On becoming a confident occupational therapist

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Dated 27 March 2013

DECLARATION

I, Kathlyn Elena Holland declare that

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SIGNED: Kathlyn Elena Holland (nee Cleland)

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ABSTRACT

This thesis presents and discusses the results of research undertaken to explore the concept 'professional confidence'. The term 'confidence', is frequently to be found in previous research, yet this has not adequately been defined. The conceptions held by occupational therapists were not clear, and the events or circumstances that fostered professional confidence in occupational therapists have not been identified. Each of these aspects was identified as an area for research in the profession.

Three studies were undertaken to gain greater insights and to add to the body of knowledge in terms of our understanding of 'professional confidence'. The studies included a concept analysis of the concept of 'professional confidence', a phenomenographic study of the conceptions of professional confidence that novice occupational therapists hold and finally, the sources or determinants of professional confidence beliefs in occupational therapy students were explored using an interpretative methodology.

The research undertaken yielded antecedents and attributes or characteristics of professional confidence, and from these a definition was crafted. The conceptions or understanding of professional confidence held by the community service therapists, namely knowing, believing and being, were closely related to the attributes raised in the concept analysis, confirming the findings of the analysis. Final year occupational therapy students highlighted a number of determinants of professional confidence, including events, situations and circumstances within their control, the control of their clinical supervisors and/or the profession. These sources in turn had been confirmed as antecedents in the concept analysis.

The research confirmed that professional identity, competence and professional confidence are inter-related and inter-dependent phenomena. Professional confidence involves a dynamic, maturing self-belief closely related to, and informed by both professional identity and competence. As such, equal attention should be given during the educational endeavour and initial employment opportunities, to the fostering of both professional identity and professional confidence while enhancing competencies. The recommendations provided within the research provide a rich source of information from which further research can be undertaken and interventions developed to assist students and novice practitioners to enhance their professional confidence.

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CHAPTER 1: INTRODUCTION

Occupational therapy has been described as a socially responsive profession and in this respect, the possibility of 'making a difference' in the lives of others is central to the practice of occupational therapy. "As a profession, we know that we can be hugely beneficial to many individuals, groups/communities and society as a whole" (Withers & Shann, 2008, p. 122). Duncan and Alsop (2006) argued that occupational therapists' resilience, effectiveness, commitment and efficacy were important factors to making a difference in their work. Within the South African context, Duncan, Buchanan and Lorenzo (2005) asserted that for occupational therapy practice to be responsive to the changing health-care landscape, occupational therapy students and practitioners required, among other things, a robust sense of agency and professional identity and needed to be emotionally resilient and confident of their skills.

CHALLENGES FACING OCCUPATIONAL THERAPISTS

From the literature, it was evident that occupational therapists globally as well as in South Africa, faced any number of challenges that required a sound professional identity, competence and confidence. These challenges relate to, among other things, society in transition (Mackey, 2007), the changing nature of practice (Higgs & Titchen, 2001), a tension between the beliefs held by the profession and the evolving culture of health care (Méthot, 2004), and the diffident nature of occupational therapists (Watson, 2002).

The world is changing rapidly due to globalization and postmodernism, implying multiple realities and truths, all equally valid (Higgs & Titchen, 2001; Mackey, 2007). South Africa is also a society in transition, with rising unemployment, rising poverty levels, tighter fiscal imperatives, health indicators heading in the wrong direction, with a loss of skills as health care workers leave public institutions to practice privately or take up posts overseas, implying a lack of support from overstretched colleagues and other team members, and few role models for younger professionals (Makhaye, 2008; Ramphele, 2008). Occupational therapists, therefore, have to cope with juggling large case loads, time and resource demands, and the need to stay abreast of new developments. The public sector, where much of the clinical teaching of health care workers takes place and where novice therapists undertake their year of community services after graduation, was also underperforming, with quality dropping alarmingly (Makhaye, 2008).

The nature of practice for occupational therapists was also not as straightforward as in the past according to Higgs and Titchen (2001). With practice environments changing rapidly as noted

earlier, new sets of skills were required from practitioners (Baptiste, 2005). The profession is also being confronted by the advent of emerging, non-traditional markets (Cameron & Morley, 2007) and occupational therapists need to be confident enough to promote themselves and their service in these emerging markets (Withers & Shann, 2008). Patient demographics are also rapidly changing with an aging population and immigration playing a role, as is increasing and greater cultural diversity (Méthot, 2004). In South Africa Tuberculosis (TB), drug and multi-drug resistant TB and HIV/Aids are on the increase (Ramphele, 2008).

The inherent tension between the beliefs of occupational therapists and the prevailing culture of health care has also been identified as being a challenging area for occupational therapists (Chevalier, 1997; Creek & Ormston, 1996; Rochon & Baptiste, 1998). In terms of the occupational therapy belief system, Méthot (2004, p. 198) was of the opinion that "our emphasis on promoting healthy occupations may be at odds with the curative approach of the medical model in health care, creating a disharmony between our philosophical roots of what we do and who we are and the realities of the work place. As a result occupational therapists may no longer feel that they have the control to be able to practice the way that they are educated". When occupational therapists failed to practice with a sound theoretical belief basis underpinning their endeavours, the profession becomes vulnerable to being hijacked and taken over by other professionals more forceful and sure of what they want, and to being dictated to by workplace obligations. Being a 'real' occupational therapist requires a proper positioning of skills and knowledge with respect to their professional mandate, to other professions and to workplace imperatives (Creek, 1999). Withers and Shann (2008) emphasised the relationship between professional confidence, competence and the professions ability to manage the sense of professional threat that frequently arises in the face of other professionals' lack of understanding and insight into that which the profession could rightfully offer and contribute. Following on this, while the health care team needs to understand its collective strengths, weaknesses and purpose, the occupational therapists, need to know their specific place in, and contribution to the team, in order to avoid role confusion and blurring (Christie, 1999; Craik & Austin, 2000; Creek, 1999; Derdall, Olsen, Janzen, & Warren, 2002; Farnworth, 2003; Withers & Shann, 2008).

As noted earlier, occupational therapist appeared at times to present themselves in a less than confident manner, with descriptions such as 'compliant', 'displaying a defeatist attitude', 'lethargic' and 'safe in behaviour' being put forward by Watson (2002) to describe the characteristics of occupational therapists. Björklund (1999) was of the opinion that a poorly defined, vague and diffident professional image did not auger well for the profession. This diffident nature could

perhaps, in part, be attributed to the profession being viewed as allied to, and being female dominated.

The profession is often named and viewed as 'allied' or 'supplementary' to some other major aspect of the field rather than as a field in its own right. This could bring with it the inference of having 'limited' competence, which, in turn impacts negatively on professional self-esteem and confidence levels in the researcher's opinion. A number of reasons for this continued categorisation have been put forward in the literature, including the view that occupational therapists have not presented a united front or a solid research base for their practice and therefore failed to talk with one voice as a profession, eroding the position of the profession, and making it vulnerable to marginalization. It could also be as a result of a reluctance on the part of occupational therapists to promote themselves, or it could be the result of the compliant nature of occupational therapists, who have failed to challenge issues at times (de Witt, 2002; Méthot, 2004; Watson, 2002).

Anecdotal evidence suggests that the profession in South Africa is also female-dominated, and the professions' roots are in a paternalistic medical model, and these factors may in fact have contributed to a degree of professional compliance. Bandura (1982) noted that female-dominated professions might assess themselves as inefficacious in a traditional male-dominated domain such as medicine. But there is, however, a counter argument to this assumption, and a South African study noted that women reported higher self-efficacy expectations in traditionally female occupations such as occupational therapy (Bergh & Theron, 2003).

Occupational therapists, as a collective have, therefore, experienced much role uncertainty and self-doubt over the years in terms of their professional identity (Christie, 1999; Craik & Austin, 2000; Creek, 1999; Derdall et al., 2002; Farnworth, 2003; Watson, 2002, 2006; Withers & Shann, 2008). With respect to this professional identity, Farnworth (2003) noted that an occupational therapist had to assert herself or himself as the 'rightful authority' and the sole keeper of this occupational therapy knowledge and practice, that is, this identity. Farnworth (2003) also argued for a strong, autonomous profession that distinguished itself from other professions, and cautioned, that while it was one thing to 'know how to' (i.e. be competent), "... unless practitioners consciously understand what they know, and as a result, can explain, communicate and investigate such knowledge ... we will fail to achieve strong, autonomous, professional status" (p. 116). The ability to assert and express oneself as a professional could be viewed, in part, as being confident. In addition, graduates needed be sure of the unique qualities of occupational therapy " so that they have the confidence to be real occupational therapists ..." according to Craik and Austen (2000, p. 338).

Having a healthy professional identity as an occupational therapist, therefore, included being competent and possessing a sense of professional efficacy or confidence, a sentiment that appeared to be supported in the literature (Björklund & Svensson, 2006; Craik & Austin, 2000; Creek, 1999; Farnworth, 2003; Mulholland, Derdall, & Roy, 2006; Toal-Sullivan, 2006; Withers & Shann, 2008). Competence, professional identity and confidence appeared, therefore, to mutually influence and inform each other.

COMPETENCE

Within the profession, competence has been viewed as including an aptitude, a proficiency, experience and a personal fitness to engage in the various roles and tasks allocated (Watson, 2002) and a 'knowing that' and 'knowing how' (Hagedorn, 2000) implying competence having both a knowledge and a skill component. Hagedorn (2000) also noted that competence was not equal to perfection, but was rather about getting the job done capably over time. There was also often an unspoken consensus within a profession about what competency entailed and a recognition of competence amongst themselves (Duke, 2004). Competency was the core of what an educational curriculum set out to develop (Mulholland & Derdall, 2004) and in occupational therapy, competencies for new graduates were recorded in Minimum Standards for the Training of Occupational Therapists (HPCSA, 2009) and the Standards of Practice for Occupational Therapists (HPCSA, 2006). Students were 'certified' competent on graduation by virtue of degree status being conferred by the educational institution.

