, NJ: Pearson.
- Clouder, L. (2003). Becoming professional: Exploring the complexities of professional socialization in health and social care. *Learning in health and social care*, 2(4), 213-222.
- Clouder, L. & Sellars, J. (2003). Reflective practice and clinical supervision: An interprofessional perspective. *Journal of Advanced Nursing*, 46(3), 262-269.
- Contu, A. & Willmott, H. (2003). Re-embedding situatedness: The importance of power relations in learning theory. *Organization Science*, 14(3), 283-296.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Crist, P. (2004, Spring) From the President. *NBCOT, Inc. Report to the Profession*, 2.
- Crotty, M. (2003). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage Publications.
- Daley, B. (1999). Novice to expert: An exploration of how professionals learn. *Adult Education Quarterly*, 49(4), 133-148.
- Denzin, N. & Lincoln, Y.(Eds). (2003). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

- Dickie, V. A. (2003). Data analysis in qualitative research: A plea for sharing the magic and the effort. *American Journal of Occupational Therapy*, 57, 49–56.
- Dreyfus, S. (2004). The five stage model of adult skill acquisition. *Bulletin of Science, Technology & Society*, 24(3), 177-181.
- Duncan-Myers, A., & Huebner, R. (2000). Relationship between choice and quality of life among residents in long-term-care facilities. *The American Journal of Occupational Therapy*, 54(5), 504-508.
- Earley, D. & Shannon, M.(2006). The use of occupation-based treatment with a person who has shoulder adhesive capsulitis: a case report. *The American Journal of Occupational Therapy*, 60(4), 397-403.
- Enns, H. & McFarlin, D. (2003). When executives influence peers: Does function matter? *Human Resource Management*, 42(2), 125-142.
- Fenwick, T. (2000). Expanding conceptions of experiential learning: A review of the five contemporary perspectives on cognition. *Adult Education Quarterly*, 50(4), 243.
- Fenwick, T. (2003). *Learning though experience: Troubling orthodoxies and intersecting questions*. Malabar, FL: Krieger Publishing, Co.
- Fenwick, T. (2008). Workplace learning: Emerging trends and new perspectives. *New Directions for Adult & Continuing Education*, 119, 17-26.
- Flanagan, J. (1954, July). The critical incident technique. *Psychological Bulletin*, 51(4), 327-358.

- French, J. & Raven, B. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies in social power* (pp. 150-167). Ann Arbor, MI: Institute for Social Research.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Hawthorne, NY: Aldine.
- Goodwin, S. (2003). Power and prejudice: A social-cognitive perspective on power and leadership. In D. van Knippenberg & M. Hogg (Eds.), *Leadership and power: Identity processes in groups and organizations* (pp. 138-152). Thousand Oaks, CA: Sage Publications.
- Guile, D. & Griffiths, T. (2001). Learning through work experience. *Journal of Education and Work, 14*(1), 113-131.
- Hitlin, S. (2003). Values as the core of personal identity: Drawing links between two theories of self. *Social Psychology Quarterly, 66*(2), 118-137.
- Hogan, K. (2002). Pitfalls of community-based learning: How power dynamics limit adolescents' trajectories of growth and participation. *Teachers College Record, 104*(3), 586-624.
- Hogg, M., Terry, D., & White, K. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly, 58*(4), 255-269.
- Howard, J. (2000). Social psychology or identities. *Annual Reviews of Sociology, 26*, 367-393.
- Ibarra, H. (1999). Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly, 44*(4), 764-791.

