NOVICE OCCUPATIONAL THERAPISTS' PERCEPTIONS AND EXPERIENCES OF PROFESSIONAL SOCIALISATION IN THE FIRST YEAR OF PRACTICE IN SOUTH AFRICA

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November 2018

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DECLARATION

I declare that the work on which this thesis: ***Novice Occupational therapy graduates perceptions and experiences within Professional Socialisation in their first year of practice in South Africa***, is my own original work (except where indicated otherwise), and that it has not previously or in its entirety or in part been submitted for a degree at this or any other university.

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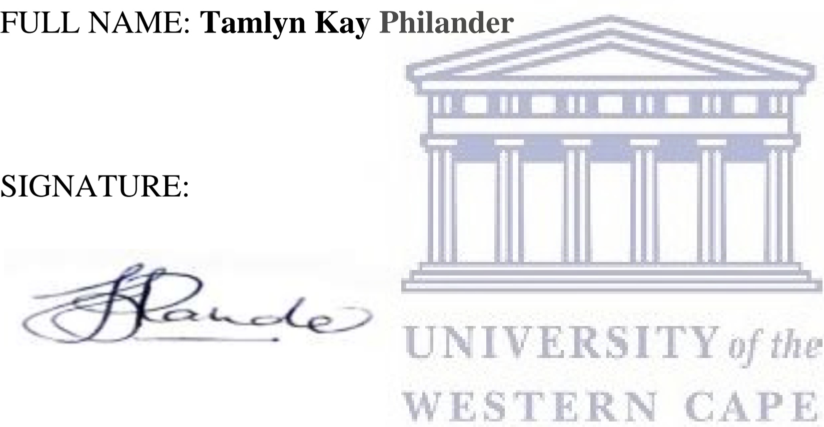

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ABSTRACT

Professional socialisation is a key dimension within the professional development of an occupational therapy practitioner. Professional socialisation in the first year of practice involves a process of change within the individual with regards to knowledge, skills and reasoning. The process further involves the novice's developmental induction into the culture of the profession and into the practice context. Novice practitioners who are not appropriately supported in their professional socialisation process may become demoralised as practitioners. It is necessary to explore professional socialisation from the perspectives of novice occupational therapy practitioners themselves, in order to generate an understanding of how professional socialisation can be supported in the first year of practice. This is of vital importance otherwise the profession may run the risk of attrition. Therefore, the aim of this study was to explore and describe novice occupational therapists' perceptions and experiences regarding professional socialisation during the first year of practice. A qualitative research approach and exploratory descriptive research design was utilised in the public health system in South Africa. Purposive sampling was utilised to select nine participants for the study. Data collection methods included two semi-structured interviews and a dyad interview discussion which were audio-recorded, transcribed verbatim and analysed through thematic data analysis. The strategies of member checking, peer review, reflexivity, and an audit trail ensured trustworthiness of the study. Ethics clearance was obtained from the UWC Research Committee. Three themes originated from the findings of this study. The first theme, stepping into the unknown, illustrates a dissonance between the participants' expectations for practice and the actual realities of practice that they encountered. The second theme, uncovering the occupational therapy culture, highlights power dynamics and inconsistencies within the profession as perceived by the participants. The third theme, becoming a professional, highlights how the participants responded to the challenge of transitioning from student to

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professional and started to internalise their professional identity. Recommendations to support the professional socialisation of novice therapists in the South African context are made in respect of occupational therapy education, continued professional development, support for novice therapists, transformation in the profession and future research.

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Keywords

Occupational therapy,

Occupation,

Professional socialisation,

Professional identity,

Novice occupational therapists,

First year of practice,

Compulsory community service,

Qualitative research.

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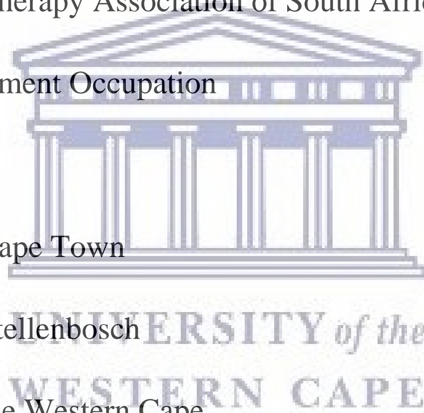
ABBREVIATIONS AND ACRYNOMS

CPD	Continuing Professional Development
DoH	Department of Health
HPCSA	Health Professions Council of South Africa
MDT	Multi-disciplinary Team
NGO	Non-governmental Organisations
OT	Occupational therapy
OTs	Occupational Therapists
OTASA	Occupational Therapy Association of South Africa
PEO	Person Environment Occupation
SA	South Africa
UCT	University of Cape Town
US	University of Stellenbosch
UWC	University of the Western Cape
WFOT	World Federation of Occupational Therapists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LIST OF DEFINITIONS

Occupational therapy is a client-centred health profession related to promoting health and well-being through occupation. Occupational therapists attain this result by working with individuals, groups of people and communities to improve and develop their ability to participate in these occupations they find meaningful and purposeful (WFOT 2012).

Occupation refers to the daily activities and tasks in which human beings engage in as individuals, in groups and with communities which contribute to bringing meaning and purpose to life (WFOT, 2012).

Novice occupational therapists refer to occupational therapy practitioners who are in their first year of practice post their graduation as a qualified professional.

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Professional socialisation is the process during which individuals or groups of people learn the roles and values needed for the partaking in social institutions. This process of becoming a part of a something or a profession is a lifelong process that begins with learning the norms and behaviours of the family or subculture or profession (Dinmohammadi, Peyrovi&Mehrdad, 2015).

Professional identity refers to the way in which a professional comprehends who they are within their chosen profession and how they relate themselves to their respective profession's values, norms, standards and ethics (Trede, Macklin & Bridges, 2012).

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Compulsory community service refers to the period of one year obligatory service that is required by all persons registered as health professionals under the jurisdiction of the Health Professions Council of South Africa after they graduate (HPCSA, 2002).

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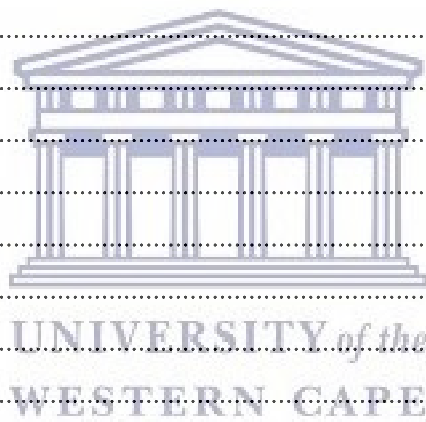
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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 Introduction

The focus of this study is the professional socialisation of novice occupational therapists in the first year of practice. For the purpose of this study, a novice occupational therapist is defined as an occupational therapy practitioner who is currently in their first year of practice following their graduation and those who are at the commencement of his or her second year of practice.

Professional socialisation is a key dimension within the professional development of an occupational therapy practitioner. According to Weidman, Twale and Stein, professional socialisation is defined as a shared 'process through which individuals gain the knowledge, skills, and values necessary for successful entry into a professional career' (p.iii). Black, Jensen, Mostrom, Perkins, Ritzline, Hayward and Blackmer (2010) describe two stages of professional socialisation: firstly, professional socialisation as a student and secondly, professional socialisation or transition of novice professionals into the workplace. According to Robertson and Griffiths (2009), novice occupational therapists seem to encounter many challenges in their first experience as practitioners. Thus, the transition going from student to independent practitioner is different therefore this shift between the roles appears to be a key factor in this process of becoming a professional. In reference to transitioning from student to practitioner, Zarshenas, Sharif, Molazem, Khayyer, Zare and Ebadi (2014) highlight that socialisation for novice health professionals entail two aspects: 1) organizational socialisation i.e. ensuring relationships with co-workers, gaining knowledge of the organizational culture, as well as comprehending the formal and informal rules of the practice environment; and

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2) professional socialisation i.e. internalisation of a set of values and the culture of the profession. It is posited by Lai and Lim (2012) that professional socialisation is a process as well as an outcome. When described as a process, professional socialisation refers to the communication of principles, beliefs and ways of seeing that are distinctive to a profession (Lai & Lim, 2012). When described as an outcome, it refers to the requisite knowledge, competencies and responsibilities to be achieved by a member of a profession to be regarded as qualified (Lai & Lim, 2012). It can thus be inferred that the development of a strong professional identity is a consequence of successful professional socialisation.

Professional identity is defined as the internalisation of the norms of the profession into the individual's self-image (MacLellan, 2011) and can be categorised as macro i.e. the status and self-image of a profession, and micro i.e. the tacit behavioural norms of a profession enacted by its members (Wackerhausen, 2009).This view is supported by Sole et al. (2012) who assert that successful professional socialisation is more than just developing clinical skills and knowledge, but that it builds new graduates' confidence in themselves and their identification with themselves as a member of a profession. They argue that the inability to develop in to a professional i.e. become socialised and gain a sense of professional identity may limit the efficiency of professional roles. It is therefore important that the process of professional socialisation is monitored.

1.2 Problem statement

Professional socialisation in the first year of practice involves a process of change within novice therapists, hence the community of practice which the novice join upon entering practice plays a critical role in the socialisation process (Zarshenas et al., 2014). This process of change may affect the novices' perceptions and experience of the profession. According to

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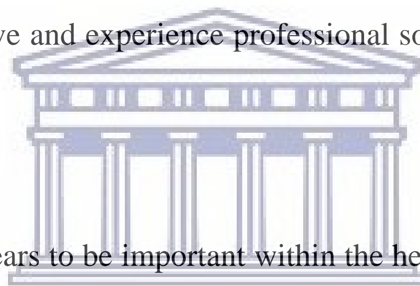
MacLellan (2011), new graduates may enter their first year of practice with a positive professional identity and commitment to being agents of change, yet may find the actual enactment of these characteristics challenging. Holland, Middelton and Uys (2013) suggest that professional confidence, competence and professional identity have a reciprocal relationship and should be explored in novice therapists. It has furthermore been noted that novice practitioners who are not properly supported in their professional socialisation process may be less content, perform inadequately and leave their respective professions (Black et al., 2010; Goodare, 2010). Similarly, if the process of professional socialisation is not experienced constructively, it may contribute to the phenomenon of attrition within the health professions (MacLellan, 2011). For this reason, it is imperative to generate an understanding of how novice occupational therapists perceive and experience professional socialisation upon their entry in to the profession.



Professional socialisation appears to be important within the health professions, including the occupational therapy profession (Tryssenaar & Perkins, 2001). Yet, there is little known about professional socialisation in occupational therapy in the South African context, particularly as perceived and experienced by novice occupational therapists in their first year of practice. However, in the health professions the phenomena of professional socialisation is broadly addressed in disciplines such as nursing and physiotherapy (Black et al., 2010; Lai & Lim, 2012; Sole et al., 2012; Dimitriado, Pizirtzidou, & Lavdaniti, 2013). It is necessary to explore professional socialisation from the perspectives of novice occupational therapy practitioners themselves, in order to understand how its success can be supported. This is of vital importance in order to inform the development of programmes to support novice therapists during the period of transitioning from student to therapists as well as to mitigate the risk of attrition in the profession (MacLellan, 2011).

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1.3 Research Question

The research question addressed in this study is: What are novice occupational therapists' perceptions and experiences of professional socialisation within the first year of practice?

1.4 Aim and objectives

The aim of the study is to explore and describe novice occupational therapists' perceptions and experiences of professional socialisation in the first year of practice.

The objectives are:

i. To explore and describe novice occupational therapists' perceptions and experiences of becoming socialised into the culture of the profession during the first year of practice.

ii. To explore and describe novice occupational therapists' perceptions and experiences of professional development during the first year of practice.

iii. To explore and describe novice occupational therapists' perceptions and experiences of professional identity formation during the first year of practice.

iv. To explore and describe barriers of professional socialisation as perceived and experienced by novice occupational therapists.

v. To explore and describe facilitators of professional socialisation as perceived and experienced by novice occupational therapists.

1.5 Study purpose and significance

The purpose of the study was to generate an understanding of the professional socialisation of novice occupational therapists during the first year of practice. The findings of the study are

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beneficial to the development of programmes to support the professional socialisation of novice therapists as they transition from student to practitioner in the South African context. In addition, the study generated knowledge to inform the development of roles of mentoring positions such as those of experienced, senior occupational therapists and rehabilitation managers who play leadership roles in the profession. A further significance of the study lies in the potential of the findings to inform the development of Occupational therapy education programmes in respect of its role in facilitating student-to-therapist transition.

1.6 Outline of the thesis

The thesis comprises the following chapters:

Chapter 1 provides the background, problem statement, research question and aims and objectives of the study. This is followed by a brief overview of the study significance and methodology utilised.

Chapter 2 presents a detailed literature review pertaining to the study's conceptual and theoretical framework.

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Chapter 3 describes the study's methodology. It outlines the research design, research setting, sampling, and data collection methods.

Chapter 4 reports on the findings of the study. It commences with a description of the participants of the study.

Chapter 5 presents a discussion of the findings reported in the previous chapter. During this chapter the research aim and objectives are addressed in relation to relevant literature.

Chapter 6 offers the main conclusions that emerged from the study, a discussion of the limitations of the study and offers recommendations as informed by the key findings.

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CHAPTER TWO

LITERATURE REVIEW

2 Introduction

This chapter aims to highlight literature on developments within the occupational therapy profession as well as the way in which novice occupational therapists are socialized into the profession. Literature pertaining to how novice therapists experience the process of entering the profession and how this influences their professional identity within their first year of practice is reviewed. Lastly, a synthesis of the theoretical frameworks underpinning this study namely Bronfenbrenner's Ecological Systems Theory of Human Development together with the Person-Environment-Occupation Model is provided.

2.1 The Profession of Occupational therapy

Occupational therapy as defined by the World Federation of Occupational Therapists (2012) is a client-centred health profession focussed on promoting health and well-being through the participation of occupation. Occupations are defined as all the tasks and activities people engage in every day which they find purposeful, meaningful and relevant to their culture (Christiansen &Townsend, 2004). Participation in meaningful occupations can give individuals a sense of purpose in their lives (Christiansen & Townsend, 2004).The main objective of occupational therapy intervention is occupational enablement which is geared towards enhancing people's ability and skill to participate in the occupations they decide to do or by adapting their occupations or by modifying environments for purposeful occupational engagement that meet their needs (WFOT, 2012).The occupational therapy profession is thus centred on using occupations that convey meaning and purpose to an individual, group or community as a key tool of practice.

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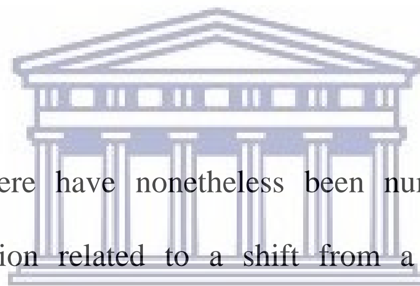
The importance of occupation in the profession emerged in the twentieth century when the therapeutic use of occupation was joined with humanistic ideals as part of the identity of the profession (Ernest, 1972). In the early years of the twentieth century, important impacts on the development of occupational therapy included the First World War and the resulting need for occupational engagement of soldiers as part of their rehabilitation. According to Ernest (1972), at the time, occupational therapy was listed as a comparatively young profession with great opportunities to situate its development within broader social, cultural and scientific contexts. However, historically, the profession has been experiencing an identity crisis where the realism of the profession and its proper place within the health care system was questioned (Gilfoyle, 1984).



In the last two decades, there have nonetheless been numerous developments in the occupational therapy profession related to a shift from a purely biomedical focus to incorporating a socio-political focus (Galheigo, 2011). This was given momentum by a renewed understanding of the role that occupational therapy could play in a socio-political context. For example, Townsend (1997) express that ‘visions of hope and possibility, of what ought to be, or what might be, can propel occupational therapists to think and act in ways that transform everyday experience’ (p.22). Through this vision of what ought to be, an ongoing transformation in the profession lead to occupational therapists beginning to act as agents of social change (Townsend, 1997).

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The core principles of the occupational therapy profession are based on the fundamental belief that people are occupational beings thus occupational engagement is regarded as a basic human need and therefore essential for health and well-being (Wilcock, 2006). Occupational science

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that is defined as the organised study of human beings as occupational beings (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolf & Zemke, 1991) is considered to be an empowerment strategy within occupational therapy (Duncan, 1999).Occupational science articulates the difference between the culture of occupational therapy and that of other disciplines and has highlighted the potency of human occupation (Duncan, 1999).

2.2 Occupational therapy constructs

Informed by occupational science, the profession saw the development of various theoretical constructs that informs current practice. According to Ward, Mitchell&Price (2007) occupation-based practice is a fundamental construct within occupational therapy as it is grounded in occupation. Hess-April, Smith and de Jongh (2016) explain that 'the concept of occupation, as understood in the profession, evolved from therapeutic activity within a medical model approach to occupational enablement as a principle of occupational justice within a socio-political approach' (p.189). Wilcock (2006) defines occupation-based practice as the facilitation of quality of life "through advocacy and mediation and through occupation-focused programmes aimed at enabling people to do, be and become according to their natural health needs" (p. 282). From this definition occupation-based practice can be understood as a form of practice that utilises relevant occupation to assist clients to meet their needs for occupational engagement and hence, health and well-being. While occupation-based interventions have been reported to be challenging particularly in medically dominated practice settings (Wilding, 2011; Galvin, Wilding &Whitford, 2011), a recent study in South Africa that explored occupation-based practice in a tertiary hospital setting showed that the participants regarded occupation-based practice positively and as essential to their professional identity (Hess-April, Dennis, Ganas, Phiri & Phoshoko, 2017).

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Client-centred practice is also an essential construct within the profession that ties in with occupation based practice. For almost 20 years, occupational therapists have advocated client-centred practice (Townsend, 2003). Client-centred occupational therapy can be considered as a relationship between the client and the occupational therapist that promotes the client to participate in functional performance and to fulfil their occupational roles in a diverse environment (Sumsion, 2000). Client-centred practice is an approach that fosters the active participation of clients by drawing on their strengths and ensuring that practice is applicable to their context, goals, values and interests (Townsend, Polatajko, and Craik& Davis 2007).