PROFESSIONAL IDENTITY

In terms of professional identity, defined as "... the occupational therapist's concept of what it means to be and act as an occupational therapist" (Mackey, 2007, p. 95), it was noted by Mackey that this identity remained elusive, a view shared by Rochon and Baptiste (1998) who used the term 'ephemeral' as a descriptor for professional identity, implying that it was by its very nature, transitory and short lived. Just as one author puts forward a view on what this identity is, in their opinion, another raises the issue from a different view-point, and it appears that professional identity cannot not be limited, or confined to one consolidated notion (Mackey, 2007).

Professional identity as an occupational therapist developed, in part, through a process of socialization or enculturation (McKenna, Scholtes, Fleming, & Gilbert, 2001), that is, the assimilation of certain ways of thinking, doing and behaving (Donaldson & Carter, 2005), a process described as very similar to osmosis (Toal-Sullivan, 2006). The educational process, including supervised clinical fieldwork, has been identified as an important mechanism for developing professional identity and

concomitant competence and professional confidence (Derdall et al., 2002; Mulholland et al., 2006), although Bossers et al. (1999) noted that the manner in which professionalism and professional identity were acquired was unclear.

During clinical supervision, amongst other attributes and functions, the clinical supervisor had time to role-model professionalism and the implied confidence demanded in the application of certain skills and knowledge (M. Duncan & Alsop, 2006). One of the primary objectives of occupational therapy education is, therefore, to equip students with the knowledge and skills (i.e. competence) required to confidently assume a professional role as an occupational therapist to meet the ever-changing needs of the working world (Björklund & Svensson, 2006; Derdall et al., 2002). Creek (1999) had warned that uncertainty about the role of occupational therapy and professional self-doubt that plagued the profession, meant that, at times, occupational therapists were ineffective, and more importantly, ineffective or anxious occupational therapists might not be in a position to prompt their students into being more confident and independent. The profession, therefore, needed a strong and confident collective professional identity and confident individual professionals practising as role models for students, to socialise students into the ways and means of the profession.

PROFESSIONAL CONFIDENCE

Confidence has been defined as trust, belief in a person's trustworthiness, assuredness, self-reliance (Reber, 1985), and synonyms for confidence were listed as boldness, courage, nerve or self-reliance (McLoed, 1984). Initial reading in occupational therapy literature highlighted the fact that another term used to denote 'confidence' was self-efficacy. Derdall et. al. (2002) were of the opinion that as the definitions of confidence and self-efficacy were in fact so similar, the terms could be considered synonymous. Whether this was an accurate assumption or not remains in question, but as Hecimovich and Volet (2009) noted, depending on the field in which authors were writing, the terms 'confidence' or 'self-efficacy' were both used to denote similar traits at times.

A search on 'confidence' as a term or concept in occupational therapy literature generated a number of positive results, where confidence, or rather the lack thereof, was identified as a problem area within the profession or an aspect requiring special attention in students and new graduates. The term 'confidence' was generally not well defined or explained in any way, and often was used in the context of research into other aspects of occupational therapy with the writers taking it for granted that everyone understood the term and that there was no need in consequence to define it (Craik & Austin, 2000; Derdall et al., 2002; Tryssenaar, 1999). In contrast, research within Nursing

has focussed specifically on confidence and researchers in this field (Brown et al., 2003; Crooks et al., 2005), while making a link between self-confidence, self-efficacy and what was termed professional confidence, opted to use the term 'professional confidence'. In chiropractic, professional confidence has been explored in terms of clinical skills and health education (Hecimovich & Volet, 2009, 2011).

In a review of occupational therapy literature that explored occupational therapists continuity in the profession, Rugg (1999) reported that as far back as 1977 it had been recorded that newly qualified American occupational therapists recorded self-confidence as one of their major difficulties. Work undertaken in Australia by Nordholm and Westbrook (1981), appears to support these earlier findings, with one third of the respondents (n=54) reporting that they felt inadequate in terms of their training, and, they therefore, felt ill-equipped to practice with confidence. Rugg (1999) further reported on research undertaken in Scotland by Parker in 1991 where respondents made reference to a lack of confidence in their own abilities as occupational therapists. Kohler and Mayberry (1993) recorded that being confident and independent were essential attributes for occupational therapists in rural placements, and Tryssenaar (1999) exploring the lived experience of becoming an occupational therapist, cited her research participant, a novice practitioner, as saying "After a year ... hopefully I will have this aura of confidence" (p. 110). Confidence, or the lack thereof, had therefore been reported as being a particular problem area in occupational therapy. A gap in terms of a working definition for 'professional confidence' was also identified, and a shared understanding of the concept, 'professional confidence', appears lacking.

There also appeared to be a general recognition that the transition from student to practitioner was a complex one, with occupational therapy students voicing, just before graduation, that they did not yet feel confident enough to function as independent practitioners (Adamson, Hunt, Harris, & Hummel, 1998; Adamson, 2005; Craik & Austin, 2000; Hayes, Bull, Hargreaves, & Shakespeare, 2008; Hodgetts et al., 2007; Lee & Mackenzie, 2003; Morley, 2006; Parker, 1991; Toal-Sullivan, 2006). In a study exploring what made practitioners stay in the profession, it was reported that newly qualified therapists first sought to feel confident and to consolidate their skills in their role as occupational therapists (Wright, 2001). Elsewhere it has been reported that graduates often actually chose their area of work based on, among other things, their perceptions of how elf-confident they thought they would be in the particular field (Craik & Austin, 2000). The transition from student to practitioner, therefore, had to be as successful as possible, otherwise practitioners might elect to leave the profession or unconsciously disengage and do very little (Quick, Forsyth, & Melton, 2007; Wright, 2001). Apart from a perceived lack of confidence, attrition from the profession has also been linked to professional identity (Robertson & Griffiths, 2009; Toal-Sullivan,

2006) amongst other issues. While it must be acknowledged that many of these reported findings in terms of confidence arose from studies not specifically focussing on confidence, the argument was advanced that students and new graduates experienced a lack of confidence in their professional abilities at some point, which impacted on their educational progress or initial work as health care workers.

To my knowledge there has been no research published in this country, or internationally, which provided evidence of occupational therapy schools graduating 'confident' graduates. Derdall et al. (2002) developed a questionnaire to investigate the confidence of students during clinical fieldwork or experiential learning, but had worked from a conceptual base of self-efficacy as noted earlier. A student's competency was assessed and reported on, but I would argue that occupational therapy educators have limited information about the professional confidence of their graduates and how this confidence could be nurtured and fostered within the educational endeavour. The minimal standards of training (HPCSA, 2009) and the Standards of Practice (HPCSA, 2006) make little reference to the attributes, values, attitudes and personal characteristics (i.e. confidence) that graduates should have, while much emphasis was placed on the knowledge and skills that should be present (i.e. their competence).

In conclusion, as a profession we do not necessarily know if we are educating professionally confident occupational therapy graduates or not. The situation is further complicated in that very little is known about how occupational therapists conceptualized professional confidence for themselves and what learning and/or practice situations occupational therapy students experienced as meaningful in terms of their evolving professional confidence. As educators, we can therefore only assume that occupational therapy education enables and/or fosters the development of professional confidence. Occupational therapy students and practitioners are more likely to benefit from learning and other opportunities when they are feeling confident, so it is incumbent on us as educators, clinical supervisors and fellow practitioners to ensure that we understand just what confidence is (Spiliotopoulou, 2007). The exploration of professional confidence as a concept, its sources within educational programmes and how occupational therapists understand and make sense of the notion is, therefore, essential.

AIM OF THIS STUDY

The overall aim of the study was, therefore, to contribute to the development of a body of knowledge in terms of professional confidence for occupational therapists. The specific research objectives of the study were as follows:

1. to analyse the concept 'professional confidence';
2. to explore the understandings held by occupational therapist of professional confidence; and
3. to investigate the determinants or sources of professional confidence in occupational therapy students.

RESEARCH QUESTIONS

The study was broken down into three phases or independent studies. The following broad research questions were posed during the respective phases:

PHASE 1

- What are the attributes or characteristics, antecedents and consequences of professional confidence?
- What surrogate terms are used in the literature, and what other concepts are related to professional confidence?
- How can professional confidence be defined?

PHASE 2

- How do novice occupational therapists (community service therapists in the South African context) describe or explain their professional confidence?
- What are the different ways that these novice therapists conceptualize their professional confidence?

PHASE 3

- What circumstances, situations, events and personal characteristics do students, and their lecturers or clinical supervisors identify as contributing to, or affecting the development of their professional confidence before graduation?

OUTLINE OF THE THESIS

This thesis, a supervised PhD undertaking, has been submitted in one of the formats approved by the University of KwaZulu-Natal, namely; one or more original papers of which the student is the prime author, published or in press in a peer-reviewed journal approved by the Board

of the relevant Faculty, accompanied by introductory and concluding integrative material. The Faculty (now College) of Health Sciences determined this rule as follows: that the PhD should consist of at least three first-authored papers, two of which report on original research.

Chapter one outlines the problem statement, the study's aim and objectives and highlights the research questions. Chapter two expounds on the conceptual framework, and highlights some of the ethical considerations taken into account throughout the study, as well discussing rigour and trustworthiness. A broad overview of the research setting is also provided. Chapter three includes the three (3) published or in-press papers presenting the original research undertaken for the study. Chapter four provides an encompassing conclusion and highlights further areas of research.