- Johnson-Bailey, J. (2001). The power of race and gender: Black women's struggle and survival in higher education. In R. Cervero and A. Wilson (Eds.). *Power in Practice* (pp. 126-144). San Francisco, CA: Jossey-Bass.
- Kearsley, G. (2009). *Explorations in learning & instruction: The theory into practice database*. Retrieved January 16, 2009, from <http://tip.psychology.org/index.html>
- Kielhofner, G. (2005). Scholarship and practice: Bridging the divide. *American Journal of Occupational Therapy, 59*, 231–239.
- Kielhofner, G. (1997). *Conceptual foundations of occupational therapy* (2nd ed.). Philadelphia: F.A. Davis Company.
- Lave, J. & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. New York: Cambridge University Press.
- Law, M. (2002). Participation in the occupations of everyday life. 2002 Distinguished Scholar Lecture. *The American Journal of Occupational Therapy, 56*(6), 640-649.
- Law, M., Baum, C. & Dunn, W. (2005). *Measuring Occupational Performance: Supporting Best Practice in Occupational Therapy*. Thorofare, NJ: Slack.
- Lee, S., Taylor, R., Kielhofner, G. & Fisher, G. (2008). Theory Use in Practice: A National Survey of Therapists Who Use the Model of Human Occupation. *American Journal of Occupational Therapy, 62*(1), 106-117.
- Letts, L., Rigby, P. & Stewart, D. (Eds). (2003). *Using environments to enable occupational performance*. Thorofare, NJ: Slack.

- Maben, J., Latter, S. & Macleod Clark, J. (2006). The theory-practice gap: Impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing*, 55(4), 465-477.
- Mackey, H. (2007). Do not ask me to remain the same: Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal*, 54, 95-102.
- Marshall, C. & Rossman, G. (2006). *Designing Qualitative Research* (4th ed.). Thousand Oaks, CA: Sage Publications
- Maxwell, J. (2005). *Qualitative research design: An interactive approach* (2nd Ed.). Thousand Oaks, CA: Sage Publications.
- Melchert-McKearnan, K., Deitz, J., Engel, J., & White, O. (1999). Children with burn injuries: Purposeful vs. Rote exercises. *The American Journal of Occupational Therapy*, 54(4), 381-390.
- Merriam, S. & Associates. (Eds.). (2002). *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.
- Merriam, S, Caffarella, R. & Baumgartner, L. (2007). *Learning in adulthood: A comprehensive guide* (3rd ed.). San Francisco, CA: Jossey-Bass.
- Merriam-Webster Online Dictionary*. Retrieved March 13, 2009, from <http://www.merriamwebster.com/dictionary/coalition>.
- National Board for Certification in Occupational Therapy (NBCOT). (2009). *Certification renewal handbook, 2009*. Gaithersburg, MD: NBCOT.

- National Board for Certification in Occupational Therapy (NBCOT). (2004). A practice analysis study of entry-level occupational therapist registered and certified occupational therapy assistant practice. *OTJR: Occupation, Participation and Health*, 24(Supplement 1), s7–s31.
- Nielson, C., Youngstrom, M. J., Glantz, C., Henderson, M. L., Richman, N., Smith Roley, S., Duran, G., Peterson, M. (2005). *Implementing Occupation Based Practice*. Retrieved from American Occupational Therapy Association website:
<http://www.aota.org/News/Centennial/AdHoc/41327/41346.aspx>.
- Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report*, 13(4), 695-705.
- Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved February 28, 2009 from <http://www.emory.edu/EDUCATION/mfp/eff.html>
- Pare, A. & LeMaistre, C. (2006). Active learning in the workplace: Transforming individuals and institutions. *Journal of Education and Work*, 19(4), 363-381.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newberry Park, CA: Sage Publications.
- Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Peshkin, A. (1988, Oct.). In search of subjectivity. One's own. *Educational Researcher*, 17(7), 17-21.

- Reicher, S. (2004). The context of Social Identity: Domination, resistance and change. *Political Psychology, 25*(6), 921-945.
- Reid, S. & Ng, S. H. (2003) Identity, power and strategic social categorizations: Theorizing the language of leadership. In D. van Knippenberg & M. Hogg (Eds.), *Leadership and power: Identity processes in groups and organizations* (pp. 210-223). Thousand Oaks, CA: Sage Publications.
- Richardson, B. (1999). Professional Development; 2. Professional knowledge and situated learning in the workplace. *Physiotherapy, 85*(9), 467-474.
- Robbins, S. & Judge, T. (2008). *The essentials of organizational behavior* (9th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Rubin, H. & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Rusbult, C., & Van Lange, A. (2003). Interdependence, interaction and relationships. *Annual Review of Psychology, 54*, 351-375.
- Salomon, G., & Perkins, D. N. (1998). Individual and social aspects of learning. Review of Research in Education, 23, 1-24.
- Schwandt, T. (2007). *The Sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Schön, D. (1987). *Educating the Reflexive Practitioner: Toward a New Design for Teaching and Learning in the Professions*. San Francisco, CA.: Jossey-Bass.