The construct of occupational justice emerged as a result of the occupational therapy profession's formulation of a response to occupational injustices i.e. situations where social injustices cause people to be deprived of access to opportunities and resources for occupational engagement (Townsend & Wilcock, 2004).Wilcock (1998) defines occupational justice as the encouragement of social and economic adjustment to enhance the individual, community and political awareness, resources and opportunities for diverse occupational opportunities which enable people to meet their potential and to experience well-being. This viewpoint is reiterated by Nilsson and Townsend (2010) who argues that closing the gap amongst the concept and practice of occupational justice requires health professionals to change practice to move around a health advocacy based on universal thinking. Likewise, Hammell (2017) asserts that occupational justice is defined as a social action that promotes equitable opportunities.

Evidence-based practice is also a pivotal construct that lays the basis for new developments in respect of literature and theories and is utilised to guide practice in the profession (Trinder & Reynolds, 2000). Evidence-based practice thus benefit clients by allowing clinicians to determine which interventions are most likely to produce desired results as informed by sound

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research relevant to a particular intervention (Rosenberg & Donald, 1995; Egan, Dubouloz, Von Zweck & Vallerand, 1998). For this reason, evidence based practice within occupational therapy is attaining drive evident in the number of occupational therapy journals that have special editions to it in the last few years (Bennett, Tooth, McKenna, Rodger, Strong, Ziviani, Mickan & Gibson, 2003).

2.3 Occupational therapy in South Africa

Occupational therapy in South Africa is perceived as a young profession. Occupational therapists in South Africa find themselves advocating for the profession due to the nature of this youthful existence. One of the fundamental philosophies of the profession is that occupational engagement is a human right (WFOT, 2006) and it is recognized that as a basic human need, engaging in occupations is critical for health and wellbeing (Hess-April, Smith & de Jongh, 2016). Similarly, healthcare is regarded as a fundamental human right (Duncan, 1999). Thus, South Africans have the right to occupational therapy services and the profession has a right to lobby for the recognition if its role as an essential healthcare provider (Duncan, 1999).

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Due to the nature of constant developments within the profession, there has been a process of constant practice changes occurring within the African and South African context (Duncan, 1999). The developments occurred in a context of fundamental changes in South Africa that involved the adoption of a social and rights-based approach to health (Hess-April, 2013). According to Duncan (1999), occupational therapy was in need for transformation into an African identity; an identity that is neither racial nor geographic but evolving and being shaped by Africans in line with contextual challenges. The essence of transformation was for the profession to remain relevant in response to the demands of the context, while being distinctly

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client-centred, focused on an ethic of care and centred on a core set of beliefs about humans as occupational beings and occupation as a basic human need (Duncan, 1999).

Occupational therapists in South Africa work in a variety of healthcare settings at all levels of care in the public health system. South Africa's health system consists of a large public sector, smaller private sector and an NGO sector (Jobson, 2015). The public health system primarily constitutes tertiary, regional and district hospitals as well as primary healthcare or community-based services i.e. clinics, and home-based services. The fundamentals of the public health system are the primary healthcare services that are the first line of access for people in need of healthcare services (Jobson, 2015). These clinics, day hospitals and community health centres provide their services free of charge. The next level of the public healthcare system is the district hospitals to which patients are referred from primary healthcare services when they need more complicated treatment. Following district hospitals is the secondary and tertiary levels where more advanced diagnostic procedures and specialist services are provided (Jobson, 2015). These services are encompassed within a service-delivery model based on comprehensive primary health care services with defined referral pathways between the different service levels (Gilson, Pienaar, Brady, Hawkridge, Naledi, Vallabhjee& Schneider, 2017).

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In South Africa, there is a need for occupational therapy services especially in rural areas and primary school settings. However, to provide efficient practice, the necessary resources are required, and this is not always easily accessible. To address this, all newly qualified occupational therapists are compelled to perform one-year community service at public health care facilities as a condition for registration with the Health Professions Council of South Africa (HPCSA) (South African Nursing Council, 2010). Community service was

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implemented for occupational therapists in 2003 with the system aiming to improve the provision of healthcare across all areas and has been considered as an effective health strategy (Van Stormbroek & Buchanan 2016). Beyers (2013) assert that community service is a 'test-drive' for university graduates in a challenging environment that is often characterised by underdevelopment.

2.4 Challenges experienced in Occupational therapy in South Africa

One of the challenges faced in the occupational therapy profession in South Africa is role confusion related to the scope of practice of occupational therapists and physiotherapists with duplication of skills, lack of professional boundaries and role overlap occurring (Smith, Roberts & Balmer, 2000). Poor awareness and understanding of occupational therapy has been widely experienced in South Africa (Smith, Roberts & Balmer, 2000). It is evident that there is a general lack of occupational therapy awareness amongst other healthcare professionals in South Africa thus contributing to the professional isolation of occupational therapists to the extent that inter-professional practices may not always occur (Hess-April, Smith & de Jongh, 2016). This phenomenon was reported to be particularly prevalent in rural practice contexts (Hess-April et al., 2016).

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An additional challenge experienced in the South African occupational therapy profession is the influential role that the medical model plays in the profession and tends to dominate practice (Hess-April et al., 2016; Naidoo, Van Wyk &Waggie, 2017).Furthermore, as a predominantly female and caring profession occupational therapy has historically been disempowered by hegemonies inherent in the dominance of the medical model and by the pervasive social phenomenon of devaluing women's knowledge(Duncan, 1999). Joubert (2010) moreover states that the Occupational Therapy Association in South Africa was chaired by a white male

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medical doctor or psychiatrist who basically dictated what occupational therapists should or should not be allowed to know and do for its first 22 years of existence. This indicates the historical influence medicine had on the profession. Duncan (1999) asserts that the profession's power lies in strengthening and articulating its canons of knowledge to balance the reductionism of the medical worldview. In the South Africa medical profession there is a hierarchy of needs with doctors holding the highest positions compared to allied health professions. This is in contrast to other international countries where all health and/or rehabilitation professionals work collaboratively on client goals on the same level.

2.5 Professional Socialisation: The concept

Professional socialisation is a developing dialectical process through which persons grow in knowledge, skills, and values essential for a successful entry into a professional career (MacLellan, 2011). Through the socialisation process, a person internalises behavioural norms and standards and forms a sense of identity and commitment to a professional field. According to Jensen, Gwyer, Shephard & Hack (2007), professional socialisation is a key developmental process in novice-to-expert transitions. These authors describe professional development as a process that incorporates change within an individual, as well as a process of social and professional enculturation. Through professional socialisation processes novices gradually develop a sense of belonging to a specific professional group (Melrose & Perry, 2015). Professional socialisation occurs through a combination of professional support, education and clinical experiences (Beck, 2014). Dyess and Sherman (2009) stress that there should be continuous professional support and mentorship throughout professional socialisation for the successful development of professional identity and skills. Similarly, Adams, Hean, Sturgis and Macleod Clark (2006) assert that the professional socialisation of novice professionals

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occurs through critical experiences where the overall experience triggers the construction of a professional identity.

Dimitriadou et al. (2013) argue that particular groups in society forces and creates to the extent that people themselves want that which society expects from them. This view resonates with that of Lai and Lim (2012) who refer to socialisation as the process of acquiring unfamiliar roles, knowledge, skills and qualities of a group in society. Thus, it is the acquisition of particular behaviours and attitudes characteristic of a particular group or profession that allow individuals to become members of that specific group or profession.

Principally, professional socialisation can be understood as a developmental process that is of central importance in contributing to the ongoing production cycle of young professionals practicing their skills in the work environment (Dimitriadou et al., 2013). The socialisation into the profession is a process of transforming a beginner into a professional and is treated as a process of integration during which the values, the norms of behaviour and the symbols of the profession are internalized. Dimitriadou et al. (2013) explain that professional socialisation could be regarded as a process of adult socialisation. Lai and Lim (2012) supports this definition in explaining that professional socialisation is a process by which a person is being adopted into a profession as qualified and having acquired the norms, attitudes, behaviours, skills, roles and values of the profession.

2.6 Stages of the Professional Socialisation process

To be socialized into a profession, individuals have to internalize the standards and morals of the profession into their own actions and performance. Lai and Lim (2012) suggest that professional socialisation could be a process and an outcome. When defined as a process, it is

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the transmission of ideals, principles and manner of seeing that are distinctive to the profession (Gilfoyle,1984) and when described as an outcome, it is the formation of specific competencies with the requisite knowledge and responsibilities that is required as a member of a profession (Lai & Lim, 2012).

According to Weidman, Twale and Stein(2001), there are four stages to Professional Socialisation: 1) the anticipatory stage where the individual becomes aware of behavioural, attitudinal and cognitive expectations held for a role. For example, novices learn new roles and procedures to be followed; 2) the formal stage where role expectations from the side of the novice are idealized and highly influenced by the novice's personal expectations; 3) the informal stage is when the novice learns informal role expectations in the sense that they are becoming aware of flexibilities in practicing these roles whilst still meeting role requirements; and 4) the personal stage where roles become internalized and professional identity is developed as novices fully assume their professional role.

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In this study, the focus is the way in which novice occupational therapists perceive and experience the process and outcome of professional socialisation during their first year of practice. Process refers to the development of character and behaviour towards the profession. Outcome refers to the ways in which that character and behaviour is carried out within practice. The ultimate goal of professional socialisation is to build up a professional identity where each one of these qualities become part of an occupational therapists personal and professional sense of self and performance (Lai & Lim, 2012).

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2.7 Professional Identity Development

Professional identity can be equated to a person's perception of his/herself as a professional within the work place (Ryynänen, 2001). The literature makes it clear that the professional socialisation process starts as a student continuing into the early years of practice and that professional identity is a component of professional socialisation (Adams et al., 2006; Trede, Macklin &Bridges, 2012; Cruess, Cruess, Boudrea, Snell, & Steinert, 2015). Adams et al. (2006) discovered that professional identity grows with time and is centred on acquiring insight into professional practices and the adoption of the characteristics and the values of the profession. Accordingly, Adams et al. (2006) posit that professional identity can be explained as the attitudes, standards, philosophy and skills that are shared within a group of professionals and relate to the professional role being undertaken by the individual. It is thus a matter of the subjective self-conceptualization associated with the work role adopted. In relation to this Trede, Macklin and Bridges (2012) highlights that professional identity is seen as the 'sense of being a professional' (p.374). Lencucha et al. (2007) further highlight that the subtle implication of this practice is that recent graduates need role models who use evidence in practice' (p. 594) which explains how important it is for recent graduates to have someone to look up to and imitate what it is their role models are doing.

According to Cruess, Boudrea, Snell and Steinert (2015) 'identity formation is a dynamic process which is achieved through socialisation' (p.1). It can thus be inferred that the outcome of sound professional socialisation is a positive professional identity as the two impacts on each other. The process of professional socialisation and the production of professional identity is thus in a dialectical relationship. Cruess et al. (2015) state that during the past two decades, awareness around the nature of medical professionalism has been concentrated on in terms of what the best way is to teach and assess it. Cruess and colleagues (2015) further explain how

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the concept of professional identity has received very little mention in medical education. They argue that human beings develop identity in stages and utilises Kegan's (1982) framework for the development of the person into a moral and meaning-making entity to assist in understanding the development of professional identity in medicine.

Kegan (1982) identifies three stages that can specifically be linked to professional identity formation and development, namely 1) imperial, 2) interpersonal and 3) institutional. In the imperial stage individuals take on a professional role but are not fully integrated into their identity. This stage can be noted as the transition phase going from student to novice in terms of the initial contact with the profession in the first year of practice. In the interpersonal stage, individuals begin to identify with the profession to the point that they become totally immersed and integrated with it. During this stage the participants have entered the profession and are becoming accustomed to the culture of the profession. The institutional stage is characterized as the self-defining professional stage where individuals can consult conflicts amongst professional values and their core belief system and may criticize or challenge aspects of the profession. At this stage, the participants are realizing the culture of a profession and to what extent they are prepared for it and agree with it based on their lived experiences during their first year of practice.

2.8 Challenges associated with professional socialisation in the health professions

In describing the challenges related with professional socialisation in the health professions, Naidoo et al. (2017), explored newly qualified occupational therapy graduates' experiences during the completion of their community service year in South Africa. The findings of the study indicated that newly qualified occupational therapists were not prepared for working in

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rural practice settings and had little previous exposure to working in primary healthcare settings. In the same study conducted by Naidoo and colleagues (2017), it was identified that novice occupational therapists were not always aware of the realities that a rural, under resourced practice context could present. For example, needing to be culturally sensitive, coping with very little resources, working within a team and engaging in administrative tasks were amongst the difficulties shared (Naidoo et al., 2017).Additional challenges related to communication and language barriers within the multi-disciplinary team (MDT) and with patients and their families. These findings of the study conducted by Naidoo et al. (2017) concurs with similar studies conducted with physiotherapy (Bartlett, Lucy, Bisbee & Conti-Becker, 2009) and nursing graduates (Sonmez & Yildirim, 2016) during the first months of practice post-graduation.

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Another challenge experienced by both novice Nursing and Physiotherapy graduates was the pressure placed on themselves in terms of improving their idealised professional role (Kelly, 1996).In addition, graduate nurses explained that their high expectations of themselves and their propensity for self-criticism added to the stress experienced in their new professional nurse roles which impacted on their job performance (Zinsmeister et al., 2009). Physiotherapists came to terms with the fact that they were required to take a livelier role in controlling their emotions to build self-confidence (Bartlett et al, 2009). The professional learning that takes place throughout the early years of clinical practice is frequently seen as a fundamental part of the growth and development of practitioners; both as a process of practice and actual clinical practice (Black et al., 2010). Knowledge translation is an essential tool for a successful transition going from being a student to professional as it creates opportunities to apply professional knowledge, skills and values in practice. It is furthermore suggested by

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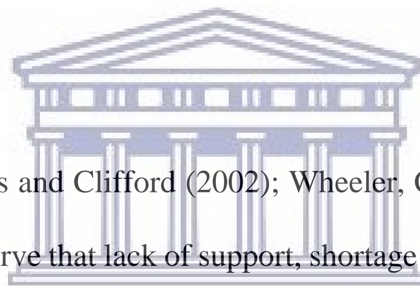
Tryssenaar and Perkins (2001) that educating new occupational therapists about the transition process may help them to progress through it more smoothly.

Additional challenges associated with professional socialisation are that of limited resources. This have been noted as problematic by novice occupational therapists in their first year of practice in South African healthcare settings to the extent that they are not always able to adhere to occupation-based practice as a core feature of the profession (Hess-April et al., 2016) In the Social work profession, newly qualified social workers are often concerned about a lack of human resources in terms of not having enough social workers within a team which often account for job dissatisfaction leading to attrition in the social work profession (Naidoo & Kasiram, 2006).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In the nursing profession, Ross and Clifford (2002); Wheeler, Cross, and Anthony (2000); as well as Whitehead (2001) observe that lack of support, shortage of staff and limited staff-nurse opportunities contributed to frustrations articulated by novice graduate nurses.To this end it has been reported that newly-graduated nurses experience stress, apprehension, and dissatisfaction during the first year of their employment due to insufficient clinical skills, heavy workload, and inability to spare enough time for patients (Sonmez & Yildirium, 2015). Likewise in an Australian study conducted by Hussein, Everett, Ramjan, Hu and Salamonson (2017), newly qualified nursing staff described how their 'first year of practice is overwhelming and stressful as they strive to apply newly acquired skills, deliver quality patient care and fit in' (p. 2). Graduate nurses nonetheless feel a sense of responsibility to maintain their professional standards in spite of the shortage of support and resources to do so (Zinsmeister & Schafer, 2009).

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In addressing the availability of supervision for novice professionals, Robertson and Griffiths (2009) assert that supervision is significant in the preliminary stages of professional development to present confirmation of strategies and to close the gap between theory and practice regardless of new graduates being well prepared in their ability to self-direct and take some responsibility for their own professional development. Tryssenaar and Perkins (2001) suggest that supervision can assist beginner professionals through demanding transitions and that a lack of supervision may hinder the transition from student to therapist. Van Stormbroek and Buchanan (2016) support this in stating that during the process of community service within South Africa, the supervision and mentorship of novice occupational therapists is crucial in the development of professional identity formation. They argue that a more formalised supervision and mentorship system for novice therapists must be taken up as a matter of priority in South Africa. Within the first year of practice, social work practitioners have also complained that supervision was poorly conducted, ineffectual and a source of stress (Simpson, 2002). According to Adams, Dominelli and Payne (2002), if supervision was correctly conducted it could be a valuable management tool for accountability, efficiency as well as a preventive measure for burnout. Similarly Naidoo et al. (2006) argues that supervision needs to be a core component of social work practice in South Africa.

2.9 Theoretical framework

2.9.1 Bronfenbrenner's Ecological Systems Theory of Human Development

The first theoretical framework that underpins this study is Bronfenbrenner's Ecological Systems Theory of Human Development, a type of systems theory that studies human development over time (Bronfenbrenner, 2005). Bronfenbrenner (1979) refers to development as a 'lasting change in the way in which a person perceives and deals with his / her

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environment' (p.3). This systemic approach examines the environment at four levels from the micro to the macro system (Shonkoff &Meisels, 2000). These systems include the microsystem, mesosystem, mesosystem, exosystem, macrosystem and the chronosystem (Bronfenbrenner, 2005). The subsystems influence one another through a series of interactions which contributes toward the development of the developing individual. The first system is the microsystem and it is the immediate setting in which individuals develop. This system evolves and develops much as individuals do themselves (Bronfenbrenner, 1979). In relation to the participants, this system can be noted as the university environment in which they interact and grow with from first to fourth year.

The second system is the mesosystem. Mesosystems are relationships among the microsystem in which the person experiences actuality and these links form a system (Bronfenbrenner, 1979). During the undergraduate programme, in third and fourth year, the participants engage in practical blocks in preparation for working within various settings after they have successfully completed the Occupational therapy course. These practical blocks under the guidance and supervision of clinicians and supervisors can be seen as the mesosystem as it has a relationship with the microsystem however, they are still interacting with the reality of the profession in terms of working.

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The third system is the exosystem which has a bearing on the development of individuals, but individuals do not play a direct role in the system (Bronfenbrenner, 1979). Meso and exosystem are set within the broad ideological, demographic and institutional patterns of a particular culture. During the process of community service, whereby which the participants become a part of the Occupational therapy culture by interacting with real life work and practice settings be it in a rural or urban environment, this first year of practice can be noted as the exosystem.

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Placing all that was learned during the micro and mesosystems in place, the participants are now gaining experience and developing into the professional they desire to be.