CHAPTER 2: CONCEPTUAL FRAMEWORK

In this chapter, the methodological principles and considerations that guided the entire study are introduced. Professional confidence was assumed to be a personally held belief, rooted in certain events, situations, experiences and personality factors. Working from a qualitative perspective made sense, as the aim of the study was not to confirm (or to deny) the existence of professional confidence or to quantify the strength of confidence beliefs as quantitative studies might seek to establish. Rather, the broad aim of the study was to establish a body of knowledge in terms of professional confidence, exploring, with people 'in the know', what their understanding was on the subject of professional confidence and what informed their confidence beliefs. As very little has been documented about professional confidence within occupational therapy, this study fitted well within Tesch's (1990, p. 67) conception of "research that seeks to discern meaning".

ONTOLOGICAL BELIEFS

Beliefs about professional confidence are a result of individual cognition and are, therefore, of individual making within a given context. Individual occupational therapy students and novice practitioners construct personal meanings concerning their professional confidence in the milieu they find themselves in, and confidence beliefs would only be meaningful to the individual to the extent that they made sense of them. Radnor (2001) confirms that it was the ideas, thoughts, beliefs and values within an environment that informs personal meanings. However, just as contexts vary over time and with time, it could be assumed that individuals would have differing confidence beliefs in different situations, and that confidence beliefs could and would differ at any one time and over time. Reality is, therefore, socially constructed, and there is not one truth or one reality in terms of confidence, as might be anticipated from a positivist perspective. Beliefs about professional confidence are an individual, personal, subjective and unique growth experience as constructed by that individual, and the only world that an individual can honestly interrogate is the world they personally experience (Sjöström & Dahlgren, 2002).

Initial training as an occupational therapist has nurtured in me a belief in the whole and unique individual. Occupational therapists make their life's work people in their environments and what it is that person engages in within that environment that has meaning and value for them. The person-environment-occupation interaction was, therefore, crucial. Duncan and Nichol (2004) in supporting this view, noted that because occupational therapy interventions put emphasis on the individual and the unique nature of each moment, interaction and activity, the qualitative paradigm, and more particularly interpretive research methodologies honoured the professional values the

profession embraced. This was supported by Kelly (1996), who argued that research in occupational therapy needed to be compatible with its philosophical roots.

EPISTEMOLOGICAL ASSUMPTIONS

From the outset, I acknowledged that as an occupational therapist and researcher, I also had professional confidence truths, beliefs and experiences. I was, therefore, well placed to assume a subjective epistemology, where I as researcher, together with the students and novice practitioners with whom I engaged, co-operatively interpreted meanings and understandings of professional confidence, an approach supported in literature (Mertens, 1998; Savin-Baden & Fisher, 2002). Knowledge about professional confidence in occupational therapy could only come from occupational therapists themselves, as they experienced and reflected on their educational experience and professional lives and sought to build understanding of their world (DePoy & Gitlin, 1994; Sjöström & Dahlgren, 2002).

During the research process, I further acknowledged and understood that I could not comfortably position myself as a far-removed, objective outsider looking in. I was, with due cognisance of the implications, a lecturer, clinical supervisor, occupational therapist, mentor, colleague and researcher in the context, engaging and interacting with the research participants. However, it must be acknowledged that a tension existed between trying to put aside personal assumptions about professional confidence and grounding the results from the studies squarely in the data. How I dealt with this tension is expounded upon in the articles included in Chapter 3. In addition, I had an interest in and an obligation to the educational centre where I worked, and therefore, my first commitment and professional need was to understand more comprehensively the situation I found myself in. This placed me firmly in an anti-positivist (Cohen, Manion, & Morrison, 2007) or non-positivist (Guba & Lincoln, 2005) position, and specifically within the interpretative or constructivist-interpretative paradigm (Denzin & Lincoln, 2005; Hatch, 2002; Mertens, 1998; Terre Blanche & Durrheim, 1999) where I could view reality as being socially constructed by those active in the research process. I was pragmatic as well because, being an occupational therapist, I preferred personal contact and an involved, co-operative style of engagement and exploration with others. This style of engagement in situations like this was supported in the literature (Denzin & Lincoln, 2005; Mertens, 1998).

PARADIGMS

This study fitted well within an interpretative paradigm, where firstly, the nature of the reality to be explored was a subjective experience acknowledging multiple realities. Secondly, the

relationship between the researcher and research participants was one characterised by being interactive, co-operative, empathetic and subjective and thirdly, the questions required the use of naturalistic methodology (Denzin & Lincoln, 2005). Relating back to the stated aim of the research, Bassey (1999, p. 44) noted that "To the interpretive researcher the purpose of research is to advance knowledge by describing and interpreting the phenomena of the world in attempts to get shared meanings with others. Interpretation is a search for deep perspectives on particular events and for theoretical insights".

METHODOLOGICAL FRAMEWORK

PHASE 1

The first study (Holland, Middleton, & Uys, 2012a) involved a concept analysis (Rodgers, 1993, 1994), as the attributes of 'professional confidence' were unclear and had not adequately been isolated from other related concepts. This implied that the concept of professional confidence was an immature one, as opposed to a mature, well defined and delineated concept (Morse, Mitcham, Hupcey, & Tasón, 1996). The level of maturity (or immaturity) of a concept has little to do with the age or use of the concept. So while professional confidence has been used as a notion in occupational therapy literature for an extended period of time, it has not been well defined. A working definition of what professional confidence is and what it means has to be derived. Baldwin and Rose (2009) argued for proceeding in this way, as they were of the opinion that clarifying concepts before engaging in more research about the concept, was as important as clarifying operational definitions before proceeding with a study.

Through the concept analysis the structural features, characteristics, boundaries, preconditions and outcomes of professional confidence were described and a definition presented. The evolutionary method of concept analysis as proposed by Rodgers (Rodgers, 1994; Rodgers & Knafl, 1993; Weaver & Mitcham, 2008) was selected for use, as this method fitted within the interpretative paradigm (Weaver & Mitcham, 2008) allowing for the concept of professional confidence to be viewed within its context(s) through exploring its usage, significance and applications.

PHASE 2

The second study explored the conceptions, or understanding, novice occupational therapist have of their professional confidence (Holland, Middleton, & Uys, 2012b). Phenomenography, a qualitative interpretive research approach, well suited for use when seeking understanding, was

employed (Marton, Dall'Alba, & Beaty, 1993; Marton & Svensson, 1979). Phenomenography had been defined as the "...empirical study of the qualitatively different ways in which various phenomena in, and aspects of, the world around us are experienced, conceptualized, understood, perceived and apprehended" (Sjöström & Dahlgren, 2002, p. 339). Further, the approach employed a second order perspective (Pang, 2003; Stramouli & Huggard, 2007), through which the researcher captured how the world appeared to the novice therapist, i.e., "... the explanations people carry around in their heads for the various aspects of reality they encounter" (Tesch, 1990, p. 49). Again, the use of this method of inquiry, through semi-structured phenomenographic interviews, suited my background and style as a professional practitioner and researcher, and fitted well into the interpretative paradigm that I was working within.

The research participants in this study were novice occupational therapists or community service therapist in the South African context. This group of therapists was targeted, as the transition from student to practitioner had previously been noted as a stressful one. However, this was the period where the foundations for professional confidence as a qualified practitioner were embedded.

PHASE 3

During Phase 3 of the study, the sources or determinants of professional confidence in occupational therapy students were explored with a cohort of final year students at one South African University (Holland, Middleton, & Uys, 2012c). Data was gathered through focus groups with students, their lecturers and clinical supervisors and from reflective journals kept by the students during a period of clinical fieldwork. Naturalistic inquiry was employed, and according to Tesch (1990) this is a way of doing research, rather than philosophising about aspects of it. Within this way of 'doing research', as researcher, the researcher became the instrument, listening, reading, looking and making notes that were later reflected on, and expressed in a narrative. Deductive thematic analysis (Braun & Clark, 2006) of the data was undertaken, and two broad themes emerged, namely external and internal determinants of professional confidence beliefs. All the determinants identified were further identified as being within the control of the student, lecturer/clinical supervisor or the profession.

STUDY SETTING

The entire study was based in South Africa, and particularly in the Province of KwaZulu-Natal. South Africa currently has 3816 registered practitioners on the HPCSA register, with 1734 students registered as at 31 March 2012 (HPCSA, 2012). The majority of working practitioners work

in the Public Service (the largest employer), but a growing percentage of practitioners are self-employed or work in private health care facilities or Non-Governmental Organisations. Approximately 10% of the registered practitioners reside in KwaZulu-Natal, and the only educational facility in the Province had a head count of 120 students during 2012.

In terms of the education of occupational therapists, the country has eight educational facilities, all offering a four year undergraduate bachelor's degree, two being Bachelor of Science based and the others Bachelor's degrees. KwaZulu-Natal has one educational facility and training started in 1982 in the Province. Approximately 36 first years are admitted each year to this facility. The reason for selection this setting was that this occupational therapy educational facility has the most heterogeneous student and staff population amongst the eight training centres in South Africa (HPCSA, 2007). Diversity issues have often not informed research in South Africa (Favish, 2005) or in occupational therapy (Ramugondo, 2000; Toal-Sullivan, 2006). It has been inferred from literature that self-beliefs might differ within various cultural backgrounds and be influenced by gender (Fitzgerald, Mullavey-O'Byrne, & Clemson, 1997; Harris, 2007; Iwama, 2005). Phase 3 of the study was, therefore, based at the educational institution concerned.