- Silverman, D. (2004). *Instances or sequences?: Improving the state of the art of qualitative research*. Paper presented at the Qualitative Research Section of the European Sociological Association, Berlin, September.
- Simon, S.(n.d.). *The Principles of Constructivism*. Retrieved March 13, 2009, from http://web.rollins.edu/~gvaliante/courses/edu272_files/Constructivism.pdf.
- Storberg-Walker, J. (2008). Wenger's communities of practice revisited: A (failed?) exercise in applied communities of practice theory-building research. *Advances in Developing Human Resources*, 10, 555-577.
- Stryker, S. (1980). *Symbolic Interactionism: A social structural version*. Palo Alto: Benjamin/Cummings.
- Stryker, S. & Burke, P. (2000). The past, present, and future of an identity theory. *Social Psychology Quarterly*, 63, 284-297.
- Swanson, H. L., O'Connor, J. & Cooney, J. (1990). An information processing analysis of expert and novice teachers' problem solving. *American Educational Research Journal*, 27, 533-558.
- Tryssenaar, J. & Perkins, J. (2001). From student to therapist: Exploring the first year of practice. *The American Journal of Occupational Therapy*, 55, 19-27.
- Van de Wiel, M., Szegedi, K. & Weggeman, M. (2004). Professional learning: Deliberate attempts at developing expertise. In H. Boshuizen, R. Bromme and H. Gruber (Eds.), *Professional learning: Gaps and transitions on the way from novice to expert* (pp.181-206). Dordrecht, The Netherlands: Kluwer Academic Publishers.

- van Knipperberg, B., & van Knippenberg, D. (2003). Leadership, identity and influence: Relational concerns in the use of influence tactics. In D. van Knippenberg & M. Hogg (Eds.), *Leadership and power: Identity processes in groups and organizations* (pp. 123-137). Thousand Oaks, CA: Sage Publications.
- Vella, J. (2002). *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults(Rev.)*. San Francisco, CA: Jossey-Bass.
- Ward, K., & Mitchell, J. (2007). Occupation-based practice and its relationship to social and occupational participation in adults with spinal cord injury. *OTJR: Occupation, Participation and Health*, 27(4), 149-156.
- Wenger, E. (1998). *Communities of practice: Learning, meaning and identity*. New York: Cambridge University Press.
- Wenger, E., McDermott, R., & Snyder, W. (2002). *Cultivating communities of practice*. Boston: Harvard Business School Press.
- Wilding, C., & Whiteford, G. (2008). Language, identity and representation: Occupation and occupational therapy in acute settings. *Australian Occupational Therapy Journal*, 55, 180-187.
- Wolfson, L., & Willinsky, J. (1998). What service learning can learn from situated learning. *Michigan Journal of Community Service Learning*, 5, 22-31.
- Yukl, G. (2009). *Leadership in organizations* (7th ed). Upper Saddle River, NJ: Pearson Prentice Hall.

APPENDICES

APPENDIX A

Participant Demographic Form

Please answer the following questions. This information will not be shared with any other party and will be destroyed following completion of this project.