The fourth system is the macrosystem which refers to the universal organizationhumanity as it is and as it might be (Bronfenbrenner, 1979). This system is also referred to as the broader system in which political, economic and ideological factors are in operation which include broader social structures (Weisner, 2010). Looking at the broader environment in which the participants interact in terms of their development as a professional within their community service year is the South African context and working within a government setting.

The last system, the chronosystem, the historical context and the manner in which time influences the different systems (Bouffard & Weiss, 2010; Hannaway, Steyn &Hartell, 2014). Bronfenbrenner and Morris (2006) further explain the dimensions within the chronosystem namely microtime, mesotime and macrotime. These 3 components of this system were integrated into the bioecological model of human development in order to include continuity and change over a period of time both the past and the future (Bronfenbrenner & Morris, 2006; Rosa &Tudge, 2013). For the purpose of this study, the theory of development will be used as a guide on how each participant's functions and develops between the systems specifically focusing on mesosystem and macrosystem.

2.9.2 Person Environment Occupation (PEO) Model

The second theoretical framework that will be utilised in this study is the Person-Environment-Occupation (PEO) Model. The PEO Model is conceptualized as the person, their environments and occupations dynamically interacting over time (Strong, Rigby, Stewart, Law, Letts & Cooper, 1999). The quality of an individual's experience, with regards to their level of

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satisfaction and functioning within their environment through their occupations is the outcome of the fit between the person-environment-occupation transactions (Strong et al., 1999). Occupations are selected to perform a purpose and for the meaning which individuals attribute to them and the PEO Model offers a way to systematically analyse what Occupational therapists see and do (Strong et al., 1999).

Concurrently, a person may experience changes in self-concept and environmental constraints within their first year of practice. Conceptualized broadly, the environment includes cultural, institutional, physical and social factors affecting occupational performance (Strong et al, 1999). Occupational performance is the outcome of the transaction of the person, environment and occupation (Law et al., 1996). Law et al. (1996) further explain how 'occupational performance is viewed as a complex, dynamic phenomenon' and that 'over a lifetime, individuals are constantly renegotiating their view of self and their roles as they ascribe meaning to occupation and the environment around them' (p. 17).

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As the study aims to gather an understanding of each participant's experience of the first year of practice, the PEO model will be used as a lens to interpret each participant's experience within their respective practice contexts. The PEO model can be applied to the participant by focussing on the participant interacting within their practice setting engaging in occupational therapy as the occupation of practice and becoming an occupational therapy professional assisting in their professional socialisation process into the occupational therapy profession. As occupational performance is shaped by the transaction of the novice (person) in community service (environment), practicing as an occupational therapist (occupation), this process of the participant entering the profession and becoming socialized into the profession can be judged in terms of optimal occupational performance or not.

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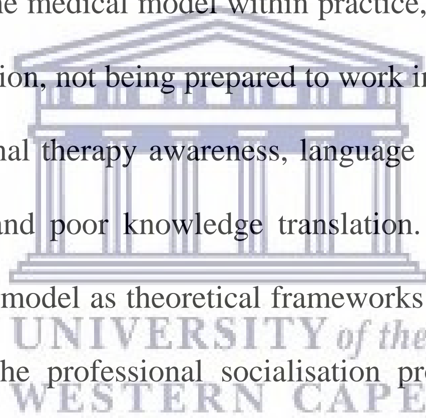
2.10 Summary

In conclusion, the literature highlights that professional socialisation and professional identity development as embedded in this process, is essential to novice healthcare professionals' experience in their first year of practice. Upon entering their first year of practice, practitioners encounter many factors which either act as a barrier or facilitator in their professional development as health professionals. With occupational therapy being a dynamic and constantly evolving profession numerous challenges are being experienced by occupational therapists in South Africa. In summary, some of the challenges experienced by occupational therapy's is the influence of the medical model within practice, limited resources to optimize occupational therapy intervention, not being prepared to work in rural settings, role confusion in practice, lack of occupational therapy awareness, language barriers with patients, lack of mentorship and supervision and poor knowledge translation. Bronfenbrenner's Ecological Systems Theory and the PEO model as theoretical frameworks provide a useful lens through which an understanding of the professional socialisation process as experienced by the participants in this study, can be generated. The chapter that follows presents the study's research methodology.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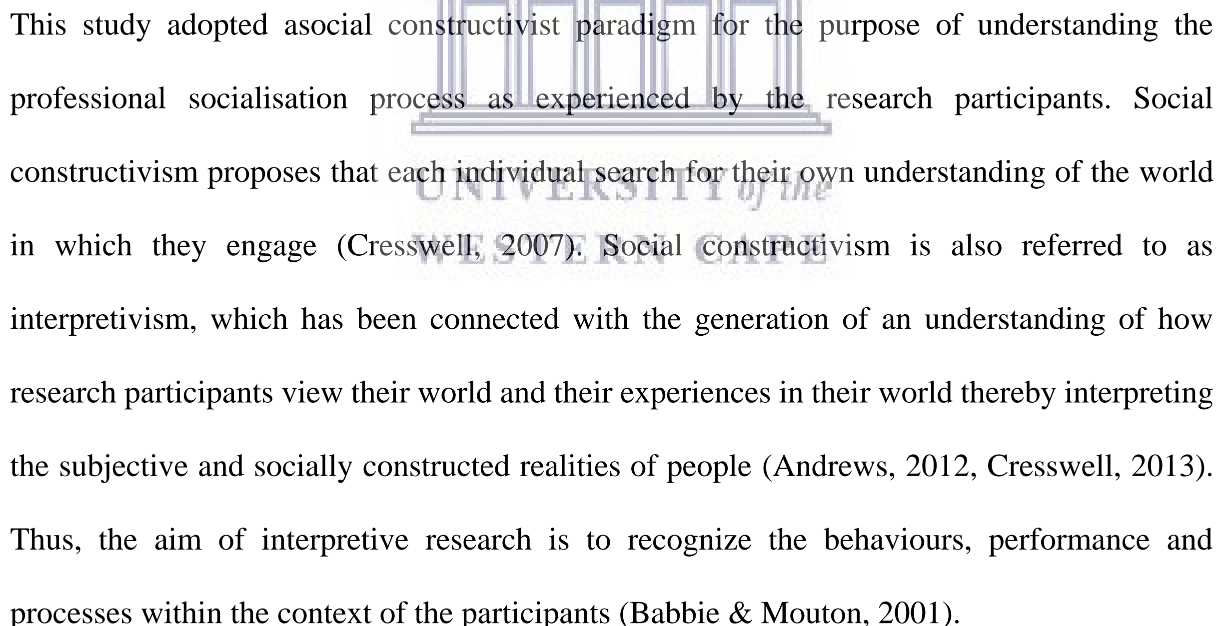
CHAPTER THREE

METHODOLOGY

3 Introduction

In this chapter a description of the methodology utilised in this study is presented. It discusses the theoretical paradigm and the methodological research approach and design. This chapter also covers the participant selection and recruitment process in the research setting and the data collection methods applied in the study. Lastly, an account of how the ethical standard of the study as well as its trustworthiness was ensured is provided.

3.1 Theoretical Paradigm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This study adopted asocial constructivist paradigm for the purpose of understanding the professional socialisation process as experienced by the research participants. Social constructivism proposes that each individual search for their own understanding of the world in which they engage (Cresswell, 2007). Social constructivism is also referred to as interpretivism, which has been connected with the generation of an understanding of how research participants view their world and their experiences in their world thereby interpreting the subjective and socially constructed realities of people (Andrews, 2012, Cresswell, 2013). Thus, the aim of interpretive research is to recognize the behaviours, performance and processes within the context of the participants (Babbie & Mouton, 2001).

The way in which the social constructivism was adopted in this study was through an exploration of the participants' experiences of becoming a professional within the Occupational therapy profession from their own perspectives. This allowed the participants to openly

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describe their experiences and for me, as the researcher, to listen to their perceptions and experiences and interpret the findings based on what they have shared (Creswell, 2013).

3.2 Research Approach

In this study, a qualitative research approach was utilised. Qualitative research explores the meaning individuals ascribe to a social or human problem (Creswell, 2007). Qualitative research entails an in-depth exploration of the natural setting the participant engages in as an everyday life experience (Magilvy& Thomas, 2009), but simultaneously does not propose to envisage any of the outcomes of these experiences (Williams, 2007). This approach adds towards extending the understanding of subjective realities compared to quantitative research which places emphasises on the role of objective facts and arithmetical analysis (Denzin, & Lincoln, 2011; Williams, 2007). Therefore, this approach was best suited to this study as qualitative research does not try to present objective truths about the participant's world but instead broadens the understanding of the research issues based on the participants lived experiences as seen from their perspectives. The participants were asked to share their practice experiences in terms of themselves as novice therapists in terms of their professional growth, identity development and professional socialisation.

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3.3 Research Design

This research study used an exploratory, descriptive research design to explore and describe the research participants' perceptions and experiences of professional socialisation in their first year of practice. An exploratory research design is a design which aims to discover more about a phenomena, especially in the case of a poorly understood problem (Robson, 2002) when there is very little known about the phenomenon under investigation (Brink, Van der Walt &Van

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Rensburg, 2006). Descriptive research is designed to create an image of a problem as it naturally occurs and may be utilised to develop theories, make judgements and validate existing practice (Sandelowski, 2000; Burns & Grove, 2003). Thus, descriptive research seeks to describe and explain patterns related to common and widely occurring incidences as well as identify relationships between phenomena (McMillan & Schumacher, 2010). Therefore, an exploratory, descriptive research design was chosen for this study as it allowed the researcher to generate an understanding of the journey of the novice therapist by gaining the perspectives of the participants on their professional socialisation process as well as to describe factors that influenced this process.

3.4 Research Setting

The research setting for this study was the public health system in South Africa. The research setting for this study was comprised out of primary, secondary and tertiary practice settings. These practice settings included mainly hospitals and one clinic. Most of the participants were based at tertiary and district hospital settings and one participant was at a primary healthcare (clinic) setting. These hospitals and the clinic were situated in urban and rural areas. Rurality in South Africa is typically characterised by resource restrictions i.e. less human and physical resources impacting on the type and availability of services. Often rural primary healthcare settings only offer the very basic medical services i.e. general practitioners, nursing staff and a small allied health team. Secondary settings do not offer the same services compared to tertiary hospitals in terms of types of specialized services, resources, staff, capacity and large allied health teams. Tertiary hospital settings have a larger patient population in terms of being able to manage a wider variety of diagnosis and accommodating specialized medical treatments with the staff maximizing. Occupational therapists in rural settings in district hospitals and primary healthcare settings often need to advocate for their role in respect of providing services.

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In urban settings human and physical resources are more easily accessible due to the nature of the specialised services being offered which implies more staff, a multidisciplinary team approach, and often more Occupational therapy appropriate referrals.

3.5 Participant selection and recruitment

This research study made use of purposive sampling for the intention of participant selection. Purposive sampling enables researchers to conduct an 'in-depth study on the phenomenon of interest' (Human, Steyn & Jordaan, 2016, p.728). Creswell (2013) explains that purposive sampling refers to the researcher chooses people and sites for study as they can purposefully provide insight into the research problem. According to Sandelowski (2000) 'in any qualitative study, the ultimate goal of purposeful sampling is to obtain cases deemed information-rich for the purpose of the research study' (p.338), therefore, selecting a smaller number of participants were suitable (Creswell, 2013). Hence, purposive sampling allowed the researcher to choose between what needs to be explored and to seek participants who could and were keen to present the information needed based on knowledge or experience (Lewis & Sheppard, 2006). Willig (2013) suggests that researchers decide on a selection by following inclusion and exclusion criteria due to the in-depth nature of the study and analysis of data required. In view of this, participants were selected according to the following criteria:

Inclusion criteria:

- Participants who were qualified occupational therapists.
- Participants who have completed their first year of practice at any of the 9 provinces in South Africa at the primary, secondary or tertiary level of care in rural or urban settings during 2016.
- Participants who were commencing their second year of practice in 2017.
- Participants who were male or female.

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Exclusion criteria:

- Occupational Therapists who were practicing for longer than 2 years as they were no longer considered to be novice therapists.

The way in which the participants were recruited was through three various mediums. The first was via contact with the three universities in Cape Town who provided a list of novice graduates who were starting their second year of practice in the Western Cape in 2017. Most participants were recruited in this manner. The second was via a medical recruitment agency in Cape Town who assisted me in recruiting two participants. The third was via making use of social media namely LinkedIn and Facebook which assisted me in recruiting one participant. One participant was based in the Free State and was prepared to participate in the study through telephonic interviews. One participant was based in the Free State and was prepared to participate in the study through telephonic interviews. At this stage, the researcher still needed to recruit participants from Limpopo province and KwaZulu-Natal. The researcher then emailed the universities in KwaZulu-Natal and Limpopo. Only the university in KwaZulu- Natal responded and provided the researcher with a list of their graduates and their email addresses together with where they were placed for community service. The researcher was given permission by the OT department to email them herself for further information. The researcher emailed the graduates of which all explained that they left to practice overseas. Due to this, the researcher was unable to recruit participants who completed their first year of practice in the KwaZulu-Natal or Limpopo province. In order to ensure nine participants were in the study the researcher had two participants from the Eastern Cape and two from the Western Cape. Table I provides a description of the participants.

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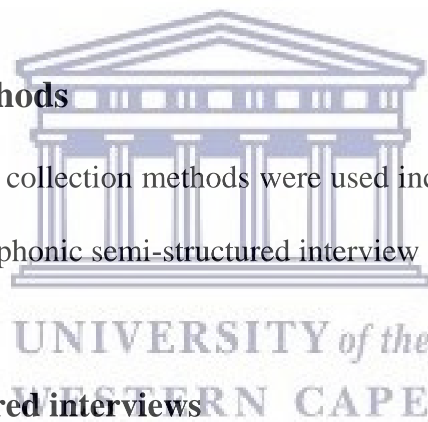
Table 1: Description of participants

Participant	Province practiced	University attended	Gender	Race	Practice Setting
Participant 1	Northern Cape	UWC	Female	Black	Urban – Secondary
Participant 2	Western Cape	UWC	Male	Coloured	Rural – Tertiary
Participant 3	Eastern Cape	UWC	Female	Black	Rural – Secondary
Participant 4	North West	UWC	Female	Coloured	Rural – Secondary
Participant 5	Eastern Cape	UWC	Female	White	Rural – Secondary
Participant 6	Gauteng	UCT	Female	Coloured	Urban – Secondary
Participant 7	Western Cape	US	Female	White	Rural – Primary
Participant 8	Mpumalanga	US	Female	White	Rural – Tertiary
Participant 9	Free State	US	Female	Coloured	Urban – Tertiary

3.6 Data collection methods

In this study, a variety of data collection methods were used including two face to face semi-structured interviews, one telephonic semi-structured interview and one dyad interview.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3.6.1 Initial semi-structured interviews

Semi structured interviews are verbal interchanges where one person attempts to elicit information from another through questions (Clifford, Cope, Gillespie & French, 2016). The interview process is a useful way of collecting in-depth information and of gaining large amounts of data quickly (De Vos, Strydom, Fourie & Delport, 2005). Utilising semi-structured interviews ensured that the topic at hand remained the focus while interviewing the participants, while simultaneously gathering in-depth information on the participants' perceptions, and experiences of the issues explored in this study (De Vos et al., 2005). Each participant engaged in two face to face semi-structured interviews with the first being an initial interview and the second being a follow-up interview. The semi-structured interviews were

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conducted outside of their official work hours at a convenient time and place. This mainly occurred at the researcher's office or the participants' homes. Only one telephonic was held with one participant who was not in the Western Cape at the time of the data collection process. Each interview lasted between 40 to 60 minutes. The interviews were audio-recorded on a recording device and transcribed verbatim for the purpose of data collection.

The initial interviews focussed on the participants' professional development and professional identity formation. The interviews were conducted based on open-ended questions utilising an interview guide (see Appendix 1). The questions included an exploration of the participants practice settings, their perception of their professional development including their least and greatest area of development, and how they experienced the transition process from student to professional.

Most of the participants reflected on what they expected from the year when discussing professional development and most of the responses closely linked to their clinical experiences. The participants tended to get stuck and dwell on one or two particular clinical issues related to them being community service therapists that they appeared to be preoccupied with at the time. However, as the researcher facilitated the questions in a more structured manner and brought them back to the specific questions asked, the flow of the interview progressed easier.

3.6.2 Follow-up semi-structured interviews

The follow-up interview focused on the culture of the occupational therapy profession as well as facilitators and barriers to professional socialisation as perceived and experienced by the participants. The follow up interview questions were further informed by issues that were identified as in need for further exploration after the initial interview. A follow up interview

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guide (see Appendix2) was constructed and used to guide the interview process. Due to the participants not reflecting thoroughly on their experiences, some of the initial interview questions were rephrased and asked again for clarification and some were linked to the second set of questions.

3.6.3 Dyad interview

The researcher initially invited the participants to a focus group discussion at a convenient time and venue on a Saturday at one of the participant's homes as suggested and agreed upon by all the participants. Only two participants were however able to attend due to various apologies received as a result of personal difficulties experienced by the other participants on the day. Asa result the researcher proceeded by conducting a dyad interview. When a dyadic interview takes place, two participants engage and respond to open ended research questions (Morgan, Ataie, Carder, Hoffman, 2013). Like semi-structured interviews, dyad interviews are conversational and informal in tone, and allow for open responses from the participants instead of close ended responses (Clifford et al, 2016). One dyad interview was conducted after a provisional analysis of the semi structured interviews was completed. The provisional analysis based on the two semi structured interviews was used as a guide to facilitate questions for the interview. A discussion guide (see Appendix 3) was constructed and utilised to guide the interview process. The purpose of the dyad interview was two-fold: Firstly, the participants were presented with the provisional analysis of the interviews, for the purpose of member checking and secondly, discussion on the provisional findings and recommendations from the participants in relation to it were elicited. The dyad interview lasted for one hour and was recorded with a digital recording device and transcribed verbatim for the purpose of data analysis.

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3.7 Data analysis

Six steps of thematic analysis were used in this study as guided by Braun and Clarke (2006). According to Braun and Clarke (2006), thematic analysis is a qualitative analytic method for identifying, assessing and writing up the patterns observed within the data.

1) *Familiarisation with the data*: involves the researchers submerging themselves in the data in order to become familiar with the scope of the data by reading. After the interviews were conducted, the interviews were transcribed verbatim. In this transcription process, the researcher became well recognized with the data and developed an initial understanding of the contents of the whole data set. The researcher then read and re-read each transcription several times and got a thorough comprehension of the data.