On graduation, all new practitioners are obliged to undertake one year of community service in a state facility within the Provincial Health Authority (The Department of Health). On successful completion of this year occupational therapy practitioners can then register with the HPCSA as independent practitioners and are free to choice their area and site of employment, including private practice. In terms of Phase 2 of the study, the Province offered more than 70 choices in terms of community service sites and anecdotal evidence from community service records kept since its inception, revealed that a large number of graduates from educational centres outside the Province elected to undertake their community service in KwaZulu-Natal, as the Province offered a number of unique opportunities to community service therapists. This made the Province an ideal site for locating Phase 2 of the study and it was presumed that the variety of placement sites and graduates added to the richness of the research process. In a phenomenographic study a range of demographic characteristics are sought, as opposed to frequency, as the researcher seeks variation, not frequency of understanding, from as diverse a group as possible (Åkerlind, 2008).

BROAD ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the University where the researcher is registered. Ethical Approval Number: HSS/0156/2010 M: Faculty of Health Sciences (Appendix 1. Page 40). In addition, gate-keeper permission was obtained from the KwaZulu-Natal Department of Health for

Phase 2 of the study (Appendix 2. Page 41), and from the Discipline (occupational therapy), School (in which the discipline resorted) and the Faculty for Phase 3 (Appendix 3. Page 42), prior to commencement of any fieldwork.

While undertaking the study a number of overarching principles, including considerations as spelt out in the Declaration of Helsinki (WMA, 2008), guided the implementation of the research. These included implementing means to ensure non-maleficence (doing little or no harm, and holding few or no risks), beneficence (the good of the 'whole', i.e. knowledge for the profession, being acknowledged), the autonomy of research participants (freedom to make an independent and informed choice as to whether to participate in the study or not), obtaining informed consent, anonymity (ensuring that the research participant were able to share freely without fear of identification within the written text), confidentiality and, finally, justice (ensuring that all participants retained their dignity and self-respect and that their involvement was perceived as fair).

It was, however, acknowledged during the process that the following aspects were difficult to ensure or assure. Firstly, if a research participant had chosen to withdraw along the way, it would have proven difficult to effect, as data gathering and analysis occurred concurrently. Secondly, maintaining anonymity of the site for Phase 3 of the study with students was problematic. Any reader familiar with the education of occupational therapy students in South Africa would be able to identify the site, but the particular site was not named and was referred to consistently in the write-up as 'the University'. A conscious decision not to name the site was taken after due consideration of the pro's and con's and best practice in research. Thirdly, in terms of anonymity, I was aware that the identity of individual research participants could unwittingly be disclosed as the occupational therapy community in South Africa is relatively small, and actual research participants will probably be able to identify themselves in some of the direct quotes included in the journal articles. However, inclusion of their responses in a composite report goes some way in meshing specific information with that of others, ensuring the hiding of identities. Fourthly, in terms of ensuring justice, member-checking exercises were undertaken with the research participants during Phase 2 and 3, unfortunately without much active involvement from those invited to comment. This meant that there was very little feedback on whether or not the research participants were in agreement with the fairness and inclusiveness of the evolving discussion and conclusions. This could perhaps be ascribed, in part, to a naivety in terms of the research participants and their understanding of what the purpose of member checking was, and that it was a legitimate and valuable exercise.

METHODOLOGICAL BOUNDARIES

The research undertaken did not presume to explore whether or not the occupational therapy students or novice therapists were in fact confident, and to what degree they were confident. The study also did not presume to foster or enhance professional confidence in any way. It was, however, acknowledged that the reflection and introspection required from the research participants in Phases 2 and 3 had positive spin-offs in terms of the participants realizing the value of reflection, and this brought to them enhanced insight in terms of professional confidence that they may not have had initially. Feedback from some of the research participants confirmed this informally with the researcher. For example during Phase 2 of the study, some of the research informants came prepared to their interviews, having written down thoughts that had come to mind before their interview.

While the research sought to explore a professional reality, two possible issues must be clarified. The first is that given the ontology of the research paradigm, the study does not wish to claim to have produced the definitive answer but rather a contextual and nuanced understanding of the phenomenon (Prichard & Trowler, 2003). Secondly, in terms of generalizability, Flyvbjerg (2001) noted that generalization of research findings is actually not possible or desirable in many instances, and he is further of the opinion that it is a misunderstanding that on this basis, research such as undertaken in this study, cannot contribute to the growth of knowledge.

RIGOUR

In terms of researcher subjectivity, this is acknowledged as a potential component of any research initiative (Glesne, 1999). I was aware throughout the process that the broad topic for the study had been determined by me together with the research methodology and the method of interpretation and analysis. It was therefore incumbent on myself, as researcher, to monitor for subjectivity, and I took cognisance of strategies to counter subjectivity put forward by Harris (2007) and Salminen, Harra and Lautamo (2006). These included actively listening during interactions, and checking perceptions through the use of reflection and paraphrasing during the focus groups and interviews, and reflecting on my self-perceptions during the process. Any subjectivity was also tempered, I believed, by having research promoters from outside the profession of occupational therapy, who could, and did, point out areas of concern or ambiguity to them along the way. Subjectivity, however, differs from the rapport I had with the research participants, where rapport referred to the quality of my interactions (Glesne, 1999).

Having an established rapport with many of the research participants was, however, acknowledged as a two-edged sword at times. Having similar experiences as a student and professional counted heavily in my favour, and this advantage is supported by Glesne (1999), who noted that having similar knowledge and experiences, meant a researcher was able to ask more informed questions, and could pay more attention to the research participants experiences, rather than focusing on peripheral questions trying to understand the (often unfamiliar) situation. I noted, however, that this familiarity had another side to it, in that it could lead to a complacency and subjectivity on my part: 'I know just what they are trying to say' rather than listening and hearing what the research participants were actually saying. Vigilance was, therefore, called for throughout the study.

At this point it is opportune to note the three lenses that Glesne (1999) identified for researchers to consider while engaged in research, namely, a personal, justice and caring lens. In terms of the personal lens, also referred to by Creswell (2003), during the process I reflected critically on my past as a student, as an occupational therapist and as a researcher in a personal diary, to better understand my role(s) in the process (Cohn & Lyons, 2003; Guba & Lincoln, 2005). I had to acknowledged throughout, that the research participants and I came from specific, but a different, social context and I was constantly reminded to consider, as Harris did "... where it isn't possible to discard the baggage ... which determines our being ... we need somewhere to place the baggage so that it doesn't get in the way" (Harris, 2007, p. 94). From the aforementioned, reflexivity on my part was at play, and mirrored Glesne's personal lens. The second lens that governed my actions was a justice lens, in the sense of wanting what's right and good for the research participants and the profession at large, a notion inherent in the rationale for the study and what initiated the process to produce a body of knowledge. And lastly, I was mindful of a caring lens noted by Glesne (1999), employed I believed, by acting with interest and care throughout the process.

According to Dyer (2006) two other characteristics, in addition to reflexivity, define and distinguish qualitative research from quantitative research, namely 'inconcludability' and 'indexicality'. I had noted and recognized that my understanding changed, evolved and expanded during data collection and analysis, but at a point I had to make a judgement call and conclude the process. As a result of this, interpretation cannot be said to have reached the point where no more understanding can be generated, and further reading of the data may well lead to new or other insights, demonstrating 'inconcludability' inherent in qualitative research endeavours. In turn this is related closely to 'indexicality', where it has to be acknowledged that my interpretations must be linked to a certain set of condition, circumstances and time frames, which I and the research

participants brought to the process at the time. Further ways of ensuring rigour within each part of the study are addressed in the articles included in Chapter 3.

ENSURING VALIDITY

It was acknowledged that it was not easy to attain consensus around setting standards for evidence in qualitative research, as the field is so diverse (Freeman, deMarrais, Preissle, Roulsten, & St. Pierre, 2007), but Creswell and Miller (2000) are of the opinion that qualitative researchers needed to demonstrate the credibility of their work. These two authors are further of the opinion that the lenses researchers chose, and their paradigm assumptions, should govern their choice of validity procedure. Using Creswell and Miller (2000, p. 126) as a guide, I employed reflexivity in the first instance, secondly, there was prolonged engagement in the field including elements of collaboration with the research participants, and thirdly, so-called thick description was employed. In part, reflexivity was employed through the use of bracketing (setting aside existing knowledge), while simultaneously acknowledging that it was not as clear-cut as often presented (Holland et al., 2012b). Prolonged engagement in the field, and a shared rapport with many of the research participants also assisted in ensuring validity. Finally, by describing the research setting and the participants and by describing and discussing the findings after data analysis in detail, it was hoped that this would enhance verisimilitude in a reader, with the reader hopefully left feeling they related to, or had experienced, what had been described in the research. Reflexivity, engagement in the field over a period of time and verisimilitude were therefore means to ensure validity in this study.

CHAPTER 3: STUDY PHASES 1, 2 AND 3

As the thesis is presented in publication format prescribed by the University where I am registered, copies of three (3) publications have been included in this chapter. Each of the papers adds to the next, and as a collective they constitute a coherent whole addressing the overall aim of the study and the research objectives.

PAPER 1

Title:	Professional Confidence: A concept analysis
Authors:	Holland, K., Middleton, L. and Uys, L.
Journal:	*Scandinavian Journal of Occupational Therapy*
Publication record:	The draft was prepared for submission to the journal and submitted on 11 June 2010, revised by 18 April 2011 and accepted on 20 April 2011. The paper was originally published as 'Early Online' in 2011 by informa healthcare before publication as a hard copy in 2012. Volume 19, Issue 2: 214 – 224.
Journal information:	On the ISI Journal list. Peer-reviewed journal. Impact factor of Journal: 1.070.
Contribution record:	Use of 'concept analysis' was first mooted by one of the supervisors, Prof Leana Uys. The decision around the actual concept analysis method was the informed decision of the candidate. The candidate, listed as prime author, undertook the concept analysis independently and drafted the article for on-line submission to the chosen journal. The suggested corrections and amendments to the article were undertaken by the candidate, who also dealt with the journal's editorial team. The two co-authors, the supervisors, were critical readers.