Pseudonym: _____

Age _____

Gender: _____ Male _____ Female

Current address: _____

Professional Credentials: _____ OTA _____ other (specify) _____

Year of graduation from OTA program: _____

OTA program(s) attended: _____

Name of workplace: _____

Type of setting:

_____ physical disabilities inpatient

_____ physical disabilities outpatient

_____ hand therapy

_____ Other: _____

Location of work setting:

_____ skilled nursing facility

_____ private clinic

_____ Physician owned clinic

_____ home care

_____ hospital setting

_____ free standing facility- hospital owned

_____ other (describe)_____

Start date at your current place of employment:_____

Time employed within current physical disabilities setting (s):

_____ 0-2 months

_____ 2-4 months

_____ 4-6 months

_____ 6-8 months

_____ 8-10 months

_____ 10-12 months

Start/stop dates for other places of employment if applicable:

Start _____ Stop _____

Practice setting of prior OTA employment:_____

How many other OT practitioners (OT/OTA) are employed at your current location?_____

Please indicate the reason that you entered into the profession of occupational therapy (check

all that apply):

_____ job security

_____ good salary

_____ benefits

____diversity of populations/work settings available

____work environment

____desire to help people

____believe in the goals of the profession

____academic program was convenient

____wanted an Associate Degree

____other (please describe)_____

Does your department as a whole utilize an occupation-based approach to OT services?

_____Yes

_____No

Do you personally use an occupation-based approach to your OT treatments?

_____Yes

_____No

APPENDIX B

IRB Approval

North Carolina State University is a land-grant university and a constituent institution of The University of North Carolina

**Office of Research
and Graduate Studies**

NC STATE UNIVERSITY

Sponsored Programs and
Regulatory Compliance
Campus Box 7514
2701 Sullivan Drive
Raleigh, NC 27695-7514
919.515.2444
919.515.7721 (fax)

From: Debra Paxton, IRB Administrator

North Carolina State University

Institutional Review Board

Date: June 22, 2009

Project Title: An Exploratory Study of the Professional Beliefs and Practice Choices of Novice Occupational Therapy Assistants

IRB#: 979-09-6

Dear Ms. Amini:

The project listed above has been reviewed the NC State Institutional Review Board for the Use of Human Subjects in Research, and is approved for one year. **This protocol expires on June 22, 2010, and will need continuing review before that date.**

NOTE:

1. This board complies with requirements found in Title 45 part 46 of The Code of Federal Regulations. For NCSU the Assurance Number is: FWA00003429.
2. Any changes must be submitted and approved by the IRB prior to implementation.
3. If any unanticipated problems occur, they must be reported to the IRB office within 5 business days.

4. Your approval for this study lasts for one year from the review date. If your study extends beyond that time, including data analysis, you must obtain continuing review from the IRB.

Please forward a copy of this letter to your faculty sponsor. Thank you.

Sincerely,

Deb Paxton
NCSU IRB

NC STATE UNIVERSITY

Sponsored Programs and
Regulatory Compliance
Campus Box 7514
1 Leazar Hall
Raleigh, NC 27695-7514
919.515.7200
919.515.7721 (fax)

From: Debra A. Paxton, IRB Administrator

North Carolina State University

Institutional Review Board

Date: August 14, 2009

Project Title: An exploratory study of the professional beliefs and practice choices of novice occupational therapy assistants

Dear Ms. Amini,

Your amendment to the study named above, to add your second set of interview questions has been reviewed by the IRB and has been approved. This approval does not change the original IRB approval expiration for the project, which is June 22, 2010. If you have any questions please do not hesitate to contact the IRB office at 919.515.4514.

Thank you,

Debra Paxton
NCSU IRB

APPENDIX C

Letter of Invitation to Participate

Dear COTA,

I am writing today to request your assistance as I pursue my doctorate in Adult and Community College Education through North Carolina State University. I am interested in exploring the professional beliefs and practice choices that novice occupational therapy assistants create and use when in a physical disabilities setting. I am interested in contributing to educational literature that will assist occupational therapy educators in their efforts to promote cohesion in professional practice.

I am seeking individuals who graduated from the occupational therapy assistant program during May of 2008, who are currently working in physical disabilities settings such as skilled nursing facilities, rehabilitation hospitals, hand therapy clinics, outpatient clinics, home health care and acute care hospital settings.

Participants will be asked to take part in two face-to-face interviews with me at either their place of employment, off site or by telephone. Each interview will take no longer than one and one-half hours. Prior to the interview, participants will also be asked to write a short reflective statement about a significant experience that they have had related to their current practice. It is expected that these interviews will take place during the Summer and early Fall months of 2009.