2) *Coding*: this entailed a conceptual reading of the data collected. The coding process was conducted manually on a personal computer. The coding process entailed reading the transcripts, line-by-line noting and highlighting of key aspects in the data with different colours. During this process of manual coding, each key aspect or code was numbered and a list of numbered codes was compiled and collated along with data extracts in a separate document. The codes were then grouped together into bundles of shared meaning with relationships identified and re-checked between codes to formulate sub-categories and categories.

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3) *Searching for and constructing themes*: In this manual process, categories sharing familiar content and interests were grouped together to formulate broader themes.

4) *Reviewing themes*: this process involved ensuring that each theme is credible and concise as well as defining the nature and link between the categories that constituted the different themes. Consequently initial themes formed were reviewed and refined into fewer themes to be clear and succinct.

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5) *Defining and naming themes*: this process entailed an in-depth analysis of each theme to explain the fundamental nature of each theme by capturing its essence.
6) *Writing up*: this process involved contextualising the data in an analytic narrative to create a consistent and convincing story about the data. The analysis was written up with supporting quotes from the data to illustrate each theme, representing the narrative written to reflect the metaphor of 'the journey of a novice'.

3.8 Trustworthiness

The set of criteria to ensure the trustworthiness of qualitative research as suggested by Lincoln and Guba (1985) namely, credibility, transferability, dependability and confirmability was applied in this study, while strategies for trustworthiness as proposed by Krefting (1991) namely triangulation, member checking, stepwise replication and an audit trail was implemented.

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3.8.1 Credibility

Credibility refers to the confidence that the researcher has in the truth value of the findings (Lincoln & Guba, 1985). To ensure credibility in this study, triangulation and member checking were used. Triangulation involves using multiple data sources in an investigation as well as comparing data with literature sources to produce greater understanding (Merriam, 1995). Lincoln &Guba (1985) consider member checks as the single most important provision that can be made to strengthen a research study's credibility. Once the data was transcribed and analysed, member checking was done to offer the research participants an opportunity to check the accuracy of each of their transcripts and to engage with the provisional analysis (Babbie & Mouton, 2001). Each participant was provided with their individual transcripts of the first interview and invited to comment in respect of its accuracy before commencing the second

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interview, while those participants who were able to attend the dyad interview were presented with the provisional analysis. All of the participants agreed the presented transcripts and findings in terms of the respective experiences. They were open to experiences being diverse based on the variety of settings. The participants had the opportunity to agree or disagree with the findings as well as add recommendations based on the findings presented.

3.8.2 Transferability

Transferability refers to whether the findings of the study can be applied to other contexts. A detailed description of the research context, as well as the research process addressing the participants involved in the research and the procedures followed to collect data, so that it is possible for this study to be replicated in future is provided (Krefting, 1991).

3.8.3 Dependability

Dependability considers whether the findings would be consistent if the study was to be replicated with the same participants in similar contexts (Lincoln & Guba, 1985), therefore a detailed explanation of the research design as well as a list of interview questions are provided (Krefting, 1991).

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3.8.4 Confirmability

Confirmability is concerned with whether the data provided are not fuelled by the researcher's thoughts but reflect the actual perceptions and experiences of the participants (Brink, van der Walt & Van Rensburg, 2013). To ensure confirmability record of the research process and trail of data analysis was maintained throughout the study and an audit trail representing a record of what was done in this investigation is available for scrutiny. It is a transparent description of the research steps taken from the start of a-research project to the development and reporting

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of findings. Peer debriefing furthermore occurred with independent peers (Krefting, 1991) and the research supervisors. During each face to face meeting held with the researcher and research supervisor, peer debriefing took place where the interview findings were discussed and the research process analysed and reflected on.

3.8.5 Ethics

Ethical approval of the study was obtained from the University of the Western Cape Research Ethics Committee (Ethics Clearance Number: HS: 17/1/33) (see Appendix 4). The purpose of the study was explained to each participant before they were invited to participate. An information sheet (see Appendix 5) that describes the purpose of the study was provided to each participant. Following this, written consent (see Appendix 6) was requested from the participants. The participants were also be asked to sign a dyad interview confidentiality consent form (see Appendix 7) which stresses the importance of group confidentiality. Autonomy was addressed through allowing the participants to have a choice in participating in the research study as they were given the freedom to withdraw from the study at any given time, without penalty or being pressured in staying. Anonymity through the use of participant numbers instead of participants' names was used in the transcripts. Participants were further ensured that their names or first year work placements will not be mentioned in any reports or publications resulting from the study. Confidentiality was practiced by ensuring that personal records of participants and all research materials are secured in a password protected computer file and locked cabinet for safety. After a 5-year period, all information gathered through audiotapes and transcripts will be deleted and destroyed. All human interaction carries some risk; therefore, it was arranged that participants who might experience any discomfort as a result of their participation in the study could be referred to a suitable professional affiliated to the UWC psychology department should the need arise. All nine participants in this study have

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access to the findings of the study. Occupational therapists and Occupational therapy students also have a right to benefit from the findings of this study.

3.9 Summary

The theoretical paradigms of social constructivism, qualitative research approach, and exploratory descriptive design were described in this chapter. The data collection methods namely semi structured interviews and data analysis were also described. The research setting in which the study was applied as well as the process of selecting and recruiting the participants was also discussed. Lastly, strategies implemented to uphold the trustworthiness and ethical standard of this study was presented. In the chapter that follows the findings of the study will be presented.

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CHAPTER FOUR

FINDINGS

4 Introduction

This chapter presents the findings based on the themes, categories and subcategories that emerged from the thematic analysis. Three themes with related categories and sub-categories emerged from the findings: 1) Stepping into the unknown, 2) Uncovering the occupational therapy culture and 3) Becoming a professional(See Table 2).

Table 2: Themes and categories

Themes	Categories	Sub-categories
1. Stepping into the Unknown	Expectations versus reality	• Novice expectations not met • Novice treated as a student
	Novice occupational therapists' need for mentoring	• Occupational therapy is not an easy profession • Being well prepared but… • Lack of support and supervision
2. Uncovering the occupational therapy culture	A passionately, confusing profession	• Contradictions within the occupational therapy profession • Insecurity within the occupational therapy profession
	Constant need for advocacy	• Lack of occupational therapy awareness • Other health professionals perceptions
	Power dynamics in the occupational therapy family	• Hostility between novice and senior occupational therapists • Hegemonic practices
3. Becoming a professional	Struggling with the transition from student to professional	• Role confusion and uncertainty • Distorted perception of self • Motivation running low • Sink or swim
	Finding the occupational therapist within	• Gaining independence as a practitioner • Factors contributing to professional identity development

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4.1 Theme 1: Stepping into the unknown

This theme highlights how the participants as young, novice therapists stepped into the unknown of the occupational therapy profession as part of the experiences. The theme is underpinned by two categories, expectations versus reality and novice occupational therapists' need for mentoring, which illustrate what the participants' expectations were versus what they encountered in reality and illuminates internal and external factors that framed this initial period of assimilation into the profession.

Table 3: Theme 1

Theme 1	Categories	Sub-categories
Stepping into the unknown	Expectations versus reality	• Novice expectations not met • Novice treated as a student
	Novice occupational therapists' need for mentoring	• Occupational therapy is not an easy profession • Being well prepared but... • Lack of support and supervision

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4.1.1 Expectation versus Reality

Many of the participants explained that they entered the profession with the expectation that they would experience continuous professional growth and development. However, as they began their professional lives as qualified occupational therapists, they felt a sense of disappointment as everything they personally had hoped for did not materialise and had to come to terms with that.

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4.1.1.1 Novice expectations not met

The participants related feelings of dissatisfaction in terms of what appeared to be unrealistic in terms of what they expected compared to what was presented to them in respect of their actual experience as part of the community service year:

> *"I ... think you need to set clear expectations for yourself because I think we all have this beautiful picture about what happens after varsity as an OT and how comserve is going to be and what life after comserve is going to be and then life happens and you're just like "Oh""*"(interview 2, participant 6,).

> *"And as a new therapist for me I was so disappointed. Because in university everything for me felt perfect… So was that whole experience in varsity a lie?*"
> (dyad interview1, participant 3)

The participants articulated how the unexpected challenges initially caused them to experience stress and emotional strain, as they thought that they should have been able to cope without relying on student notes or anyone to refer to in terms of support:

> *"It's okay to go back to notes and try and figure out because now we put too much pressure on ourselves to be this perfect therapist when you come out of varsity we have that we put pressure on ourselves and we don't really think that okay it's okay to open up a text book because now you supposed to be qualified because 'you know."* (interview1, participant 3).

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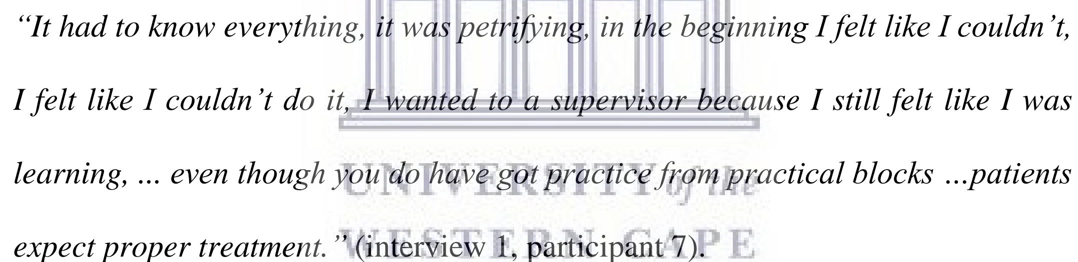
There were also many expectations placed on the participants by others that they were not always prepared for as these were not always of a clinical nature. They articulated that an expectation to know it all like an experienced therapist caused added pressure that added to their stress levels and that it should not always be that way, it should be okay to refer should one require some clarity:

> *"I think something negative that affected my development was the uncertainties when you become a com serve OT that feeling of all of a sudden the training wheels has come off abruptly. They expect you to perform like a therapist who has been there for 5 years so it's the pressure of expectation that's been laid out for you…"*(interview2, participant 3).



> *"It had to know everything, it was petrifying, in the beginning I felt like I couldn't, I felt like I couldn't do it, I wanted to a supervisor because I still felt like I was learning, ... even though you do have got practice from practical blocks ...patients expect proper treatment."* (interview 1, participant 7).

From a more managerial perspective, there were also aspects that the participants were not expecting and prepared for:

> *"I was the only occupational therapist, it was me and the Physio as the com serves, running the department ... I was expected to do everything from management, admin, and seeing actual patients*." (interview 1, participant 6)

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One participant related how certain expectations from experienced more senior therapists were experienced as disheartening as it was perceived as a set up expectations to fail and not succeed. This lead to feelings of being undermined and thus the constant need to seek approval and prove capability:

> *"They have this great expectation but it's more an undermining feeling that you get from them. It's not like they expect you to do great but they subtly create the perception that they hope you will fail. So that pressure made me question why I was doing OT…it's already tough for me to be an OT and now I have to be dealing with all these people making me feel like I have to prove myself constantly."* (interview 2, participant 3).

4.1.1.2 Novice treated as a student

Within this situation of feeling pressured, the participants appeared to experience a sense of confusion because of being expected to perform as seasoned professionals on the one hand while being treated as students on the other hand. The participants articulated that while they were excited about their new status as newly qualified therapists, they were still seen and treated as students and not professionals. Consequently, they felt that they were not receiving the respect they expected as a member of the multi-disciplinary team:

> *"…you expected so much more from the team approach and then nothing happens"* (interview 2, participant 8) ... "*You are treated as a student and not as a colleague but a student"* (interview 2, participant 7).

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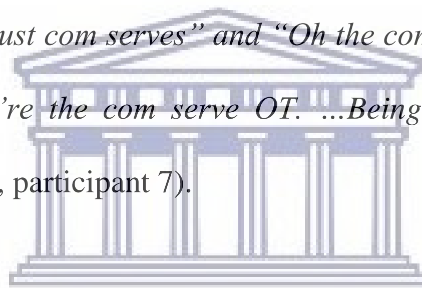
They felt as if they were not taken seriously as a professional or even treated as a colleague. They explained their expectations around the team approach in terms of the fact that they were hoping to be treated as part of the team and not as merely a student due to the title of community service occupational therapist:

> *"And also they don't take you seriously as a com serve so even in multidisciplinary team meetings you would find that no one values your opinion so you could make a suggestion but they aren't going to take you seriously because you have no experience"*(interview 2, participant 3).

> *"It's "Don't worry it's just com serves" and "Oh the com serves can do this" So, you're not an OT, you're the com serve OT. ...Being just treated a little bit differently"* (interview 2, participant 7).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4.1.2 Novice occupational therapists' need for mentoring

The participants generally felt that they were well prepared for their first year of practice as their respective universities ensured this through the education that they received. They felt confident in their acquired knowledge and skills and were ready to place it into action. The participants however referred to the fact that while they felt prepared, the first year of practice nonetheless highlighted just how challenging being an occupational therapist is, regardless of the practice setting.

4.1.2.1 Occupational therapy is not an easy profession

All the participants felt that occupational therapy is not necessarily an 'easy' profession in respect of being able to apply what was learned at university, coping with the work load and

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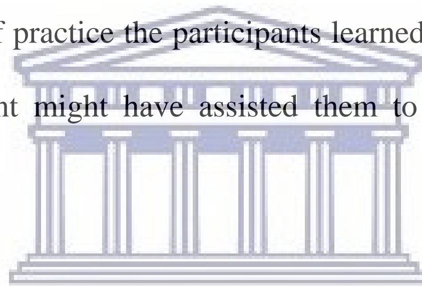
dealing with professional dilemmas. They articulated that these were challenges they encountered that often lead to self-doubt:

"I think it made me feel as if I am worth less you know, because you feel as if you cannot do it …you lose your trust within yourself and... You feel so unsure all the time"(interview 2,participant 8).

"There were a lot of times where I would doubt myself" (interview 1, participant 9).

In reflecting on the realities of practice the participants learned that setting realistic goals for their professional development might have assisted them to reduce their initial levels of disappointment:



"By the end of the year, I felt a little guilty about the fact that I had so many goals, but I didn't achieve any of them …I think if I had been more realistic, or perhaps had another year I could have achieved some of it"(interview 2, participant 5).

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The participants furthermore explained that while they felt prepared they still expected to continuously grow and develop from their experiences and learn as much as they could especially from therapists who have been in the profession for a longer period. They soon learned that what was taught at university was only a portion of the professional development that would follow in reality:

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"…you know at university they teach you everything over the 4 years and then you… you on a level but now you go to com serv and then you obviously supposed to grow more, you are always supposed to grow" (interview 1, participant 4).

4.1.2.2 Lack of support and supervision

Having a sense of support was a fundamental component all the participants found they needed to add value to their development within this process of becoming a part of the profession.

"I think in an ideal world every single com serve OT should have somebody there that is like there supervisor, mentor, someone that they can contact and chat to" (interview2, participant 7).

Nonetheless, many found that there was a lack of support from their respective settings in terms of other therapists and healthcare workers who acted as supervisors. One participant described her frustration at the fact that hers was a medical doctor and not an Occupational therapist:

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"Factors from last year that made me feel like it wasn't beneficial were the lack of supervision, so you're kind of thrown into the deep end …I had the contact details of the OT who was at the clinics uhm in case I had any questions, but my supervisor was a medical doctor who didn't know what OT was" (interview 1, participant 6).

Participant 6 later added that due to being left to her own devices she was feeling overwhelmed with the expectations of the year and had to resort to external support figures that assisted her in her development as she was placed alone in her first year of practice:

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"I had to rely on two best friends that graduated before me and had gone through that transition already so by the time when I was in com serve they were on their first year post com serve" (interview2, participant 6).

The participants felt that the lack of support and they received resulted in poor professional development which caused a lack of confidence working amongst a larger MDT or group of Occupational therapists in turn:

"I think most people will say that the jump from university to like your first year of being an occupational therapist is scary so you want, you want that support uhm I'm sad I didn't get that support and actually maybe looking back, my least professional growth occurred maybe, if I think about it now, I'm scared, to go into a place where there's a whole lot of OTs there I think I would be nervous for like a lot of OTs together but I also think I'd be okay" (interview1, participant7).

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They disclosed their insecurities when making reference to working in a tertiary setting with more Occupational therapists and other health professionals and how being isolated without support has contributed to that:

"I don't feel as if I grew to that level on working at a tertiary level because of the limitations in the hospital which was mostly like my supervisor ... you obviously can't say I want this client or I want to see that client you just have to see …that's just my fear if I were to get a new one day" (interview 1, participant 4).

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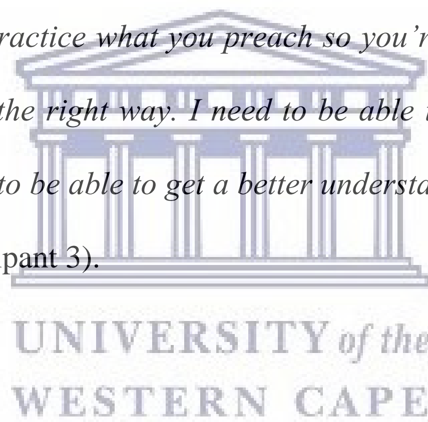
Not having supervision or the necessary support made them question to what extent they were of any benefit when she cannot serve her sole purpose for year.

> *"I feel like we useless man, you putting a baby alone in a hospital, she doesn't know what she is doing she doesn't have any supervision she is not growing but she is also not giving back so what is the point of community service?"* (dyad interview , participant 3)

They stressed the importance of having role models in senior occupational therapists in order for novices to follow them and find their feet:

> *"Be a role model and practice what you preach so you're an older therapist you should be doing things the right way. I need to be able to see 'okay, this is how things are done' for me to be able to get a better understanding of who I am as an OT*" (interview 2, participant 3).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4.2 Theme 2: Uncovering the occupational therapy culture

This theme illustrates how the participants perceived the culture of the profession particularly the attitudes and values that are upheld by its member's i.e. occupational therapy practitioners. During the process of becoming socialised into the profession as novices the participants described how for them, sometimes surprisingly so, a true reflection of the profession was illuminated.