PAPER 2

Title:	Professional Confidence: Conception held by novice occupational therapists in South Africa.
Authors:	Holland, K., Middleton, L. and Uys, L.
Journal:	*Occupational Therapy International*
Publication record:	The draft was prepared for submission to the journal and submitted on 23 July 2012 and accepted for publication on 27 November 2012. The article is

	currently with the production department of Wiley-Blackwell. Proof of acceptance by the journal has been included with a copy of the early online edition
Journal Information:	On the ISI Journal list. Peer-reviewed journal. Impact factor of Journal: 0.526.
Contribution record:	The candidate, K Holland, independently undertook the entire study, including data collection and analysis, and independently drafted the article for submission to the chosen journal. Ethical clearance from the Department of Health to undertake the study was sought and obtained by the candidate prior to commencing fieldwork. The candidate, named as prime author, undertook the initial online submission, and is independently dealing with the Journal's editorial team. The two co-authors, the supervisors, were critical readers.

PAPER 3

Title:	The sources of professional confidence in occupational therapy students
Authors:	Holland, K., Middleton, L. and Uys, L.
Journal:	*South African Journal of Occupational Therapy (SAJOT)*
Publication record:	The draft paper was prepared for submission to the journal and submitted on 21 May 2012 and accepted for publication on 26 September 2012. Published by SAJOT in December 2012. Volume 42, Number 3: 19 - 25
Journal Information:	Official publication of the Occupational Therapy Association of South Africa. Peer- reviewed journal. On SAPSE publication list.
Contribution record:	The candidate, named as prime author, undertook the entire study, including data collection and analysis, independently. Gate keeper permission was sought and obtained by the candidate. The article was drafted independently by the candidate, who also independently engaged with the Journal's editorial team during the review process. The two co-authors (supervisors) were critical readers.

PAPER 1

Scandinavian Journal of Occupational Therapy. 2012; 19: 214–224

informa
healthcare

ORIGINAL ARTICLE

Professional confidence: A concept analysis

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Abstract

Introduction: Professional confidence is a concept that is frequently used and or implied in occupational therapy literature, but often without specifying its meaning. *Method:* Rodgers's Model of Concept Analysis was used to analyse the term "professional confidence". Published research obtained from a federated search in four health sciences databases was used to inform the concept analysis. *Results:* The definitions, attributes, antecedents, and consequences of professional confidence as evidenced in the literature are discussed. Surrogate terms and related concepts are identified, and a model case of the concept provided. Based on the analysis, professional confidence can be described as a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences. *Discussion:* Developing and fostering professional confidence should be nurtured and valued to the same extent as professional competence, as the former underpins the latter, and both are linked to professional identity.

Key words: *curriculum development, occupational therapy, occupational therapy education, Rodgers's Model of Concept Analysis*

Introduction

Professional confidence underpins competence and is inextricably linked to professional identity (1,2). Competence appears well defined and understood as a concept, and what is required in terms of this is recorded for the profession of occupational therapy in our Minimum Standards for Education (3,4). These minimal standards inform the contents of education and training programmes, and are the yard-stick against which they are assessed and accredited. Much has been written about professional identity as an occupational therapist, but there is very little reference in the literature to what professional confidence entails and how it is understood.

The importance of professional confidence to competent practice is emphasized in varying degrees in studies exploring the processes and experiences of student and novice occupational therapists. For example, a number of studies make reference to the fact that occupational therapy students often voice concern, shortly before graduation, about not feeling confident to operate as independent practitioners (5–10). Other studies highlight the fact that newly qualified occupational therapists experience a further loss of confidence when first entering the work environment (2,11–16). Although many of the studies did not initially seek to explore professional confidence, its perceived absence was invariably raised as one of the findings, with recommendations advocating for enhancing, encouraging, and/or nurturing it. No direct reference as to what was meant and/or implied by use of the term professional confidence could be found in this literature, although it was at times described as being part of, integral to, or related to a number of other concepts including self-efficacy,

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self-esteem, and self-concept (17). The conceptualization and development of professional confidence in occupational therapy education and practice therefore remains unclear but important.

Clarity of disciplinary concepts is essential and a discipline is responsible for, and establishes itself by, building its scientific research base from a set of well-developed key concepts related to its phenomena of interest (18). In addition, concepts are thought to guide a discipline, linking theory, research, and practice (18), and allow for clarification, identification, communication, and a shared understanding of a concept within a profession (19). Concepts are also the main building blocks of theory (20–23) and, according to Baldwin and Rose (24), clarifying them before proceeding with research is as important as clarifying operational definitions.

The term "concept" has been accepted as a method of naming or labelling the things, events, ideas, and other realities we think about and perceive. There are two ways of viewing concepts, employing either an entity or a dispositional view (19,25). An entity perspective views a concept as a thing, devoid of any context, while a dispositional view addresses the meaning of the concept in use by those who use the concept, and the behaviours the concept make possible. Kim (21) proposed the term process concepts, which is associated with the dispositional view, a useful way of perceiving the concept of professional confidence as it appears to relate to a process. There is no definite start or end to being professionally confident, which appears to be dynamic in nature and to be context related, e.g. professional confidence as a student, professionally confident as a graduate. According to Rodgers (26,27), a proponent of the dispositional view, concepts develop over time, and this development is informed and influenced by three aspects, namely the concept's significance, its use, and its application. A concept's significance, that is, its value in solving problems of interest to a discipline, is indicated by its frequency and extent of use within the discipline. As a consequence of this use over time, a concept acquires meaning through ongoing dialogue, and begins to be used in a common way. The concept's continued use therefore informs its definition and a concomitant set of attributes (28). Application refers to the growing understanding and use of the concept in various settings over time, and within contexts such as different cultural groups or particular disciplines.

While professional confidence is important to occupational therapy as a discipline, it is an emerging or immature dispositional concept, as it currently appears to lack a meaningful definition. Neither its characteristics, nor its preconditions, outcomes, or boundaries are clearly defined, and these criteria are used to determine concept maturity (22). Accordingly, if a concept is immature, then research to clarify the concept is indicated, and concept analysis methodology as proposed by Rodgers (25–29) appeared well suited to the task. Rodgers (26,28) was of the opinion that analysing the common use of a concept facilitated defining it, thereby helping to clarify it, and served as a precursor for further research. She was also of the opinion that her methodology imposed no predetermined view of reality on the concept, merely presenting what was common to its existing use in literature. The aim of this paper is therefore to present a concept analysis of the term "professional confidence" for the occupational therapy profession.

Material and methods

Weaver and Mitcham (18) stated that "Concept analysis involves the formulation and clarification of a mental construct, systematizing relevant information in ways that enables its appraisal and enhancement as an element that serves to both advance theory and guide practice". The following activities, as proposed by Rodgers (26–28), were used during this concept analysis, the process being iterative and directed towards clarifying the term professional confidence.

- Identify the concept of interest, which in this case is professional confidence.
- Identify surrogate terms for the concept. These are other ways or means of expressing the concept, often sharing the same basic set of attributes.
- Identify and select an appropriate realm (sample) for data collection. Rodgers (26,27) proposed that data be drawn from computerized databases, as concept analyses are essentially literature-based. Risjord (30) indicated that in a theoretical concept analysis data should only be collected from scientific literature. Rodgers (27) intimated that researchers were unable to identify a complete and definite collection of all literature that existed in terms of a certain concept, but that the method of data collection proposed still held certain advantages over a convenience sample. This approach to concept analysis is differentiated from a colloquial concept analysis (30) where the aim would be to represent the concept from the perspective of a particular group of people, with data also being drawn from interviews.
- Identify the attributes or characteristics of the concept. Attributes are the critical components of a concept that are present when it is defined, and are also referred to as clarifying key components (31). While attributes may be found in available definitions of the concept, Rodgers (27) made the point that authors do not often provide

definitions, hence the need to search for statements or words that they use to explain the concept.
- Identify the antecedents, consequences, and references of the concept where possible. Antecedents and consequences are the situations and events that either precede or follow an example of the concept under review. References denote situations in which the concept is applied.
- Identify concepts that are related to the term of interest. Related concepts may bear some relationship to the concept, but do not share the same characteristics or attributes, and are also seldom used as synonyms.
- Identify a model case of the concept. The case needs to be an everyday example illustrating the concepts attributes, antecedents, and consequences.

Data collection

A federated search was conducted using the following databases; CINAHL (Cumulative Index of Nursing and Allied Health Literature), Health Source: Nursing/Academic Edition, MEDLINE via Ebscohost, and PUBMED, as they are health science specific. English, full text available articles from the years 2000–2010 with references available were tagged (query limiters), and the search term "professional confidence" in "all fields" was used. The search term "health professional" was also included to limit the search as it shares a common approach to education, with students being exposed to theoretical and practical training, and all professions expecting competent practitioners who can function independently by the end of their educational programme.

The search listed 33 items, but two articles were duplicated, leaving 31 articles which were reviewed. However, this number was reduced to 26 following the exclusion of an article on teachers (health professional was a query limiter), four others outside the scope of this research, and an article in Norwegian (English was a query limiter). However, of these 26 articles, 21 were eventually used in this analysis and it was decided to proceed with the concept analysis as an exhaustive library search failed to produce any further material. Table I, included in the article provides a summary of the articles with nine articles from nursing, three from medicine and one each from occupational therapy, speech/language pathology, social work, marital and family therapists, chiropractics, and radiation therapy technology. The research participants in the remaining three articles came from a variety of fields including nursing, medicine, and other professions allied to medicine. A limitation of this study may be that only one article from occupational therapy was identified during the search. However, the study aimed to provide clarity on the concept for occupational therapy, not necessarily from or based on occupational therapy literature.