If you are interested in participating in this endeavor, please contact me via e-mail at occhand@aol.com or phone me at 910-520-2145 by May 30, 2009. I look forward to hearing from you and working with you as I complete my dissertation process.

Sincerely,

Debbie Amini

APPENDIX D
First Interview Guide

Pseudonym:
Interviewer: Debbie Amini
Date: TBD

Place: Clinic or neutral setting
Scheduled Time: TBD
Start: _____ End: _____

Opening questions (self and overall work experience)

- Tell me a little bit about yourself.
- Describe your work setting.

RQ1. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?

- If you had to describe yourself to a colleague, what would you say?
- What have you learned about OT since beginning clinical practice?
 - What have you learned about OT that you did not expect to learn since working in the field?
 - How does what you have learned in the field compare to what you learned in school?
 - How has being in the field affected the way you think about the profession?
- Describe someone that you consider to be a role model in your current place of employment?
 - What professional characteristics does your role model possess?
- What is the most significant or meaningful experience that you have had since working at this site?
 - How did this experience influence your thoughts about OT?

RQ 2 What environmental factors shape the practice choices of OTAs within the clinical setting

- What are your thoughts about the type of OT that is conducted at your place of employment?
- Since graduation, what sources (people, books, periodicals) have you relied on to help you with choosing client treatments?
- Share your relationship with the managers or supervisors within your site
 - How do you describe the level of support that those in authority have for your treatment decisions?
- What factors support your OT treatment choices within your setting?
- What factors hinder your OT treatment choices within your setting?

RQ 3 How do novice occupational therapy assistants enact their professional belief within their clinical setting?

- Tell me about your job, describe what you do on a typical day at work.
 - Describe the kind of practice that you conduct.
 - Describe the response of others in your work setting with regard to your approach.
- How do you know when you are successful or not successful in the clinical setting?
- How would a peer describe you as an OT professional?

Closing questions

- What do you think it takes to be a successful OTA in this setting?
- What advice would you give to new OTA graduates entering the field?
- What thoughts would like to add that we may not have addressed during this interview?

Thank-you for sharing your experiences and for participating in this interview!

The following are probes that will be employed as suggested by Bogdan and Biklen (2002):

What do you mean?

What were you thinking at that time?

I'm not sure that I am following you.

Give me an example.

Would you explain that?

Tell me about it.

What did you say then?

Take me through the experience.

Interview questions for second interview sessions will be formulated following first interviews.

APPENDIX F

Context Observation Tool

This tool will be used to record informal observations made of the clinical environment and of study participants.

Facility _____

Setting _____

Date _____

Attribute	First Interview (if applicable)	Second Interview (if applicable)
Type of setting (clinic, client hospital room, therapy room, client home)		
Number of individuals present in interview setting chosen by participant. Clients Therapists Other (identify)		
Interactions observed between individuals in the environment (group/one-on-one)		
Proximity of people to each other (when more than one individual present in setting)		

Equipment present in environment (ADL, crafts, games, contrived games, active exercise, passive exercise)		
Positioning of individuals within environment if observed (wheelchair, regular chair, standing/walking)		
General affect of individuals in setting (audible laughter, quiet, talking)		
Attire of individuals in environment (uniforms, street clothes, hospital gowns, pajamas)		
Additional Informal observations		

APPENDIX G

Document Review Form

Marketing documents for physical disabilities setting

Criteria	Facility #1	Facility #2	Facility #3
Separate description for rehab			
Separate description of OT			
Goals of OT/rehab present			
Photos present			
Photos depict functional activities			
Photos depict therapeutic exercise			
Photos depict functional activities			
Photos depict therapeutic exercise			
Text describes functional tasks			
Text describes client-centered approach			
Text describes OT as occupation-based			
Other			

APPENDIX H

Critical Incident Activity

Dear Study Participant,

In an effort to learn more about the factors that have helped to form your current beliefs about the profession of OT and your methods of treating clients, I am asking you to write a brief description of something interesting that has happened in your career.