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Table 4: Theme 2

Theme 2	Categories	Sub-categories
Uncovering the occupational therapy culture	A passionately, confusing profession	• Contradictions within the occupational therapy profession • Insecurity in the occupational profession
	Constant need for advocacy	• Lack of occupational therapy awareness • Other health professionals perceptions
	Power dynamics in the occupational therapy family	• Hostility between novice and senior occupational therapists • Hegemonic practices

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4.2.1 A passionately, confusing profession

The participants reflected on being an occupational therapist in terms of how it makes them feel. They portrayed enthusiasm for the profession that was evident in the manner in which they shared their passion for it and related how it shaped their perception of what it means to be an occupational therapist:

> *"I'm so passionate about being an OT"*(interview 2, participant 2).

> *"I know that as an OT this is, I feel like it's part of my identity as well like, what I do ... So, I think I'm very happy and I think I'm quite passionate about it and I like it"*(interview 2, participant7).

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4.2.1.1 Contradictions within the profession

The participants noted that there were numerous inconsistencies within the profession that made them feel somewhat despondent and dampened their initial enthusiasm. These inconsistencies were related to a perceived dissonance between what the participants felt they were equipped with in respect of knowledge and skills as students and with what they observed in practice:

> *"…as a student coming into com serve you have this knowledge of what OT is and what it should be and then you get the experienced people who aren't doing what you were taught"*(interview 2, participant 6)
>
> *"…they don't do evidence-based practice from what I've seen uhm, they don't do that… client centeredness, you would find that they don't even care about the activities that are meaningful and these are all things that we are taught at varsity"* (interview 2, participant 3).
>
> *"It felt like a lie. It felt like what I had learned or what …I was brought up to believe as an OT in this specific culture was all talk and actually no action because here you are taught to believe that the client comes first etc and then you go into a setting where no one actually believes or shares the same values as you. And you kind of question… what was I taught… because no one is following that trend and confuses you like what is OT then?"*(interview 2, participant 4).

4.2.1.2 Insecurity within the occupational therapy profession

It was indicated during both interviews with one participant that to some extent there was a lack of confidence within the profession and amongst occupational therapists. She felt strongly

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about this and explicitly addressed it compared to other participants who were timid about the idea. She felt as if therapists were always anxious within their role and interpreted it as insecurity within the team and/or profession:

> *"I have always felt like a lot of the times OTs portray… an insecurity in terms of their profession you know a lot of people don't know what we do"*(interview 1, participant 1).

She felt that occupational therapists do not display confidence in their roles and therefore management or those in high positions do not take occupational therapy seriously:

> *"… The whole insecure about your profession …thing…it would…be the reason as to why management isn't doing much"* (interview 1, participant 1).

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One participant suggested that one way in which occupational therapists could deal with some of these insecurities would be the creation of opportunities for constructive dialogue between occupational therapists:

> *"I think OTs need to have a long and hard look at themselves and we are quite reflective I think, uhm about themselves and how they perceive their identity as a therapist…maybe having little groups of OTs and just talk about you know, how we feel about being an OT"* (interview 2, participant 1).

In the dyad interview when the emerging findings were discussed, recommendations were also offered in respect of constructive dialogue as a way forward.

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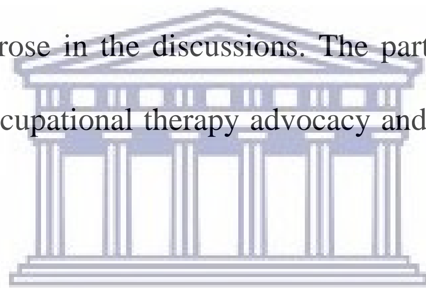
"I know I'm not the only person who feels this way. I speak to friends and whatever and it's something that always comes up in discussion about how insecure OTs are I suppose it's not everyone as well. But like where is this stemming from and how do we deal with it going forward… Have the young and the old, have a real conversation about what this profession really is you know and why we feel so insecure." (dyad interview, participant 1).

4.2.2 Constant need for Advocacy

Together with the participants' observations and experiences regarding the sense of insecurity within the profession the issues of a lack of occupational therapy awareness and other professionals understanding arose in the discussions. The participants felt that these issues created a constant need for occupational therapy advocacy and creating awareness about the profession.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4.2.2.1 Lack of occupational therapy awareness

It was evident that the participants found the general lack of occupational therapy awareness that they encountered in their practice contexts a challenge. Having to constantly advocate for the profession appeared to play a significant role in their process of professional development.

"Confidence and advocating for your profession was a huge thing that I was forced to learn"(interview 1, participant 6).

"Having to advocate all the time also strengthens your understanding of OT even though at the end of 12 months I'm still the 'Physio'"(interview 1, participant 6).

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They felt that occupational therapy is not well known due to it being uncommon and thus they understood why advocates are necessary to provide education regarding the profession and its role:

> *"And I get that OT…we're not a rare breed but it's like, difficult to understand for other people ... I also think that, I do think that we need a lot more advocates in our field to get our profession out there"*(interview 2, participant 2).

> *I think we as OTs must spread the word because we know best about what it is that we ... not everyone comes across an OT on a daily basis especially in Afrikaans 'Arbeidsterapeut' so ja, I don't think we must get angry about it I think we must use the opportunity to educate people about it*(interview 2, participant 8).

In the dyad interview it was evident that a consistent lack of understanding and respect for Occupational therapy in the health care arena has led some participants to question the viability of continued advocacy when despite this happening, the profession still does not receive the recognition it deserves:

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> *"I didn't feel like fighting it because why must I constantly prove myself? Why we are in this situation where we constantly in health need to fight to be recognized as your own department?"* (dyad interview, participant 3)

> *"I mean no one understands what I do, why push so hard for a profession that isn't even recognised amongst other health professionals?"* (dyad interview, participant 1).

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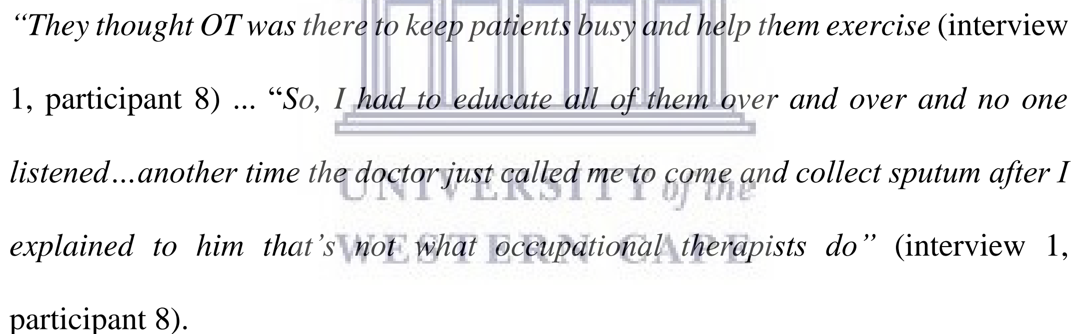
4.2.2.2 Other healthcare professional's perceptions

The participants found that poor understanding of what the role of the occupational therapist is, led to a negative impact on their performance due to their frustration within the Multidisciplinary Team.

> *"I think ... in the hospital setting, one thing that I learnt to accept is that our profession isn't seen as relevant as every other profession within the setting"* (interview 1, participant three).

One participant unpacked an experience which occurred to her with regards to a lack occupational therapy of awareness:

> *"They thought OT was there to keep patients busy and help them exercise* (interview 1, participant 8) ... "*So, I had to educate all of them over and over and no one listened…another time the doctor just called me to come and collect sputum after I explained to him that's not what occupational therapists do"* (interview 1, participant 8).



Some of the participants noted the impact of that senior therapists have on the profession in terms of how other health care professionals view their practice and Occupational therapy on a whole. From their perspectives senior therapists do not always abide by the norms of the profession in terms assessment and/or treatment principles, causing other healthcare professionals to not respect Occupational therapy accordingly:

> *"But therapists don't do things that back up or inform our procedures…So not sticking to the knowledge we've accumulated overtime, like not using standardised*

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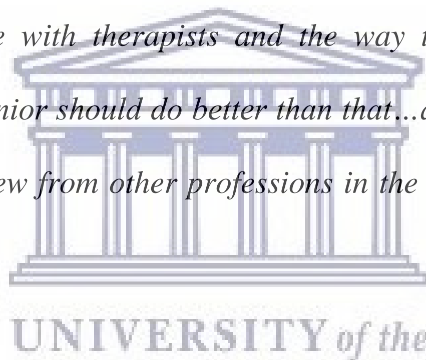
assessments kind of waters down our profession… other health professionals don't take us seriously because of that…so that makes me feel like am I really a professional or am I a glorified assistant?"(interview 2, participant 3).

The participants felt that occupational therapists themselves can be responsible for the way in which other professionals view the profession. They suggested that perhaps due to occupational therapists being in a routine or set way of doing things they do n always question why things are being done in that manner.

I think a lot of experienced therapists are set in their ways and…don't always question the reason behind what they do. Or they don't talk about it?…and sometimes you disagree with therapists and the way they do things and you sometimes think your senior should do better than that…and that then sometimes can cause a negative view from other professions in the hospital … (interview 2, participant 5).



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One way in which the participants felt that occupational therapists could counter others' perceptions of the profession is by standing up for themselves and showing confidence in their role:

"There's sometimes doctors that just decide that this is your job and this is what you do ... so you need to say 'no this is not what I want' or 'no I do not want this patient to be discharged"(interview1, participant 5).

"You need the senior OTs to say, "Look here, this is what we're doing, like the WFOT conference is happening, that's a good thing so we need more people to say "This is what OT is about""(interview 2,participant 2).

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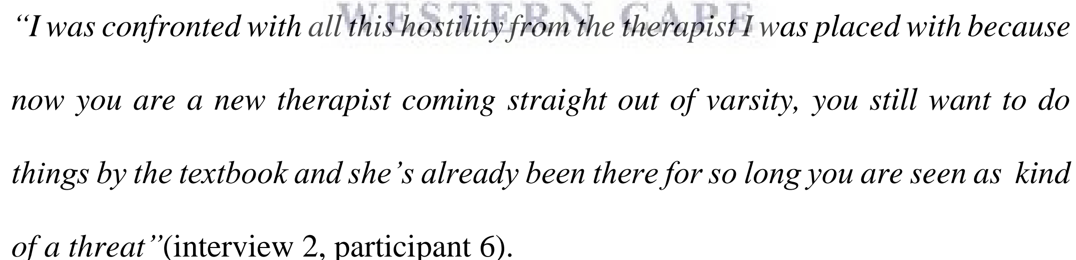
4.2.3 Power dynamics in the occupational therapy family

Issues of power were addressed by the participants based on shared observations and experiences within their first year in the field. It was only during this journey and through their actual day-to-day experiences as a full member of the profession that the participants became attentive to certain dynamics of power which the participants observed to exist amongst Occupational therapists. They acknowledged that the culture of the profession was characterised by issues of power amongst occupational therapists themselves that influenced team dynamics and relationships.

4.2.3.1 Hostility between novice and senior occupational therapists

The participants felt that experienced therapists practiced in routine ways that from their perspective were not up to date with new developments in the profession. This lead to feelings of hostility between therapists who have been practicing for years compared to the novice who entered the field with new knowledge and skills: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> *"I was confronted with all this hostility from the therapist I was placed with because now you are a new therapist coming straight out of varsity, you still want to do things by the textbook and she's already been there for so long you are seen as kind of a threat"*(interview 2, participant 6).

> *"I was the new fresh out of varsity com serv still doing everything by the textbook and she was in the game a lot longer so she in a sense felt that now I am making her look bad to other staff members so then it created a sort of friction between the two of us"*(interview 1, participant 3) ... "*Hegemony? It is real! It is real! It is so real!"* (interview 1, participant 3).

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The participants discussed how therapists who have been in the same setting for a long time have created a routine for themselves where younger therapists were expected to adjust to their customary practices and not open to new ideas.

> *"My supervisor, her mentality of what occupational therapy is I guess uhm like she's very like old school, stuck in her own ways, and what she knows is what she knows she was not open to learning more from us"* (interview 1, participant 4).

4.2.3.2 Hegemonic practices

The participants articulated that upon entering the work environment they were exposed to hegemony within the profession itself. They encountered that therapists who were placed in a position of power had a sense of control over them and this made them feel powerless and placed strain on their process on their development:

> *"I think maybe the protected nature and those people being set in their ways kind of hindered my progress I would say because then I just felt like you know what is the point of trying to bring across new ideas because I really don't know what the response is going to be"* (interview 1, participant 1).

Participant 3 was rather transparent about her experiences when it came to the issue of power in practice:

> *"We already had an oppressive situation amongst each other... What you seek is a mentor not someone who is trying to dominate you. That's where the problem lies; they don't understand the difference between guidance and being a bully and trying*

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to make someone feel inferior. I had a senior therapist ...I never got guidance instead she would just ignore my existence most of the time. You come to the therapist with an idea and immediately it's shot down even though you know that your idea will work..."(interview 2, participant 3).

Participant 3 found the issues around power as one of the most threatening factor she encountered in her first year of practice. She was passionate about explaining her experience on power struggles and how this influenced and contributed to her professional development within occupational therapy:

"I think it's not wanting to be undermined ... Or wanting to have that power over another therapist. So it's the power struggle. It's the 'you just came from varsity you don't know, I'll show you' even though you've been working for 2 years, I've been working for 3 years so I'll show you because I have that one year on you"(interview 2, participant 3).

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4.3 Theme 3: Becoming a Professional

This theme highlights the meaning of becoming a professional through the journey of transitioning from student to professional and how the participants adapted and coped with the obstacles. The theme illustrates how the participants professional identity developed over this period and how the factors that either contributed to or hindered this process.

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Table 5: Theme 3

Theme	Categories	Sub-categories
Becoming a professional	Struggling with the transition from student to professional	• Role confusion and uncertainty • Distorted perception of self • Motivation running low • Sink or swim
	Finding the occupational therapist within	• Gaining independence as a practitioner • Factors contributing to professional identity development

4.3.1 Struggling with the transition from student to professional

Participants shared that there were difficult challenges which have raised questions and concerns about the transition from student to professional. They acknowledged that these challenges hindered their transition from student to professional causing it to be not as smooth as they had hoped.

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4.3.1.1 Role confusion and uncertainty

All the participants highlighted role confusion between Occupational therapy and Physiotherapy as a challenge and a source of professional uncertainty. Based on the overlap between occupational therapy and speech therapy and occupational therapy and physiotherapy the participant discussed how they experienced role confusion and how it influenced their practice. They discussed how they struggled to distinguish the difference between how they practiced compared to what a physiotherapist would have done because of how the 2

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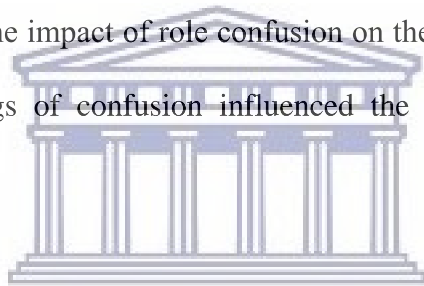
professions overlap and they questions where the essence of occupational therapy was in the session which ought to make it uniquely occupational therapy.

> *"There's always role confusion between Speech and Physio and OT and then you have to advocate"*(interview 1, participant 5).

> *"I mean there are times where I see patients and at the end I'm like "I just felt like a Physio now" where is the OT in that?"* (interview 2, participant 6).

4.3.1.2 Distorted perception of self

The participant's articulated the impact of role confusion on their struggle to transition. They highlighted how their feelings of confusion influenced the way they see themselves as professionals.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> *"I think the biggest factor that influences how I see myself at the moment is how other staff members see OT because I still feel like I'm still trying to figure out my occupational identity. I haven't gotten to a point where I know exactly who I am in OT".* (interview 2, participant 3).

They felt that the difficulties they encountered lead to feelings of self-doubt and having to reach deep within themselves an effort to create the pretence that they were coping when in fact they were not:

> *"There were a lot of times where I would doubt myself*"(interview 1, participant 9).
> *"I kind of just had to like, fake it to make it"* (interview 1, participant 7).

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One of the challenges encountered by the participants that were strongly influenced by how others perceived Occupational therapy was a struggle with their identity as occupational therapists:

> *"I'm still trying to figure out my occupational identity. … I haven't gotten to a point where I know exactly who I am in OT. So, what makes it a lot difficult for me in terms of how I view myself is how other people view OT"* (interview 2, participant 3).

They related how they questioned who they really are as professionals despite them feeling that they do have an understanding of who they are meant to be professionally:

> *"I think there are people who don't know and then that makes you kind of feel like you don't know who you are either because what OT is if they don't really know and they think they have this idea about it and then you have this idea about it then it's confusing"*(interview 2, participant 7).

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4.3.1.3 Motivation running low

All the challenges that the participants encountered during their transitioning from student to therapist did not only influence their perceptions of themselves but also affected their drive and motivation. The participants shared how a lack of motivation to push through the year based on external factors that influenced their development as Occupational therapists:

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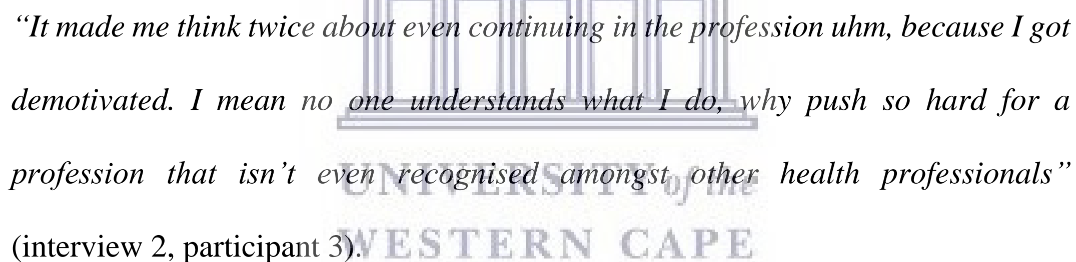
"I think something that negatively impacted my development as an OT wasn't really an incident. It's more a lack of motivation to stay on top of things"(interview 2, participant 6).

"I didn't have that much motivation by the end of the year anymore it was just like negative and then you were doing all your stuff then no one sees it and no one motivates you" (interview 1, participant 8).

A few participants was so dissatisfied with the process of becoming a professional that they considered leaving the profession the obstacles they faced have led her to question her ability to continue working as an Occupational therapist: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"It made me think twice about even continuing in the profession uhm, because I got demotivated. I mean no one understands what I do, why push so hard for a profession that isn't even recognised amongst other health professionals" (interview 2, participant 3).