Data analysis

Theoretical thematic analysis as described by Braun and Clarke (32) was undertaken using a coding framework, informed by the categories of data as proposed by Rodgers, i.e. the attributes of, antecedents for, and consequences of professional confidence. Within each of these aspects, all relevant content from the articles was identified, conflicting views were highlighted, and details clarified. The data were then synthesized and refined into a cohesive and comprehensive description. Surrogate terms and related concepts were identified from articles in the literature search and from wider reading as suggested by Rodgers.

Results

Surrogate terms for professional confidence

Confidence (33–36), self-confidence (37,38), professional self-confidence (39), and self-efficacy (1) were used in the literature as surrogate terms, and were often used as synonyms for professional confidence. Hecimovich and Volet (34) reported that the terms confidence and/or self-confidence were favoured in professional education literature, while self-efficacy was frequently used in educational psychology literature. Brown et al. (40) made a link between professional confidence, self-efficacy, and self-confidence, and asserted that the sources of professional confidence and self-efficacy beliefs were in fact similar.

Confidence is defined as "a belief in one's own abilities, self assurance" (41). Self-confidence sees the addition of *self-* to the notion of confidence, and refers to a self-assessed belief, and is defined as "confidence in one's own powers, judgements" (41) or trusting yourself, believing in your own trustworthiness, feeling self-assured, and relying on yourself (42). A concept analysis undertaken by White (43) elicited three attributes of self-confidence, namely, a definite personal belief that one can achieve a positive outcome in a particular situation, persistence when confronted with stumbling blocks, and self-awareness in order to limit anxiety. Self-confidence was described as contextual and task specific, similar to self-efficacy, and, according to White (43), as the two terms were frequently used interchangeably in literature, discriminating between the two may prove difficult. Berg and Hallberg (39) used the terms "professional self-confidence" and "professional confidence" interchangeably in their article. The inclusion of the

Table I. Summary of articles used.

*	Title	Authors	Type of article	Journal/year	Research participants	Methodology
(33)	Critical incidents in the professional lives of first year MFT students	Lee R, Eppler C, Kendal N, Latty C	Research	Contemporary Family Therapy/ 2001	Marital and Family Therapists (MFTs)	Critical incident methodology
(34)	Importance of building confidence in patient communication and clinical skills among chiropractic students	Hecimovich M, Volet S	Literature review	Journal of Chiropractic Education/2009	Fields: Professional confidence Chiropractic education	Literature review
(35)	Study at Master's level: A qualitative study exploring the experience of students	Conneeley A	Research	British Journal of Occupational Therapy/2005	Occupational therapists	Phenomenology Lived experience
(37)	Clinical supervision in the emergency department: A critical incident study	Kilroy D	Research	Emergency Medicine Journal/2006	Medical students	Critical incident methodology
(38)	Faculty perceptions of gender discrimination and sexual harassment in academic medicine	Carr P, Ash A, Fieldman R, Szalacha L, Barnett R, Palepu A, Moskowita M	Research	Annals of Internal Medicine/2000	Medical school faculty	Survey questionnaire
(39)	Psychiatric nurses' lived experience of working with inpatient care on a general team psychiatric ward	Berg A, Hallberg I	Research	Journal of Psychiatric and Mental Health Nursing/2000	Psychiatric nurses	Latent content analysis Qualitative
(40)	Professional confidence in baccalaureate nursing students	Brown B, O'Mara L, Hunsberger M, Love B, Black M, Carpio B, Crooks D, Noesgaard C	Research	Nurse Education in Practice/2003	Baccalaureate nursing students	Focus groups Qualitative
(45)	Development of professional confidence by post diploma baccalaureate nursing students	Crooks D, Carpio B, Brown B, Black M, O'Mara L, Noesgaard C	Research	Nurse Education in Practice/2005	Baccalaureate nursing students	Focus groups Qualitative
(46)	Advanced practice issues for radiation therapists in the province of Ontario: A case study	Bolderston A	Research	Canadian Journal of Medical Radiation Technology/2005	Radiation therapy technologists	Case Study
(47)	Exemplar: Professional confidence	Weiner K	Personal reflection	British Journal of Perioperative Nursing/2004	A nurse	Personal reflection
(48)	Benefits of interprofessional learning: An interprofessional MSc in child health	Payne H, Pelz F, Brooks R, Horrocks L, Kemp, A, Webb, E, Street, E, Sibert, J,	Research	Hospital Medicine/2005	Various, including doctors, nurses, physiotherapists, an occupational therapist	Case study
(49)	Confidence in controlling a SARS outbreak: Experiences of public health nurses in managing home quarantine measures in Taiwan	Hsu C-C, Chen T, Chang M, Chang Y-K	Research	American Journal of Infection Control/2006	Public health nurses	Survey Qualitative
(50)	Second dose of MMR vaccine: Health professionals' level of confidence in the vaccine and attitude towards the second dose	Smith A, McCann R, McKinley I	Research	Communicable Disease and Public Health/2001	Various, general practitioners, nurses, health visitors	Survey questionnaire

Table I. (*Continued*).

*	Title	Authors	Type of article	Journal/year	Research participants	Methodology
(51)	Nurses' responses to expert patients: The rhetoric and reality of self-management in long-term conditions: A grounded theory study	Wilson P, Kendall S, Brooks F	Research	International Journal of Nursing Studies/2006	Nurses	Grounded theory
(52)	Oncology nurses' perceptions of their supportive care for parents with advanced cancer: Challenges and educational needs	Turner J, Clavarino A, Yates P, Hargraves M, Connors V	Research	Psycho-Oncology/ 2007	Nurses	Focus groups, interviews Qualitative
(53)	The California nurse mentor project: Every nurse deserves a mentor	Mills J, Mullins A	Report Opinion paper	Nursing Economic$/2008	Field: nursing	Report/Opinion paper
(54)	Is multidisciplinary learning effective among those caring for people with diabetes?	Munro N, Felton A, McIntosh C	Literature review	Diabetic Medicine/2002	Fields: Multi-disciplinary learning (doctors, nurses, professions allied to medicine) Diabetes	Literature review
(55)	Work satisfaction of Japanese public health nurses: Assessing validity and reliability of a scale	Yamashita M, Takase M, Wakabayshi C, Kuroda K, Owatari N	Research	Nursing and Health Sciences/ 2009	Public health nurses	Questionnaire
(56)	The cost of caring? Social workers in hospitals confront ongoing terrorism	Dekel, R, Hantman S, Ginzburg K, Solomon Z	Research	British Journal of Social Work/2007	Social workers	Questionnaire Quantitative
–	Undergraduate medical school education in substance misuse in Britain, III: Can medical students drive change?	Crome I, Shaikh N	Research	Drugs: Education, Prevention and Policy/2004	Medical students	Questionnaire
–	Leading the change effort: Real and perceived challenges in working with speech–language pathology assistants	Goldberg L, Williams P, Paul-Brown D	Opinion paper	Communication Disorders Quarterly/2002	Fields: speech–language pathology therapists and assistants	Document review, opinion paper

Note: *The numbering used relates to the table of contents for cross-referencing purposes.

term *professional* is, in the authors' opinion, a way of relating or linking self-confidence or confidence to a professional.

Self-efficacy refers to an individual's assessment of whether she/he believes ther/himself capable of performing a given task and an individual's expectation concerning the effectiveness of her/his own behaviour, i.e. "can I do this task under these conditions?" (1). Self-efficacy is an all-inclusive personal judgement of perceived ability to perform a defined task, it has a dynamic nature, changing as new information and experiences are added, and involves a going-over-to-action component (44). According to Zulkosky (31), self-efficacy "influences how people think, feel, motivate themselves and act". How an individual perceives her/his self-efficacy is an important determinant of performance, and explains in part why some individuals, known to have acquired a skill, fail to use that skill in practice. Individuals will avoid activities that they perceive will surpass their coping capabilities, and self-efficacy also appears to determine how long an individual will persist with a certain task when experiencing difficulty with the task.

The attributes or characteristics of professional confidence

The articles presented a single definition of professional confidence, namely "an internal feeling of self-assurance and comfort, as well as being tested and/or reaffirmed by other nurses, patients and

friends ..." (45) while the definitive measure of professional confidence in nursing was described as "you feel like a professional nurse, not 'just a nurse'"(45). Brown et al. (40) reported a lack of precision in characterizing professional confidence, and their research with baccalaureate nursing students was undertaken for this very reason. Where other authors identify similar characteristics, this is highlighted.

Brown et al. (40) described the key components or attributes of professional confidence as evolving through seven iterative processes beginning with "a sense of feeling good about one's self in first year ..." to becoming "a professional nurse by the fourth year" (40). The attributes of professional confidence were related to a (i) *feeling* (45), explained as a generalized sensation of feeling good about oneself and feeling comfortable in a certain setting. It was also about (ii) *knowing* (45), i.e. knowing and accepting that one did not know enough about a certain topic or acknowledging that one had the required knowledge. It further related to (iii) *believing* (45), explained as liking yourself, having faith, or trusting yourself and (iv) *accepting*, for example, your knowledge base, being open to feedback and working with it. This evolved into (v) *doing* (46–48), as in taking the initiative and completing the task and (vi) *looking* within, considering how others see you in terms of your confidence, and reflecting on these two sets of information. The entire process resulting in (vii) *becoming* (47,48) confident. Professional confidence is, however, acknowledged as being transient (47), understood to take time to develop, and can be shattered or destroyed. Transitional periods, change, unrealistic expectations, uncertainty, anxiety, and stress are some of the factors identified as impacting on confidence (47,49,50).