To complete this activity, please spend several moments reflecting upon an event that has occurred in your work as an OT assistant since you became employed. This event should be one that you feel has significantly impacted you professionally. For example, you may describe a moment that you feel you gained better understanding of the profession, a moment where you decided to change your approach or were reassured that you are on the right track, or an event that caused you great concern or great happiness with your decision to become an OTA.

Following reflection, please write or type a synopsis of the event and the affect that it has had upon you. Remember, there is no right or wrong response to this prompt; your thoughtful insight into a critical moment in your career will be used to bring richness to this study.

Feel free to use the following ideas to guide your thinking if you desire:

- a. What event had great meaning to me as an OTA?
- b. How did I feel when this event was occurring?
- c. How did I feel following this event?
- d. What did this event teach me about myself, about my profession, or about my clients?
- e. How do I feel about my actions during the event?
- f. How would I change the outcome of the event if I could and felt that change was needed?

Please type your critical incident if possible and use your pseudonym for identification.

APPENDIX I

Consent Form North Carolina State University INFORMED CONSENT FORM for RESEARCH

Title of Study: An exploratory study of the professional beliefs and practice choices of novice occupational therapy assistants.

Principal Investigator: Deborah “Debbie” Amini

Faculty Sponsor: Dr. Tuere Bowles

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the investigator for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the investigator(s) named above.

What is the purpose of this study?

To explore the choices that occupational therapy assistants make with regard to professional beliefs and treatment choices that they choose within the dynamic culture of the physical disabilities settings (e.g. rehabilitation, skilled nursing facility, home care). This knowledge will assist adult educators in creating curricula and continuing education activities to support enactment of the espoused beliefs of health care professionals. Understanding of the meaning making of novice clinicians will shed light on the workplace elements that inform their daily learning and how those forces may be best utilized in adult education venues. Occupational therapy must remain a unique and viable profession or risk losing federal and private healthcare insurance funding (e.g. Medicare). Loss of funding would result in loss of services available to those with physical dysfunction who rely on occupational therapy to assist them with return to desired quality of life and ability to engage in desired occupations. Creating a cogent profession with a recognizable identity will be the desired outcome of adult professional OT education.

What will happen if you take part in the study?

If you agree to participate in this study, you will be asked to:

- a) Be identified as a potential subject through investigator list of OTA program graduates from 2008.
- b) To be contacted via personal e-mail or personal telephone with request to participate in research process.
- c) Make appointments for first interview via e-mail or telephone.
- d) Complete a critical incident essay that will be provided to investigator at time of first interview (approximately 30 minutes anticipated for completion).
- e) At time of interview, sign consent form following review.
- f) Participate in face to face, one to one format in private setting or other setting selected by you. If required, interview may also take place via telephone. It will be optimal for one interview to involve brief tour of participant work facility for informal observations of investigator.
- g) Allow interview to be recorded for transcription.
- h) Scheduled 1.5 hours to complete interview.
- i) Allow for informal observations of yourself and your surrounding environment
- j) Schedule second interview at conclusion of first.
- k) Participate in second interview in face to face, one to one format in private setting or other setting selected by you. If required, interview may also take place via telephone.

- l) Interview will take 1.5 hours.
- m) Following interviews, review coding of interviews and coding of critical incident essays, you will be asked to review these outcomes to ensure validity/accuracy of conclusion.

Risks

Time away from work may impact your pay, therefore interviews will be conducted at time that best meets your needs. Lunch hour, or before/after work hours or weekend hours will be offered. Telephone interview may be preferred by participant for the second interview and will be acceptable to the investigator.

All information will be kept confidential. All names inadvertently mentioned by participants during course of interviews will be taken from transcripts and substituted with pseudonym.

You may be concerned that questions seek “correct” response that will be supportive of former teacher’s belief system. I encouraged you to answer all questions honestly. Be assured that investigator is no longer in the role of teacher and will maintain objectivity. The investigator will not be adverse to any answers provided by participants.

Benefits

Following completion of this study and completion of the dissertation, findings will be available to you. This information may assist in your understanding of the factors that play a role in the meaning that OTAs make with regard to the practice options available and how they use this information to guide their professional beliefs and treatment modality choices.