4.3.1.4 Sink or swim

In relation to sink or swim subcategory, it emerged from one of the participants who shared the struggles to cope with the obstacles encountered through the transition process from student to therapist. The participants appeared to experience psychological effects like anxiety. They however related how they managed to keep their heads above water in order to get through the year having developed personally and professionally:

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> *"The transition for me definitely wasn't smooth, it was kind of a sink or swim situation. I'm straight out of varsity so it wasn't smooth sailing it was a lot of uncertainty, a lot anxiety, but I got through it eventually and yeah it made me a better therapist afterwards"*(interview 1, participant 3).

The participants' attempts to keep their heads above water however appeared to be a lonely and isolating experience. This was highlighted when one of the participants in reflecting of her experience of socialisation indicated that she did not feel that she became a part of the OT family:

> *"Just thinking of every time we talk about transitioning and professional socialisation ... I keep thinking of like ... the fact that people are members of this group and ... feel like a family, I'm not there yet"* (interview 2, participant 6).

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4.3.2 Finding the occupational therapist within

This category focuses on the participants' views on who they are as a professional specifically speaking to some of the personal characteristics the participants perceived to be necessary to 'be' an occupational therapist.

4.3.2.1 Gaining independence as a practitioner

The participants found how critical confidence is as an occupational therapy practitioner and unpacked some of their experiences with regards to gaining independence and confidence in their role. They explained how they developed self-determination as they became more independent in terms of practicing as a professional together with building up the momentum to stand firm in their role as an occupational therapist:

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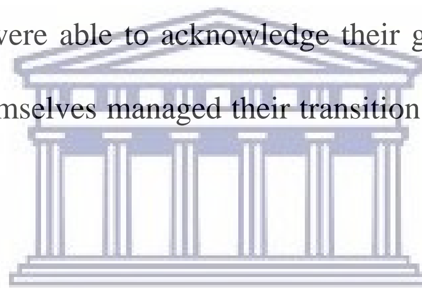
> *"I think because of last years' experience I've learnt to become more independent and to advocate more for my role"*(interview 2, participant 3).

> *"I think it's just the more and more you do things independently* (interview 2, participant 5) *... You not in a department where you can ask your seniors you are the OT, you the boss and you have to make the decisions and you have to rely on your reasoning you don't have a textbook with you so I think it is just that independence"* (interview 2, participant 5).

They reflected on how they were able to acknowledge their growth and development upon looking back on how they themselves managed their transition from being a student to being an occupational therapist: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> *I also think my growth from being a student to being you know in a hospital just looking back on like how far I've come you know that gives me my own personal validation as a therapist… seeing I've grown so much and I've learnt so much and I've done so much it allowed me to feel grounded as an OT and own that* (interview 2, participant 1).

Most of the participants explained what kind of people they thought that occupational therapists are in terms of their values and personal qualities which they perceive to contribute to who they are and what makes them unique as professionals that make up this profession:

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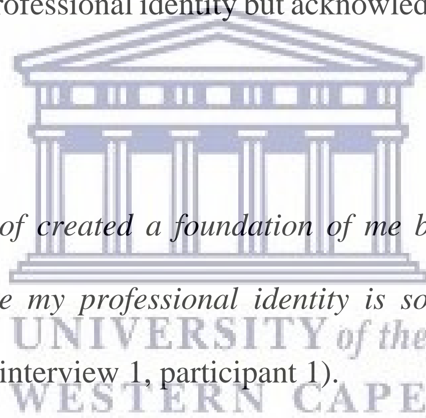
"And I think OT's are generally quite the caring nature, the giving nature and wanting to grow and develop people. I think that's a general theme for OTs"(interview 2, participant 1).

"I think the OT's are also like creative and are problem solvers, I think that's also important in whichever setting you're working in" (interview 2, participant 7).

4.3.2.2 Factors contributing to professional identity development

The first year of practice appeared to have been crucial towards the development of identity formation based on the responses of the participants. They acknowledged that this was particularly the case for their professional identity but acknowledged that this is still developing and will continue to do so: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"I think last year kind of created a foundation of me building my professional identity... I think for me my professional identity is something that is kind of continuously growing" (interview 1, participant 1).

Most participants spoke about factors that they perceived to have contributed to their growth and development in becoming an occupational therapist. The sense of accomplishment after a therapy session contributed to this and led to a sense of improved confidence within their roles as occupational therapists:

"That fulfilment you get out of seeing therapy actually work is what made me feel like an occupational therapist... I felt like okay this is my professional identity"(interview 2, participant 3).

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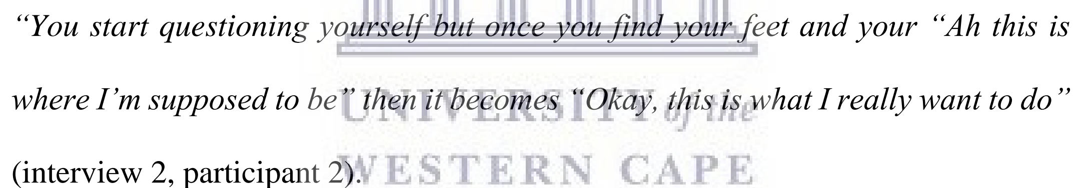
Most participants acknowledged their love for the professions and felt that being passionate and appreciating the value of the profession made them feel proud to be associated with occupational therapy as one of its members:

> *"Every time I reflect on the year I think about how I started appreciating OT in the sense of looking at a patient holistically and understanding their situation…I think that I found my professional identity in that I can pin point my value and I love OT because of that reason"*(interview 1, participant 5).

In this journey of becoming an occupational therapist, the participants expressed that finding the area your niche area that you take pleasure in is the most valuable as it fosters your identity as a professional.

> *"You start questioning yourself but once you find your feet and your "Ah this is where I'm supposed to be" then it becomes "Okay, this is what I really want to do"* (interview 2, participant 2).



4.3.3 Summary

In this chapter the study findings were presented as three themes. Theme 1, *stepping into the unknown*, described how the participants as young, novice therapists experienced their early entrance into the profession and the dissonance between their expectations and the realities they encountered in practice. Theme 2, *uncovering the occupational therapy culture*, described the participants' perceptions and experience of the values, attitudes upheld by its member's i.e. occupational therapy practitioners. In Theme 3, *becoming a professional,* how the participants developed their professional identity and gained independence as a professional was presented.

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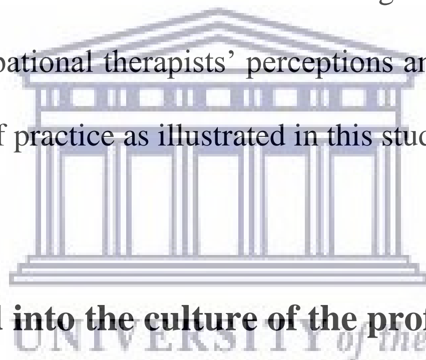
CHAPTER FIVE

DISCUSSION

5 Introduction

This chapter focuses on the discussion of the findings in relation to the study objectives while reflecting on the literature pertaining to professional socialisation. The discussion addresses how the participants experienced becoming a part of the culture of the profession and their professional development. The challenges they faced and factors that facilitated their professional socialisation are addressed. Bronfenbrenner's Ecological Systems Theory of Human Development and the PEO-Model assist in offering a synthesis and comprehensive understanding of novice occupational therapists' perceptions and experiences of professional socialisation in the first year of practice as illustrated in this study.



5.1 Becoming socialised into the culture of the profession

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Professional socialisation is described as the process of introduction into the culture of a profession (Naylor, 2007). Upon the journey of being a novice, as represented in the participants' perceptions and experiences that emerged from the findings, many discoveries were made regarding the professions culture i.e. values and norms. The participants have come to understand how the profession functions, observed how senior more experienced therapists practice and started to compare what they were taught during their education to the realities of what they experienced in practice. It is significant that they identified a dissonance between their practice and that of senior therapists and that this in some instances, resulted in feelings of animosity between themselves and their seniors. Hess-April et al (2016) also found this dissonance in her study with new graduates who were completing their community service

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year. The findings of the study highlighted that the participants thought that senior therapists do not always practice according to the fundamental principles and constructs of the profession. It could be argued that due to recent developments in the profession around occupational science, occupation-based practice, (Wilcock, 2006; Ward, Mitchell & Price, 2007), occupational justice (Townsend & Wilcock, 2004) and client-centered practice (Townsend, Polatajko, Craik & Davis 2007), therapists that have qualified a number of years ago may not yet have been updated on these developments and was therefore not on the same page as novices.

It could also be inferred that due to the dominant medical approach still influencing the culture of the profession, (Joubert, 2010) implementing occupation-based interventions could be challenging (Wilding, 2011; Galvin, Wilding & Whiteford, 2011), and has thus not quite influenced the professional identity of practitioners in the practice context. This concurs with a study conducted by Hess-April et al. (2016) who explored newly qualified Occupational therapy graduates' practice on occupational injustice in South Africa, where the participants who practiced in rural settings also explained how the medical model dominates. Likewise Naidoo et. al. (2017) in their study with community service graduates in primary health care settings found that medical dominance was a challenge for graduates.

It is acknowledged in literature that occupational therapy is a widely misunderstood profession and that this misconception of the profession often leads to role confusion particularly between occupational therapy practitioners and physiotherapists. (Smith, Roberts & Balmer, 2000; Hess-April, Smith & de Jongh, 2016). It is therefore not surprising that the participants of this study singled out dealing with role confusion as a key challenge in respect of their professional socialisation. Combined with a lack of occupational therapy awareness, a lack of assertiveness

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described by the participants as a failure of therapists to stand up for occupational therapy, and a constant need for advocacy, the participants questioned their sense of belonging to the profession while they simultaneously experienced a negative influence on their professional identity.

In the study conducted by Van Stormbroek and Buchanan (2016) the therapists also found that occupational therapy is poorly recognised as a profession and that their roles were poorly understood which caused role confusion and limited understanding and value of occupational therapy by the MDT. The participants found that there was a constant need for advocacy due to the poor awareness of occupational therapy. A study conducted with occupational therapists in a tertiary setting by Hess-April etal. (2017) highlighted how the therapists perceived themselves not only as therapists providing therapy but as advocates as well. This could indicate that advocating for the profession has become a part of the culture of the profession. According to Townsend, Polatajko, Craik and von Zweck (2011), to improve occupational therapy awareness, widespread leadership is needed by all practitioners. Leadership in this sense refers to occupational therapists actually practicing the core principles of the profession such as client centred practice and occupation-based practice.

Hess-April et. al. (2017) argue that 'constraints to occupation-based practice include occupational therapists' failure to use terminology that clearly defines what occupational therapists do' (p. 26). This indicates how therapists themselves play a role in the way in which the profession is portrayed and how they themselves have to consider if and how they are accountable to the values of the profession. Furthermore, when reflecting on the mindsets of experienced therapists and the way in which the profession is perceived, the participants questioned to what extent this can be changed as this challenge has been present in the

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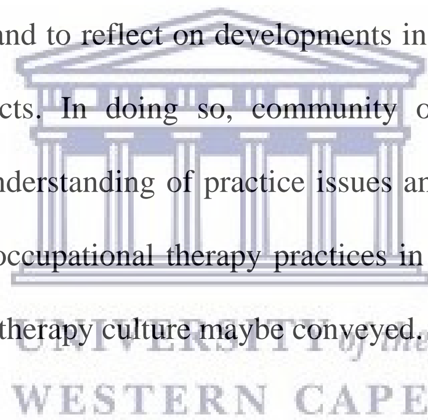
profession for so many years. Duncan (1999) states that as a ‘predominantly female and caring profession we have been disempowered by the hegemony inherent in the dominance of the medical model’ (p.46). She further argues that occupational therapy’s professional power lies in strengthening and articulating our canons of knowledge as these balance the reductionism of the medical worldview’ (p.46). Thus, if occupational therapy is so closely linked to the medical profession it may be required for efforts of transformation to be intensified particularly when novices are at risk of falling into the same patterns of complacence with the state of the occupational therapy profession that has been around for years.

Occupational therapists should consider forming and joining communities of practice (Wenger, 1998) to explore this notion, and to reflect on developments in the profession around related occupational science constructs. In doing so, community of practice groups can build relationships, develop their understanding of practice issues and together implement actions towards developing relevant occupational therapy practices in South Africa. Hence, a more positive, unified occupational therapy culture maybe conveyed.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Developing a sense of belonging and a positive professional identity are both fundamental dimensions within a successful process of professional socialisation (Adams, Hean, Sturgis & Macleod Clark, 2006; MacLellan, 2011; Melrose & Perry, 2015). Based on the findings, the quality and measure of success with regards to the participants’ entry into their professional career is however questionable. The findings revealed how hegemonic practices and power dynamics between therapists impacts occupational therapy culture. Most of the participants have come to observe and perceive insecurities within themselves that include not feeling valued or a part of a team, leading them to question to what extent the professional culture resembles a family which in itself could be regarded as a metaphor for unity within the

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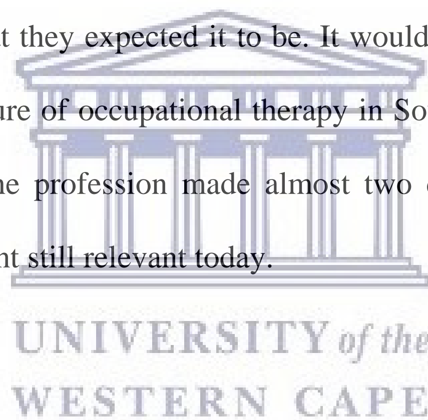
profession. Some of the participants related how they felt oppressed as novices. This had an impact on their professional development and capabilities, in turn minimising their learning, while some were resistant in identifying themselves with the reality of the culture they discovered.

Socialisation into a profession is a process of integration during which the values, the norms of behaviour and the symbols of the profession i.e. its culture, is internalised (Dimitriadou et al., 2013).However, when it comes to hegemonic practices, it can be argued that the true culture the participants hoped to claim and uphold by nature of who they are as occupational therapists, could not be embodied by them in relation to the professional values, norms and standards they encountered compared to what they expected it to be. It would furthermore appear that calls for transformation of the culture of occupational therapy in South Africa consistent with the fundamental philosophy of the profession made almost two decades ago, (Duncan, 1999, Joubert, 2010) is to some extent still relevant today.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5.2 Professional Development

Learning that occur during the early years of practice is a vital part of the growth and professional development of novice practitioners (Tryssenaar & Perkins, 2001; Black et al., 2010). This refers to professional socialisation as an outcome, that entails the formation of specific competencies with the requisite knowledge and responsibilities that is required as a member of a profession (Lai et al., 2012). The findings show that this was not any different for the participants of this study as they were willing to apply all the knowledge they acquired during their years of education but also expected to gain new skills in order to develop their practice. It was also evident that the participants directly linked their clinical experience to the influence it had on their professional development. This concurs with McKenna and Green's

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(2004) view as well as that of Hussein, Everett, Ramjan, Hu &Salamonson, (2017) who state that in terms of professional development, new graduates mostly focus on clinical knowledge and skills during their first year of practice. This could perhaps explain why there was little to no reference made to occupational justice and the socio-political aspects of practice by the participants. However, despite their readiness to apply their knowledge and skills together with the hope of furthering their professional development, the participants in this study complained of a lack of clinical exposure and poor learning experiences to the extent that they felt that their existing clinical skills were underutilised or not expanded at all. According to Robertson and Griffiths (2009) supervision is crucial in the early stages of professional development to close the gap between theory and practice even though new graduates are able to take some accountability for their own professional development. This was however not the case for the participants of this study as, due to being restricted in their practice settings, poor learning environments, and lack of supervision and support, some regarded their first year as not very constructive for their professional development.

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In the studies conducted by Van Stormbroek and Buchanan (2016), Naidoo et al.(2017) and Hess-April et.al, (2016) on the practice of new graduates' first year of practice in South Africa, the researchers found challenges like not being able to work in a team and a lack of physical and human resources, impacted the novice therapists' professional development. They also found that novice occupational therapists were not always aware of the realities and complexities that the South African practice context present, while novice nurses were found to lack sufficient clinical skills and unable to cope with heavy workloads (Sonmez &Yildirium, 2015).On the contrary, a study done by Naylor (2007) highlighted that an environment that closely resembles undergraduate student clinical placements, positively contributed to novice physiotherapists' professional development and socialisation. This raises the question of the

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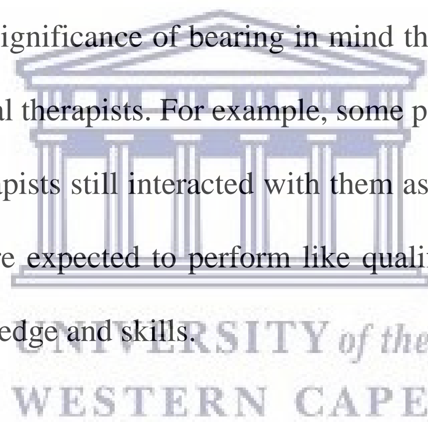
relevance of health professions education and in particular, occupational therapy education in South Africa, and the extent to which it facilitates students' exposure to fieldwork placements similar to those they would be exposed to during their first year of practice.