From the preceding review it is evident that professional confidence is characterized by being a process and evolving over time. The measure of professional confidence as reported by Crooks et al. (45) also links it with professional identity, another clarifying attribute, while Brown et al. (40) noted that the former was integral to the latter.

In summary, there appear to be four components to professional confidence, namely affect, reflection, higher cognitive functioning, and action. The affective component is encapsulated in feeling at ease and comfortable in a situation, while the reflective component is evidenced in looking within and reflecting on practice and feedback received. These two characteristics, together with knowing, believing, and accepting, all imply a level of intellectual insight and higher order cognitive functioning to confirm and consolidate this professional confidence and, lastly, there is an action component in doing, taking the initiative, and engaging. However, transitional periods, change, and stress are known to break down existing professional confidence.

In the diagram (Figure 1), professional confidence is represented as a spiral, with each component or attribute influencing and informing the next attribute in an ever-increasing area of influence and/or impact. Transitional periods or change might shrink the area of influence, with the practitioner moving inwards

Figure 1. A diagrammatic representation of the attributes of professional confidence and how they interact.

into a more familiar band of feeling comfortable, before venturing out again, experiencing and recognising success as such after reflection and feedback from others. The growth and contraction of the professional confidence spiral is a dynamic process, the goal being to feel like a professional as described by Brown et al. (40).

The antecedents of professional confidence

Antecedents are the situations, events, and phenomena that precede a concept (27). Professional confidence had its genesis during university study and continued during a professional's practising of her/his chosen vocation (34). In terms of the antecedents, first, one had to possess certain personality characteristics and general life experience, and hold a firmly grounded belief in self (even as a child and adolescent) as being able to do what was required. Prior experiences of success, a perception of the environment as supportive and nurturing, and involvement in close encouraging professional relationships were further identified as important antecedents to professional confidence.

Certain personality characteristics and general life experiences before entering the profession as a student were noted by Brown et al. (40) as antecedents to the development of professional confidence. These included, an inclination to "be involved and to take initiative", seeking out leadership-type opportunities, involving themselves in projects, and venturing out from a young age. Crooks et al. (45) and Bolderston (46) noted that this trait needed to continue into later life as a professional, as venturing into unknown territory was important for fostering continued professional confidence. However, the reverse situation is also true, as a professionally confident therapist was prepared to venture out, which encouraged further professional confidence. A firmly grounded belief in self was necessary to be able to do what was required. During their career, professionals who had a strong belief in their own abilities and their chosen profession (34,39,51,52), who internalized the values, knowledge, and skills of the profession (45), felt competent (48,53), and were able to act independently as a multidisciplinary team member (39,48,51) were more likely to experience professional confidence. These aspects were also closely linked to a growing professional identity (45). The ability to cope with anxiety and stress through the use of adequate coping mechanisms was emphasized (34), with Brown et al. (40) listing being prepared as an important strategy. Continual reflection-in and reflection-on practice was critical in order to learn more about the self (40,45).

The nature of experiences was also noted as being critical, these being characterized by mastery (34) and perceived success (33,34,45), often implied and verified in feedback from tutors, peers, or colleagues as well as through self-reflecting in and on practice (34,45). The individual professional needed to be successfully solving clinical problems, and meeting or exceeding the required skill levels (45). The events that they were exposed to needed to be understood as significant and suitably challenging (40), such experiences leaving the professional wanting to know and engage more. Conversely, unrealistic expectations left practitioners (students or qualified therapists) feeling that their professional confidence was vulnerable and under threat (33). It was therefore proposed that time be made available to practise and gain the required expertise in a challenging but controlled environment (34). As noted earlier, the nature of actual experiences is relevant throughout a professional's life, with Conneeley (35), for example, noting that occupational therapy graduates undertaking Master's studies reported increased confidence levels as they successfully engaged in challenging study at this level, with the concomitant growth in competence and perceived success.

With regard to the nature of the environment, a number of authors spoke of the setting, initially for the student and later for the qualified therapist, as needing to be encouraging, supportive, and safe (34,40,45). In addition, the environment needed to include an opportunity to practise and improve their skills (34). Within this environment, particularly for the student professional, there need to be teaching strategies that increase confidence. These, for example, included small-group learning, the use of standardized patients to practise on, a variety of teaching methods (40), and learning in multidisciplinary settings (48,54).

Relationships with clinical tutors and lecturers, peers, and other colleagues were important antecedents (34,37,40,45,53,54). Peers, mentors, and other team members needed to be viewed as encouraging, with professional relationships being characterized by a commitment to mutual respect and acceptance (40). Within these professional relationships, the individual needed to be validated by co-workers (37), enjoy a close working relationship with fellow team members (34,48,53,54), and be provided with peer support (53). Role modelling by more senior or experienced staff was highlighted (45), and mentoring of staff was viewed as essential to foster professional confidence (34,53). If such relationships were characterized by encouragement, respect, and acceptance, feedback and constructive evaluation could be readily given and would more willingly be accepted, a necessary precursor to fostering and validating professional

confidence through enhanced knowledge of self (34,37,40).

Two of the articles focused on the effect of contradictory information as an antecedent to professional confidence levels. Hsu et al. (49) reported that nurses confronting a Severe Acute Respiratory Syndrome (SARS) epidemic in Taiwan lost professional confidence when they experienced an environment they felt they had little control over and where contradictory information was presented. The health workers concerned observed a drop in SARS cases, but news reports continued to report sensationally around the epidemic, making these health workers question their efficacy in the situation and the health sectors ability to cope. The study by Smith et al. (50) noted that despite recent research that found no causal link between the measles, mumps and rubella (MMR) vaccine and autism spectrum disorders, previous well-publicized research, later noted to be misleading and un-replicable, linking the two, continued to influence and affect the confidence of health care workers in terms of administering a second dose of MMR. Both groups of researchers, working in two different arenas, noted the need for congruency between observations and reports, that health workers themselves needed more ongoing education in the field and to be part of any policy-writing initiatives. This has implications for professional practice as an antecedent to professional confidence.

From the preceding it is clear that while certain personal characteristics are essential, without the required relationship with peers and colleagues, and self-reflection within a supportive and encouraging environment, professional confidence will not be fostered optimally. Writing from within the related discipline of chiropractics, Hecimovich and Volet (34) noted, as did the occupational therapy authors mentioned in the introduction (2,11–16), that transitional periods, for example moving from student to independent practitioner, were of particular concern. Questions that arose were whether professional confidence only grows in ideal situations, if it also grows in more challenging situations, and what level of challenge becomes counter-productive?

The consequences of being professionally confident

Both positive and negative consequences were reported in the literature, these coming after an incident of the concept, or occurring as a result of the concept. On the positive side, realistic and appropriate professional confidence was viewed as underpinning competence leading to engagement, effective practice, and skill deployment, with resultant better and more effective patient outcome expectations (34,40,45). Crooks et al. (45) and Bolderston (46) described this variously as being encouraged to take chances, learning more as a result, growing as a professional, feeling excited about trying out new things, and thinking in a wider-ranging manner. Hecimovich and Volet (34) and Crooks et al. (45) noted that professional confidence had a positive effect on critical thinking and/or clinical reasoning, and that these positively influenced one another, leading to engagement in more advanced practice (46). Positive experiences and concomitant evolving professional confidence stimulated further innovative engagement and the opportunity for strengthened professional confidence. This positive spiral is likely to contribute to greater job satisfaction, another positive consequence of professional confidence (55) as well as less anxiety, stress, and/or distress. When dealing with complex distressing situations, such as the urban violence circumstances described in the Dekel et al. (56) study, it was noted that the greater the sense of professional confidence of health professionals, the lower their personal potential levels of distress were in these dangerous health provision situations.

On the negative side, being under- or over-confident impacted professionally on patient outcomes. The under-confident professional would not engage with the situation or trust her/his clinical reasoning, preferring to rely on outside resources to assist, even when not needed (34). According to Hecimovich and Volet (34), such professionals shied away from patient contact and lacked the required leadership in such contacts. The Dekel et al. (56) study reported that a lack of professional confidence stimulated stress and post-traumatic stress disorder symptoms amongst health professionals in life-threatening health provision situations. In contrast, the over-confident professional could precipitate errors, leading to harmful or detrimental patient outcomes with malpractice consequences (34,45). Professional confidence therefore needed to be both realistic and appropriate for the situation.

Concepts related to professional confidence

The related concept of self-esteem is defined as "respect for or a favourable opinion of oneself" (41) and describes affective responses to tasks undertaken, e.g. feeling good or bad about yourself, or the degree to which the person values her/himself. Self-esteem does not necessarily relate to doing a task better or being motivated to do a task, and a high or low self-esteem fosters good (bad) feelings in spite of effort or achievement (57). The emphasis with self-esteem is therefore on evaluative judgement, while self-concept is how an individual views her/himself and is defined as "the whole set of attributes, opinions, and cognitions that a person has of himself"

(41). It is important to be able to distinguish between the concept being analysed and related terms.

Discussion

Identification and discussion of a model case

Rodgers (27) suggested that the model case serve to illustrate the concept and that rather than being constructed to illustrate the concept as proposed in some versions of concept analysis, that it could legitimately be identified from literature outside of that obtained during the data-gathering exercise. The purpose of a model case is to provide an everyday example of professional confidence in a relevant context, including references to the attributes, antecedents, and consequences of professional confidence. The model case presented covers an occupational therapist's transition from student to clinician, and illustrates a scenario that many occupational therapists could relate to.