This information can be used by academic programs and continuing education providers when designing educational experiences intended to facilitate paradigm change within profession to ensure future viability of Occupational Therapy. Continued viability of the profession will ensure future employment opportunities for you and availability of this necessary rehabilitation profession to future clients.

Confidentiality

The information in the study records will be kept strictly confidential. Data will be stored securely in the home office of Debbie Amini. No reference will be made in oral or written reports that could link you to the study. You will NOT be asked to write your name on any study materials; no one can match your identity to the answers that you provide.

Compensation

You will not receive anything for participating.

What if you have questions about this study?

If you have questions at any time about the study or the procedures, you may contact the investigator, Debbie Amini at 3412 Red Berry Dr. Wilmington, NC or 910-452-0970/ 910-520-2145 or daamini@ncsu.edu.

What if you have questions about your rights as a research participant?

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Deb Paxton, Regulatory Compliance Administrator, Box 7514, NCSU Campus (919/515-4514).

Consent To Participate

“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.”

Subject's signature _____ **Date** _____

Investigator's signature _____ **Date** _____

APPENDIX J

Second Interview Guide

Pseudonym:
Interviewer: Debbie Amini
Date: TBD

Place: Clinic or neutral setting
Scheduled Time: TBD
Start: _____ End: _____

Opening comment

Some of the questions I ask may cause difficulty for you if the information was somehow made available to others. However, all responses will be stored in my home office, all will be coded and the findings will be reported in an aggregate form. You may decline to answer any question that makes you uncomfortable or causes you concern.

Opening questions:

- Has anything changed for you in your job or work status since we last spoke?
- What types of educational activities have you participated in since the last time that we spoke. What did you learn?

RQ1. How do novice OTAs create their personal understanding of the profession of OT while in the clinical setting?

- Since you have started working, what things do you think have influenced you most with regards to the way you think about OT?
- What do you think has most influenced the way that you conduct OT practice since becoming employed?
- Think back to the various types of activities employed by OTs according to the OTPF (e.g. preparatory, purposeful, occupation-based). How do your treatments compare to these categories?
- How do you believe that OTAs decide how to approach clients?
- What would you identify as the top three reasons that OTAs conduct the type of OT that they do?
- In your opinion, what is the most important thing about being an occupational therapy practitioner?

RQ2 What environmental factors shape the practice choices of OTAs within the clinical setting?

- How does one come to feel like a team member of the OT department at your facility?
--Please describe your journey.
- Please identify the top three things (e.g. policies, financial support, other clinicians) found in your facility that support your treatment choices.
--Please elaborate as to how your treatment choices are supported.
--What treatment choices do you require support to complete?
- Please identify the top three things (e.g. policies, financial support, other clinicians) found in your facility that do not support your treatment choices.
---Please elaborate, explain how your treatment choices are not supported.
---What treatment choices do you not feel supported in?
- What do you believe is at the heart of the profession of OT?
--How do the beliefs of your organization/management/colleagues mesh with the heart of OT?

RQ3 How do novice occupational therapy assistants enact their professional belief within their clinical setting?

- If I were a fly on the wall and watched you complete a treatment on a client from start to finish in the treatment room, what would I observe?
- If you were a fly on the wall and watched all fellow OTs complete a treatment on a client from start to finish in the treatment room, what would you observe?
- Can you elaborate on the thoughts that you had in your critical incident survey?
- Describe a recent day or a situation when you feel that you had a “good OT day/moment”
- What distinguishes a good “OT day” from a not so good “OT day”?

Closing questions

- What thoughts would like to add that we may not have addressed during this interview?
- What would you like to see happen to the profession of OT in the future?
- If you could change one thing about the type of OT that you were taught in school that would make a difference for you and your clients, what would it be?

Thank-you for sharing your experiences and for participating in this interview!

The following are probes that will be employed as suggested by Bogdan and Biklen (2002):

What do you mean?

What were you thinking at that time?

I'm not sure that I am following you.

Give me an example.

Would you explain that?

Tell me about it.

What did you say then?

Take me through the experience.