It is however encouraging to note that many of the participants in this study entered their first year of practice with an open mind as they considered it the best way to start this journey. Yet, they were deeply disappointed with the dissonance they encountered between what they expected in terms of their professional development and the realities of their respective practice settings of the profession. The professional challenges the participants faced further influenced their growth in becoming a confident therapist and negatively impacted their motivation. Sutton and Griffin (2000) stress the significance of bearing in mind the met and unmet expectations in newly qualified occupational therapists. For example, some participants found that initially, many of the experienced therapists still interacted with them as if they were students and not as professionals, yet they were expected to perform like qualified therapists i.e. being fully competent in respect of knowledge and skills.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As suggested by Wright (2001) the participants expected to learn, grow, and develop their skills while getting a sense of confidence in their role, and having access to role models and supervision similar to when they were students. This concurs with literature that emphasise the formal recognition of, and support for, the mentoring of new graduates by supervisors and experienced clinicians (Tryssenaar, 1999; Australia, Hummell & Koelmeyer, 1999; Sweeney, Webley & Treacher, 2001; Van Stormbroek et al., 2016) as it is believed that how well practitioners settle into their role is largely dependent on how supported they feel (Kasar&Muscari, 2000; Blackman, Miller, Steadman, Eraut, Maillarde & Ali, 2003).Nonetheless, all of the participants reported a lack of supervision or in some cases, being

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supervised by other health professionals like medical doctors, leaving them frustrated and feeling isolated. These findings make it imperative for the Occupational therapy Association of South Africa (OTASA) to renew efforts for the formalisation of mentoring systems for new graduates as this would contribute to mitigating the risk of attrition which often results from novices' sense of dissatisfaction experienced during the early years of practice (Black et al., 2010; Goodare, 2010; MacLellan, 2011)

5.3 Professional identity development

The findings highlighted significant issues related to the participants' perceptions of themselves as a professional within the work place, which is also referred to as their sense of professional identity (Ryynänen, 2001). It emerged from the findings that the participants experienced a sense of self-doubt which lead to them being in a position of fight versus flight at times as they questioned who they really were as professionals and allowed themselves to be influenced on the basis of others' definitions of the profession. Most participants shared how they were not valued as a member of the MDT that led them to feel a lack of appreciation and recognition, while some became despondent with having to constantly advocate from the profession and yet others started thinking about leaving the profession altogether. Furthermore, due to the lack of support and supervision they received, the participants started to feel unsure and doubted their capabilities. These issues concur with Blackman et al.'s (2003) assertion that a lack of feedback triggers feelings of self-doubt in novices and negatively influence their professional identity.

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In the study conducted by Van Stormbroek and Buchanan (2016), community service occupational therapists who reported a sense of pride were more likely to have a strong identity as an occupational therapist. The participants in this current study explained how they were

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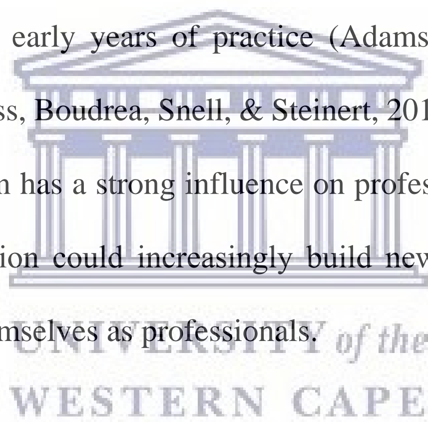
easily influenced by how other healthcare professionals within their respective teams including experienced occupational therapists, treated them. This negatively shaped their views of themselves as professionals. When comparing the two studies, the participants in this current study placed more value on how others perceived them which in turn affected how they perceived themselves compared to the participants in Van Stormbroek and Buchanan's study. However, in Van Stormbroek and Buchanan's study, the participants already had established a sense of value of themselves as occupational therapists evident in their positive professional identity, despite being novices in their first year and despite experiencing similar challenges as the participants in the current study. The literature makes it clear that professional identity is a component of professional socialisation and that the professional socialisation process starts as a student continuing into the early years of practice (Adams et al., 2006;Trede, Macklin &Bridges, 2012; Cruess, Cruess, Boudrea, Snell, & Steinert, 2015). It can thus be inferred that occupational therapy education has a strong influence on professional identity. This warrants considerations of how education could increasingly build new graduates' competencies in managing others' views of themselves as professionals.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As discussed earlier, role confusion was a key challenge the participants encountered that also influenced their sense of professional identity. Interdisciplinary teamwork is a core competency of rehabilitation professionals, but as working within a team develops professional autonomy decreases and professional boundaries may become blurred (Naylor, 2007). The participants however found that working within a team led professional boundaries to become totally unclear and it appears that there was a quest for role security and an appreciation of what each profession has to offer towards clients' rehabilitation protocols. Booth and Hewison (2001) explain that role overlap was regarded as a challenge to professional security for the occupational therapists and physiotherapists they interviewed to explore this phenomenon, and

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that the main strategy used to overcome role confusion was an emphasis on the professional uniqueness through role demarcation. In the current study the challenge of role overlap was reflected in some participants' responses to the issue of role confusion. They believed that a good response to overcoming their feelings of professional insecurities would be to assert themselves professionally, stand up for occupational therapy, and advocate for their unique role. This way of thinking nonetheless did not take away how insecure as a professional they felt and there was little evidence that their thinking manifested into actual actions. What could have contributed to this is the absence of role models that they could observe to guide them in their response to the challenge of role confusion. It is regarded as important for recent graduates to have someone to look up to and imitate as role models (Lencuchaet al., 2007). Notwithstanding a lack of role models, the participants' demonstrated passion for the profession evident in the instances where they asserted themselves as occupational therapists and showed commitment to engaging in continued advocacy for the profession.

The participants' professional identity formation and development can be understood according to three stages of Kegan's (1982) framework for the development namely 1) imperial, 2) interpersonal and 3) institutional. During stage one, imperial, which can also be seen as the transition phase going from student to professional, the participants adopted their professional role as they entered the profession however this was not an easy transition. Due to the transitioning from student to profession being challenging in terms of facing the realities of every day practice, the participants struggled to adopt an identity as a qualified occupational therapist. It was only during stage two, interpersonal, where the participants began to really identify with the profession in terms of having a better understanding of what their role was. During this stage, the participants also started to become aware of the culture of the profession as perceived and experienced by them as they became more conscious of broader professional

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issues and how it affected them. During stage three, institutional, the participants noticed conflicts within their working environments which they did not necessarily agree with. Some participants took a stand, advocated for what they thought was right, and tried to challenge issues from an occupational perspective, as described in their own words, it was about having to *"sink or swim"*.

5.4 Barriers to professional socialisation

During the process of entering the profession, the participants experienced unexpected encounters which they were not necessarily prepared for and which made becoming a part of the profession challenging. It has been recognised that the shift from student to newly qualified practitioner is a difficult process and that 'the first year of practice is a transforming year for new graduates and there is a growing recognition that this transition is complex and takes time' (Morley, 2006 p.231).Based on many of the responses from the participants, it was clear that occupational therapy is not an easy profession to adapt to and become a part of, as they felt as if they were not necessarily equipped for everything they experienced.

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The participants explained that in their transition process they have come to learn what the realities of the occupational therapy profession are. They reflected on the transition process as a daunting one. Tryssenaar and Perkins (2001) assert that having mentors may be of benefit to assist newly qualified professionals through the transition period. Similarly, Zinsmeister (2009) a study with novice nurses in the United States of America showed that a supportive environment contributed positively to the transition into their professional roles. More recently, based on a study done on novice nursing graduates in Australia, Hussein et al. (2017)explains how these participants who reported receiving support and a formal orientation were able to 'find their feet' (p.9). Hussein et al. (2017) add that this is important to note as the staff working

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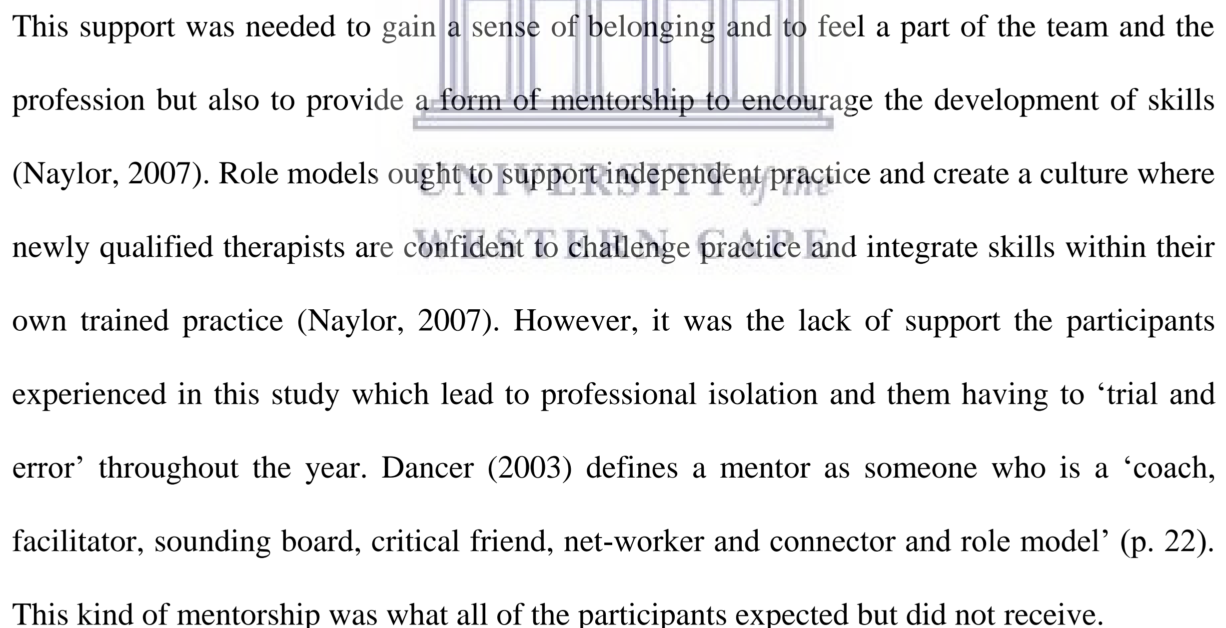
with newly qualified nursing professionals need to 'understand their clinical capabilities and not have unrealistic expectations' (p. 31).

One of the expectations the participants had prior to entering the profession was that they would initially receive guidance and supervision merely to learn from experienced therapists. This guidance would also facilitate the transitioning process of their entrance into the profession. However, one of the main barriers that stood out for the participants was the fact that they did not feel well supported within their working environments. The participants found that the lack of support, supervision and mentorship from colleagues in the MDT and especially from senior occupational therapists, influenced their confidence in practice. The support they needed as a platform for shared learning, growth and development was not present.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This support was needed to gain a sense of belonging and to feel a part of the team and the profession but also to provide a form of mentorship to encourage the development of skills (Naylor, 2007). Role models ought to support independent practice and create a culture where newly qualified therapists are confident to challenge practice and integrate skills within their own trained practice (Naylor, 2007). However, it was the lack of support the participants experienced in this study which lead to professional isolation and them having to 'trial and error' throughout the year. Dancer (2003) defines a mentor as someone who is a 'coach, facilitator, sounding board, critical friend, net-worker and connector and role model' (p. 22). This kind of mentorship was what all of the participants expected but did not receive.

Dinmohammadi, Peyrovi and Mehrdad (2013) argue that in order for individuals to be successfully socialized into their profession, measures such as the provision of comprehensive educational programmes, competent role models, supportive educational and clinical

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structures, opportunities for experience, and constructive feedback are determining factors of success of this process. However, as illustrated in this discussion, these are all factors that were highlighted by the participants of this study as barriers to their professional socialisation. It has been noted that novice practitioners who are not appropriately supported in their professional socialisation process may be less satisfied, perform poorly and leave their respective professions (Black et al., 2010; Goodare, 2010). Therefore, these findings raise concerns about its implications for the growth of the profession in South Africa where there is already a shortage of occupational therapists thus compromising the profession's ability to adequately respond to the populations' health and well-being needs around occupational engagement.

5.5 Facilitators of professional socialisation

The community service occupational therapists that participated in Van Stormbroek and Buchanan's (2016) study experienced a sense of satisfaction from interacting with their patients despite all the challenges experienced and indicated a pride in the profession as it was making a difference in patient's lives' (p. 67). This shows that there are certain personal characteristics associated with being an occupational therapist that appears to contribute to the resilience that some occupational therapists show in in the face of the practice challenges they encounter. The link between personal characteristics and being and occupational therapists was also illustrated in this current study where the participants identified qualities like being passionate and believing in the profession's value; having confidence and a sense of self-determination; having a creative and caring nature; and gaining independence in their own niche areas gradually enhanced their process of professional socialisation. By drawing on these qualities, they witnessed successful practice outcomes, engaged in team work and experienced some sense of belonging to a group of people who share similar values and norms and thus felt like a valuable member of the team despite being novices.

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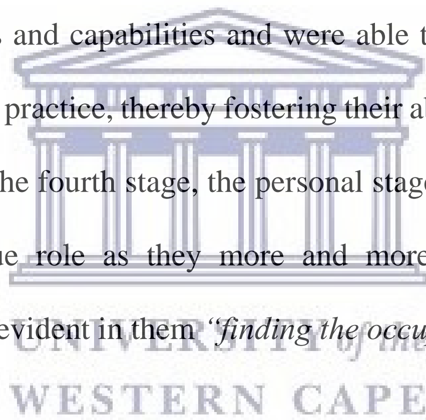
The four stages of professional socialisation as outlined by Weidman, Twale and Stein (2001) is helpful in understanding how these factors facilitated the process as experienced by the participants. In the first i.e. the anticipatory stage, the participants demonstrated passion for and a belief in the value of the profession and were open to learn the role expectations and procedures to be followed in their respective practice settings. In the second, i.e. the formal stage, the participants after initially being rather idealistic, started getting used to their settings and their related role expectations on a clinical level. It was only during stage three, the informal stage, where the participants gradually started to find their feet in terms of what was expected from them and their role. It was during this stage that they slowly started to affirm their unique personal qualities and capabilities and were able to persevere as they started to acknowledge the value of their practice, thereby fostering their ability to stand firm in their role as occupational therapists. In the fourth stage, the personal stage, the participants reflected on and self-affirmed their unique role as they more and more internalised what being an occupational therapist means, evident in them *"finding the occupational therapist within"*.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5.6 The Professional socialisation process: transitioning from student to professional in the first year of practice

Bronfenbrenner's Ecological Systems Theory of Human Development (Bronfenbrenner, 2005) will be used to synthesise the way in which the participants transitioned from student to professional in their first year of practice.

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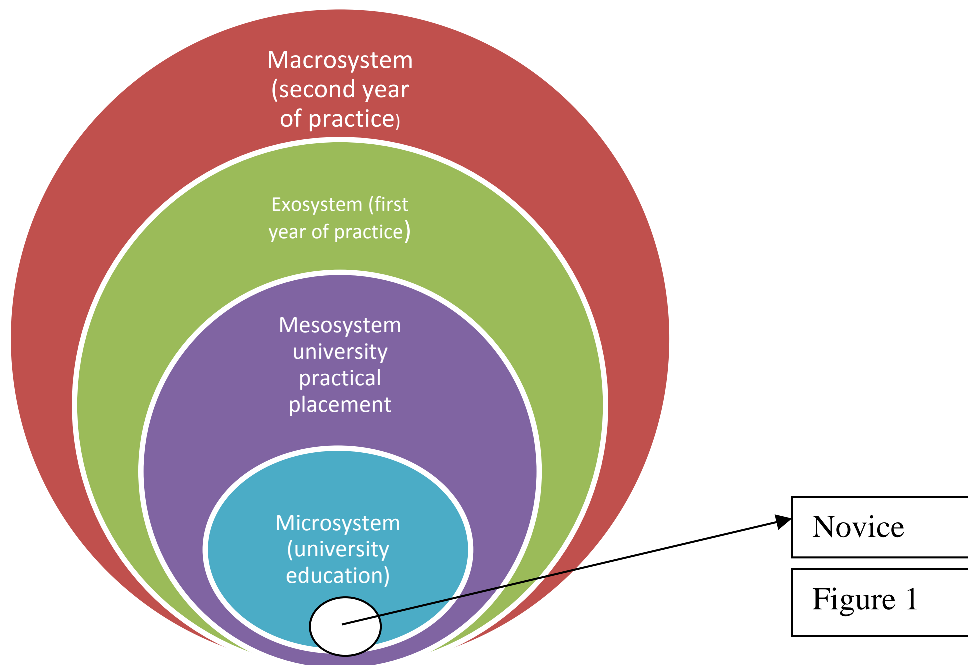
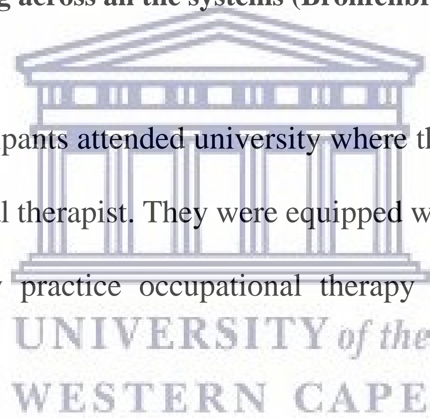


Figure 1: The novice developing across all the systems (Bronfenbrenner, 2005).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In the microsystem, the participants attended university where they were shaped and moulded into becoming an Occupational therapist. They were equipped with the values, knowledge and skills needed to competently practice occupational therapy as a student and later as a professional.

As the mesosystem has a direct relationship with the microsystem it can still be seen as part of the participants' undergraduate journey. As part of the undergraduate programme, the participants engaged in practical experiences simulating work environments in preparation for when they enter the profession. Within these practical experiences, the participants were provided with clinical and theoretical supervision and guidance from occupational therapists at their placement and from the university. The participants began to get a sense of what the profession will be like once they graduate even though they were still being supervised. Being within a clinical environment supported by professionals and gaining experience in working with clients/patients shaped the participants' ideas of the profession. For many of the

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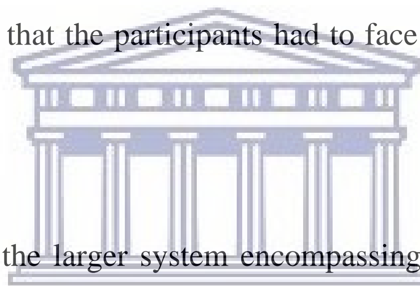
participants, this system provided a sense of comfort as they had access to learning opportunities, support and guidance.

In the exosystem, the participants engaged in the profession on a larger scale compared to when they were students at university. After the successful completion of their studies, the participants began the journey of being a novice therapist. During their community service year or their first year of practice, they were novice professionals and were expected to apply everything that was taught to them in the micro and macro systems. During the exosystem, the process of socialisation intensified as it was the first time the participants started to merge with the profession and truly began to understand what it is like to become a part of the profession. It was also during this system that the participants had to face unexpected challenges within their first year of practice.



The macrosystem focuses on the larger system encompassing factors on a broader societal level. When considering the broader environment the participants needed to interact with, it can be seen as working in broader practice context in South Africa. This system would influence occupational therapy practice around addressing occupational injustices and practicing as agents of social change. The focus being the first year of practice, there was no evidence of this reflected in this study but it can be assumed that it would probably reflect in the second year of practice when they no longer require supervision and receive the title of independent practitioner from the HPCSA.

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The last system is the chronosystem which does not focus on the journey of the novice within their first year of practice.

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5.7 The Professional socialisation process: person-environment-occupation interaction.

The Person-Environment-Occupation Model (Law e.g. al. 1996) offers a useful lens to better understand the person-environment-occupation interaction as it occurred within the process of professional socialisation for the participants as illustrated in Figure 2:

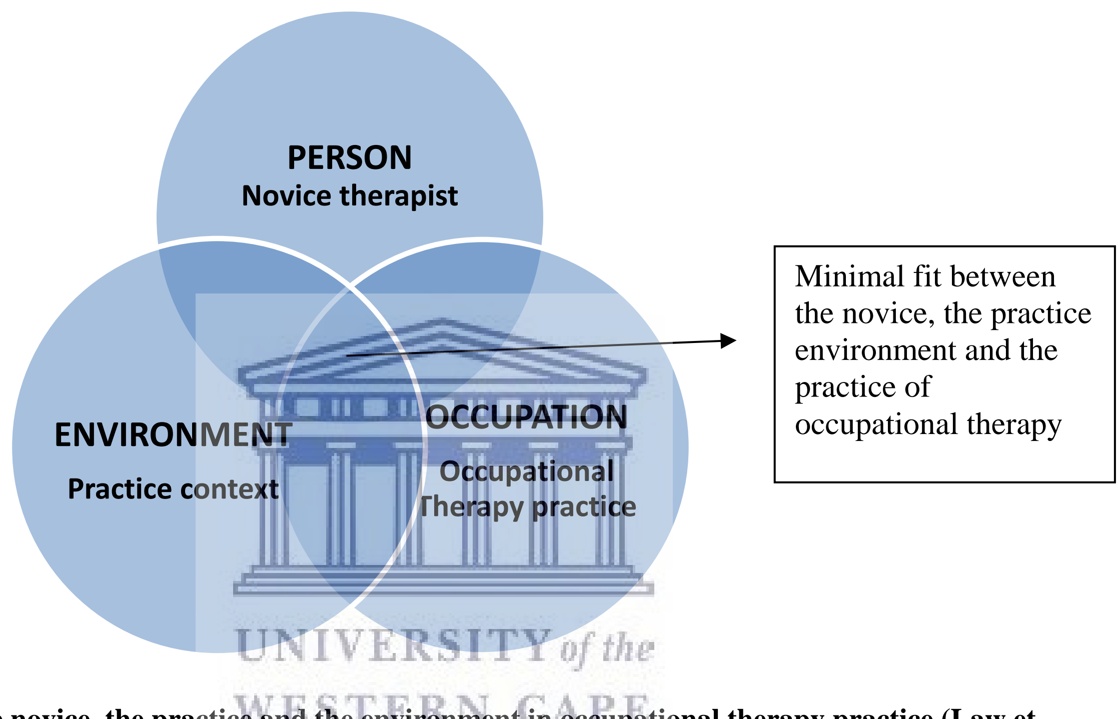

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Figure 2: The novice, the practice and the environment in occupational therapy practice (Law et al, 1996; Strong et al, 1999).

5.7.1 Person (P) – Novice occupational therapist

The participants exited university ready to enter the working world equipped with the necessary knowledge and skills needed to excel within practice. They displayed feelings of excitement and shared their expectations for the year. However, upon entering into the profession, they encountered unexpected challenges and had to face the realities of practice. Many of these challenges were not necessarily what the participants were prepared for thus leading them to feel isolated, strained and internally challenged their view of themselves and doubting their capabilities.

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5.7.2 Environment (E) – practice /context

Whilst engaging within their work environment, including interacting with experienced therapists, they became aware of the culture of the profession. The participants found that the practice context did not reflect the true essence of occupational therapy which led the participants to question what the culture of occupational therapy really is. They longed for a mentor or role model; however their settings did not provide them with that opportunity. The few participants who were fortunate to receive a mentor found that having someone to engage with contributed to their growth and development in becoming an independent practitioner.

5.7.3 Occupation (O) – occupational therapy practice

Many of the participants found engaging in their occupation i.e. their clinical practice, contributed to their professional identity. As the year progressed, the participants came to the realisation that it was more their support structures or lack thereof that was hindering their professional growth and development. This hindrance affected them to the extent that what they felt prior to entering the profession was no longer present. The influence of their environment more so than their occupation, impacted their occupational performance.

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5.7.4 Minimal fit between novice (P), practice context (E) and practice (O)

It is evident that when the participant entered the practice context i.e. their environment and begins to engage in practice (the occupation), there is major interaction between the environment and the novice participants' practice (environment and occupation). The participants struggle to adjust to their practice settings and the culture of the profession. It appears as if the practice setting and profession does not make room for the participant to fit despite the participant being ready for it. It appears that this transaction between the setting and

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the profession largely influences each other and the participants are forced to adjust their practice. In relation to professional socialisation the process of the participant becoming successfully socialised in terms of practice values, norms and standards can be viewed as optimal occupational performance. However, in the case of the participants in this study, there is minimal fit between the P-E-O components as illustrated in the imbalance caused by the environment that does not accommodate the participants or their needs. Consequently, their practicing as novices requires major adjustments from them leaving them dissatisfied and despondent.

5.8 Conclusion

The findings of this study highlighted newly qualified Occupational therapists practice experiences in their first year of practice. These experiences informed the generation of an understanding of the process of professional socialisation inclusive of how their professional identity and development was shaped during this period of transitioning. The analysis of this process of becoming socialized into the profession indicates that the participants experienced barriers which hindered the process but simultaneously also experienced facilitators that assisted in their growth and development in becoming an occupational therapist.

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CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6 Conclusion

The aim of this study was to explore and describe novice occupational therapists' perceptions and experiences of professional socialisation in their first year of practice in South Africa. Three themes emerged from the findings of this study 1) stepping into the unknown, 2) uncovering the occupational therapy culture and 3) becoming a professional. The findings of this study illustrate how the journey of the novice was shaped in their first year. On this journey the participants encountered barriers which hindered their professional development, as well as facilitators that fostered their professional socialisation process.

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From the participant's perspective, the Occupational therapy profession is not an easy profession to become a part of despite being well prepared for it. The participants found that there is still a lack of awareness of occupational therapy influencing the multidisciplinary team approach. This has resulted in a lack of occupational therapy recognition, appreciation and constant role confusion leading occupational therapists to feel insecure in their role and having to constantly advocate for the profession.

Due to being restricted in their practice settings, poor learning environments, and lack of supervision and support, some participants regarded their first year as not very constructive for their professional development. Combined with a failure of therapists to assert themselves and stand up for occupational therapy, and a constant need for advocacy, the participants questioned there sense of belonging in the profession while they simultaneously experienced a negative

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influence on their professional identity. The participants however identified qualities like being passionate and believing in the profession's value; having confidence and a sense of self-determination; having a creative and caring nature; and gaining independence in their own niche areas as factors that facilitated their professional socialisation. In conclusion, it emerged that hegemonic practices and power dynamics between therapists impact occupational therapy culture, implying that calls for transformation of the culture of occupational therapy in South Africa made almost two decades ago are still relevant today.

6.1 Recommendations

The findings of this study are beneficial to the development of actions to support the professional socialisation of novice therapists as they transition from student to practitioner in the South African context. In relation to this, recommendations are made in respect of the following:

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6.1.1 Occupational therapy education

It is recommended that the key issues raised by this study should be highlighted at university, as part of the undergraduate occupational therapy programme. University staff involved in the education and practice development of occupational therapy students should be made aware of the critical issues related to occupational therapy practice and consider how it may differ to what is being taught and how to equip students to better understand and respond to it.

The OTASA education committee should engage with universities regarding considerations of how curricula could increasingly prepare new graduates for the realities of practice in South Africa as well as build new graduates' competencies in managing others' views of themselves as professionals.

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6.1.2 Continued professional development

Occupational therapists should consider forming and joining communities of practice to develop their understanding of developments in the profession around new theoretical constructs and practice approaches, and together develop and implement actions towards developing relevant occupational therapy practice in South Africa.

6.1.3 Support for novice occupational therapists

One of the main issues addressed in this study was the importance of having a mentor, role model or supervisor to provide ethical, moral, clinical and emotional support during the first year of practice. This study should be disseminated to the Occupational therapy association of South Africa (OTASA) to advocate for renewed efforts for the formalisation of supervision and mentoring systems for new graduates during their community service year.

Experienced clinical Occupational therapists working in all settings in the public healthcare system in South Africa have to be made aware of the findings of this study. It is recommended that OTASA offer workshops for senior, experienced therapists to develop mentoring skills, to raise awareness of their role in assisting novice therapists in the process of professional socialisation, and to facilitate their understanding of how influential their role is in this process.

It is also recommended that communities of practice specifically for novice Occupational therapists be implemented to share experiences, build relationships and assist in any clinical queries and problem solving. Creating this kind of supportive platform on social media would be beneficial to novice therapists in their first year of practice.

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6.1.4 Transformation in the profession

OTASA should be made aware of the challenges novice therapists face with regards to professional socialisation. OTASA should renew efforts around transformation in the profession particularly to address power dynamics between therapists. Structures whereby hegemonic practices that occur in practice settings could be addressed in a safe and transparent matter needs to be established. A task team to investigate issues related to the transformation of the culture of the profession in respect of power dynamics between senior therapists and novice therapists should be implemented. The Focus, OTASA's newsletter should create a platform for novices to share their first year practice experiences more broadly to raise awareness regarding transformation issues affecting novice-senior therapist dynamics.

6.1.5 Future research

This study provided insight into how novice therapists experience Occupational therapists who have been in the field for many years. However, it would be of benefit to understand how experienced therapists find the development of the profession and how much it has transformed compared to when they graduated. This may shed some light into why experienced therapists practice opposing to the expectations of newly qualified Occupational therapists.

All the participants in this study graduated from one of the three universities in the Western Cape. It would be of benefit to explore the way in which newly qualified therapists from all universities in South Africa experience the culture of the profession.

It is also recommended that future research explore the perceptions and experiences regarding professional socialisation from the respective managers and colleagues in the participants respective practice settings.

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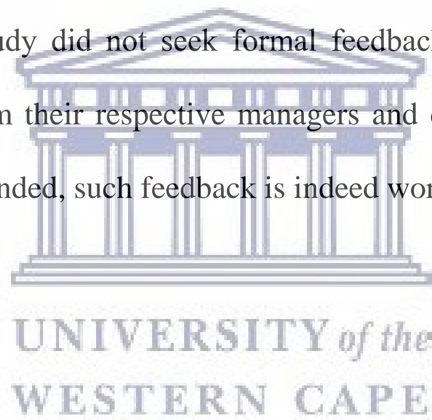
6.1.6 Limitations of the Study

During the data collection phase of the study, it was difficult to locate participants from KwaZula-Natal and Limpopo province who were practicing in the Western Cape during 2017 thus, this study only represent the perspectives of participants for seven provinces out of the nine in South Africa.

During the last phase of the data collection process, not all the participants were available to meet at the same time for the dyad interview. The purpose of the dyad interview was to share the key findings of the study and to gain the participants opinions around it.

It is a limitation that this study did not seek formal feedback related to the participants' professional socialisation from their respective managers and colleagues in their respective practice settings. As recommended, such feedback is indeed worthy of future research.



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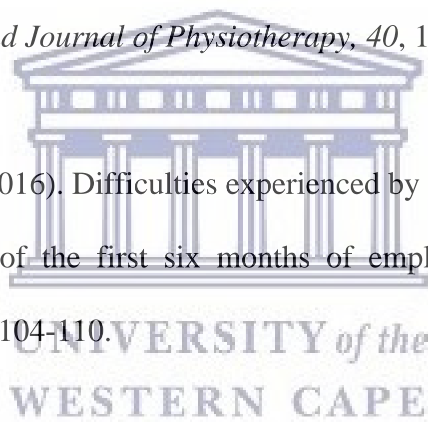
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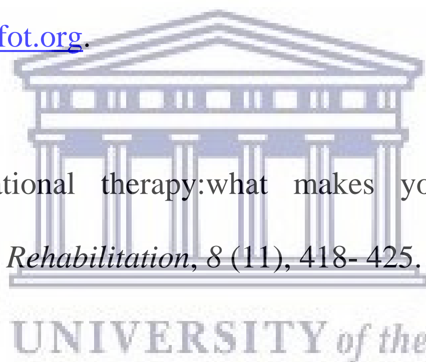
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Appendix 1: Initial interview guide

INTERVIEW GUIDE 1

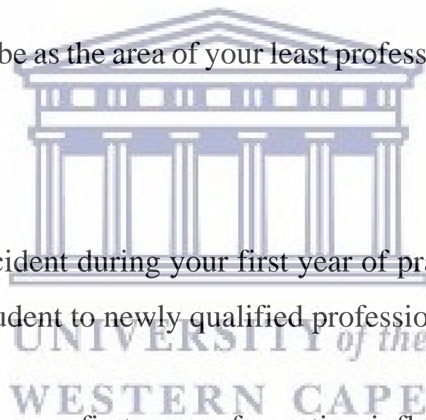
Initial Interview

1. Could you please explain the practice setting where you practiced in your first year?

2. How do you feel about your professional development over the first year?

3. What would you describe as the area of your greatest professional growth and development the first year?

4. What would you describe as the area of your least professional growth and development in your first year?



5. Please describe any incident during your first year of practice that you feel influenced your transition from student to newly qualified professional.

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6. Which experiences in your first year of practice influenced the formation of your professional identity? Please explain.

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Appendix 2: Follow up interview guide

INTERVIEW GUIDE 2

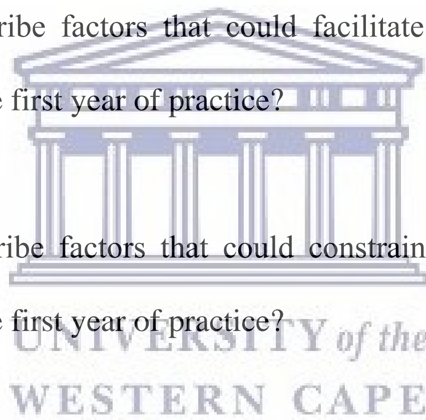
Follow-up interview

1. How would you describe the culture of the occupational therapy profession?

2. Do you perceive yourself to be part of that culture after your first year of practice? Please explain.

3. How would you describe factors that could facilitate new graduates' professional socialisation during the first year of practice?

4. How would you describe factors that could constrain new graduates' professional socialisation during the first year of practice?



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Appendix 3: Dyad interview discussion guide

DYAD INTERVIEW GUIDE

After presenting the findings to the participants ask the following;

1. How do you perceive the analysis of the findings of the study?
2. Do you agree or disagree with the findings of the study?
3. Is there anything you would like to add in addition to the findings?
4. What can you recommend for the profession going forward based on the findings?
5. What would you recommend for novices going into their first year of practice?

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Appendix 4: Ethics letter

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14 February 2017

Ms T Philander
Occupational Therapy
Faculty of Community and Health Science

Ethics Reference Number: HS17/1/33

Project Title: Novice occupational therapists' perceptions and experiences of professional socialization in the first year of practice in South Africa.

Approval Period: 03 February 2017 – 03 February 2018

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

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Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER - 130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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Appendix 5: Information sheet

UNIVERSITY OF THE WESTERN CAPE

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INFORMATION SHEET

Project Title:

Novice occupational therapists' perceptions and experiences of professional socialisation in the first year of practice in South Africa.

What is this study about?

This is a research project being conducted by Tamlyn Philander at the University of the Western Cape. You are invited to participate in this research project because you are a newly qualified or novice Occupational Therapist who has completed the first year of practice in one of the Provinces in South Africa and now working in the Western Cape.The purpose of this research project is to explore and describe novice occupational therapists' perceptions and experiences regarding professional socialisation during the first year of practice.

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What will I be asked to do if I agree to participate?

You will be asked to join the researcher for an initial semi structured interview, a follow up interview and a dyad interview. The interviews and group will be at a central, convenient location for all participants. The *initial interview* will focus on the participants' professional development and identity formation. The *follow-up interview* will focus on the culture of the occupational therapy profession as well as facilitators and barriers to professional socialisation as perceived and experienced by the participants. Additionally, any issues that the researcher identified for further exploration after the initial interview, will be explored. Each interview and group will be recorded through audiotapes and later transcribed verbatim. Each interview will be 45 minutes to one hour long.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, the study will not contain any information that may personally identify you. To ensure your confidentiality, pseudonyms will be used, transcripts will be password protected in a folder on a password protected computer and later discarded after 2 years. If a report or article is written about this research project, your identity will be protected. This study will use dyad interviews therefore the extent to which your identity will remain confidential is dependent on participants' in the Dyad interview maintaining confidentiality.

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What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. Such risks will nevertheless be minimised and you will be promptly to assisted if you experience any discomfort during the process of your participation in this study.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the occupational therapy profession and the professional development of novice occupational therapists such as yourself. In the future, other people might benefit from this study through improved understanding of the professional socialisation and identity development of novice occupational therapy graduates in South Africa.

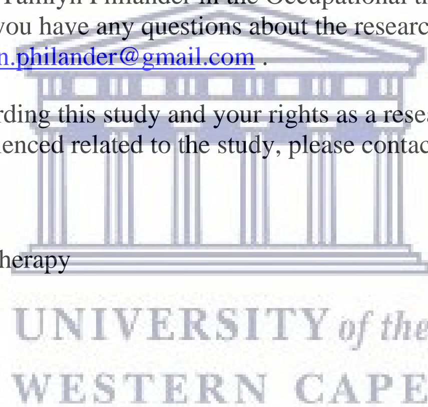
Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Tamlyn Philander in the Occupational therapy Department at the University of the Western Cape. If you have any questions about the research study itself, please contact Tamlyn on 0722789015 or on tamlyn.philander@gmail.com .

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: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OR

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chs-deansoffice@uwc.ac.za This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

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Appendix 6: Consent form

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E-mail: tamlyn.philander@gmail.com

CONSENT FORM

Title of Research Project:

Novice occupational therapists' perceptions and experiences of professional socialisation in the first year of practice in South Africa.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name………………………..

Participant's signature……………………………….

Date………………………

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Appendix 7: Dyad interview Confidentiality Binding Form

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DYAD INTERVIEW CONFIDENTIALITY BINDING FORM

Title of Research Project:

Novice occupational therapists' perceptions and experiences of professional socialisation in the first year of practice in South Africa.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Dyad interview maintaining confidentiality.

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I hereby agree to uphold the confidentiality of the discussions in the dyad interview by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……………………………………….

Participant's signature…………………………………..

Date………………………

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