Tryssenaar (16) reported the lived experience of an occupational therapist in a single case study. During her student years "Maggie" was described as someone who would make a good clinician, motivated and apparently professionally confident, this being evidenced in her assuming the role of a research assistant over and above her role as student. This demonstrates that Maggie appeared to possess the required personality characteristics as an antecedent to professional confidence, as she is noted seeking out new experiences and being involved in a range of initiatives. However, in contrast, her initial work setting lacked a number of features identified in the literature as being necessary antecedents. This could be related in part to occupational therapy not being valued at the institution, with Maggie questioning her professional identity and her role within the team and the institution. Her belief system, her belief in her abilities, and the value and scope of the profession were shaken. She also encountered a lack of professionalism amongst team members, and the situation where the various team members seemed to be at odds with one another. Morale was described as low, and at the time of the research staff were on strike, something that Maggie found very hard to deal with, considering her continued concern for the clients. The implication of all this was that Maggie appeared to lose her professional confidence and found herself floundering. The link between professional identity, professional confidence, and competence is clearly demonstrated at this point in Maggie's story.

While acknowledging that she lacked experience and competence, she reported continuing to try, and found the feedback from her clients the most encouraging, hoping that with further experience and success she might again begin to feel professionally confident as an occupational therapist. While recognizing what her environment was doing to her, through reflection Maggie identified that which buoyed her, and then consciously sought out collegial support from certain individuals and attempted to avoid detrimental situations. In the midst of all this, through reflection, she realized that she needed to take control of her situation, used feedback received, and went over to action. Maggie understood that she needed to use that which was available to her, and further believed strongly that she could be effective and make a difference as an occupational therapist. She actively engaged in attempting new interventions, refusing to have her enthusiasm dampened by others. The interplay of the attributes of professional confidence, namely affect, reflection, higher cognitive functions, and action, is evidenced in this portrait used as a model case.

Professional confidence can therefore be defined as a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences. A number of attributes or clarifying key components of professional confidence were uncovered in the literature, and these assisted in defining the concept. Certain personality characteristics and a belief in self, experiencing success, the environment, and relationships were identified as precursors or antecedents to professional confidence. There were both positive and negative consequences to being professionally confident. For the occupational therapist, these included either growing as a professional and experiencing greater work satisfaction or stagnating with resultant non-engagement and heightened stress. Those using their services could expect improved intervention outcomes when interacting with a professionally confident and competent therapist.

If it is accepted that professional confidence underpins competence, and that both in turn are linked to professional identity (2,40,45), then it is of concern that professional confidence has not been explored and described in any detail in the occupational therapy literature. The first implication is therefore for professional confidence to receive greater recognition as a concept worthy of and requiring exploration, debate, and investigation. Professional confidence is acknowledged as having its roots in initial university study (34), where competence is developed and professional identity fostered.

Second, the nature of the teaching and learning environment and the actual experiences students are exposed to need to be considered (34,40,45,53).

Reference was made to the need for learning environments that offered opportunity for exploration in safe but challenging environments, where mastery and success could be achieved. Some suggestions were offered, for example small-group learning and the use of a variety of teaching and learning methods. The experiences of students in terms of what they perceive as contributing to their professional confidence has, however, not been explored, and what constitutes a safe encouraging environment is again not described in any detail. Emphasis needed to be placed on cultivating skills in reflecting on and in practice, to enable a student or practitioner to evaluate for her/himself how successful her/his intervention was, and how she/he personally performed, weighing this up against other feedback received.

Third, the relationship between student practitioner and preceptor or supervisor, and between mentor and therapist needs to be explored, as feedback from peers, tutors, and colleagues is vital in implying and verifying success (34,40). There are currently no specific outcomes in terms of therapeutic and professional relationships listed in the minimal standards for training of occupational therapists in South Africa (3), and the authors are of the opinion that educational institutions often unwittingly fail to give sufficient attention to the theory behind, the development of, and assessment of such relationships during training. This appears to be an area needing more direct attention and input, which might involve training preceptors or clinicians as clinical supervisors, encouraging mentorship skills in mentors, preparing students for their supervisee role, and therapists for their role as a mentee, to enable relationships to be mutually beneficial and productive. Role modelling in all these areas was highlighted as being a critical factor.

Fourth, there is a need to explore the selection and admission of suitable candidates into occupational therapy educational programmes. What personality characteristics and general life experiences should we be looking for in applicants? Certain personal characteristics and early life experiences were identified as being antecedents for the development of professional confidence. Currently, the majority of occupational therapy programmes in South Africa (for example) admit students on an academic merit basis rather than any other criteria.

Finally, the perceptions of students and staff in terms of the factors they believe impact on professional confidence need to be investigated more fully, and with a better understanding of what constitutes professional confidence (the attributes of professional confidence) there is a basis from which to start.

As a profession, occupational therapy has acknowledged that professional confidence is an issue for students just before graduation, and that newly qualified therapists experience a further loss in this regard when they begin their careers. Frequent reference was made to nurturing and enhancing professional confidence, but what this entails has not been described in any consolidated way. This investigation sought to analyse the concept of professional confidence, highlighting the attributes, antecedents, and consequences of professional confidence, and finally proposed a definition.

Rodgers (27) was clear that the results of such an analysis "do not provide the definitive answer to questions concerning what the concept is ..."; rather, such an analysis affords insights on the current position of the concept through a process of consensus, and highlights further possible avenues for research. In addition, this concept analysis should be considered temporary, as concepts are constantly subject to change (26). This concept analysis is therefore the first step in bringing about some clarity and a shared understanding of professional confidence for occupational therapy.

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PAPER 2

The sources of professional confidence in occupational therapy students

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ABSTRACT

Introduction: *While undergraduate training in South Africa places an emphasis on ensuring the competence of occupational therapy graduates, very little attention has been paid to exploring their professional confidence, despite the fact that this has been highlighted as an issue for students. The foundation for professional confidence is laid during student years, and is influenced by a number of determinants, which this study aimed to identify.*

Methods and material: *Qualitative methodology was used with a purposive sample of nineteen final year occupational therapy students. Students were invited to participate voluntarily in focus group interviews and/or submit their reflective journal. Five lecturers and six clinical supervisors at the University concerned also participated in focus group interviews. Deductive thematic analysis of the data was undertaken.*

Results: *Two broad themes emerged. The first theme, external determinants, included clinical experience, relationships with peers, staff and patients, and the changing environment in which they worked. The second theme, internal determinants, included certain identified personal characteristics and influencers. The external and internal sources of professional confidence beliefs were either within the control of the student, or the lecturer/clinical supervisor or the profession.*

Discussion: *A number of recommendations ranging from re-thinking clinical practicals and supervision are made. These findings have implications for student selection, teaching methodology and experiences, and the professional identity of the profession. Greater formal emphasis needs to be placed on confidence building during the undergraduate experience.*

Key words: Professional confidence, occupational therapy students, occupational therapy education, clinical practical, reflective journaling, supervision

Introduction

Occupational Therapy has been recognised as a health profession in South Africa since the early 1940's and the first students started their training in 1943. Eight Universities now offer accredited programmes, with approximately 250 graduates entering the market each year. Despite comprehensive training which includes theory and practical experience, graduates' lack of confidence in their ability to practise has been raised as a matter of concern by students and staff. While some international studies have been done to identify how professional confidence manifests[1-4], Brown et al[1] reported a vagueness in characterisation of the concept and that little is known about how confidence is fostered.

In South Africa, students undertake a four year undergraduate professional bachelors degree and are required to complete 1000 hours[5] of clinical work (clinical practice) before graduation. How these hours are allocated over the four years of a programme is not prescribed, but for example, at the University in question, approximately 800 of these clinical practical hours are completed in the final year, within four clinical practical modules, and a three week full-time, ungraded, elective block at a venue of the student's choice undertaken just before the final examinations. Students are allocated individually, or as a small group (two - five students), to a clinical supervisor at a specific site during each of the four clinical practical blocks. In South Africa this group mode of supervision is frequently used, as the number of sites available for clinical practice are limited and University departments lack the resources to place students in a 1:1 model with a supervisor. The term clinical supervisor is used to imply any occupational therapist who supervises a student while on a clinical block and can be the clinical therapist employed by the site, a university lecturer or an externally appointed supervisors whose sole responsibility it is to supervise the student. These periods of clinical practice are interspersed with theoretical blocks, and students also undertake an honours level research project in small groups during the year. Clinical practice follows a traditional professional socialisation process, through which students are essentially facilitated into the ways of the discipline[6].

According to Rodger et al[7], the purpose of an occupational therapy education programme is to "... produce competent generalists ..."[7:48] with "... rudimentary skills, fundamental knowledge and attitudes ..."[7:51] while providing those "... experiences considered crucial in preparation for beginning to practice"[7:4]. However, the process of transforming students from their undergraduate status to being graduate professionals is not well understood[8]. Traditionally, the focus of teaching has been on developing practical skills to ensure competence. While these skills are essential to the art of the profession, a number of authors have argued that this emphasis has been to the detriment of consciously developing other important abilities, including, but not limited to, an appreciation of life-long learning[9], communication skills[10], coping strategies[6] and, most importantly, professional confidence[11-15].

Although a number of studies[16-19] have highlighted the issue of student's perceived lack of professional confidence, suggestions on how this complex phenomenon can be supported and nurtured are limited. This is of concern, particularly since the foundations for becoming a professionally confident health care practitioner are established during student years[3]. Professional confidence is a strongly desired trait, as suitably equipped students are more likely to take on and benefit from educational opportunities made available to them[12,20,21]. Professional confidence is viewed as "... one of the most important personal factors influencing clinical

decision making, because if a clinician believes that he or she has the skills to assess a patient's concerns and that the outcome of this assessment will lead to improved quality for the patient, it is more likely that the clinician will engage ..."[3:153]. Professional confidence therefore appears to underpin competence, both of which have been linked to professional identity[2,22]. While competence and professional identity have received wide ranging attention within occupational therapy literature, professional confidence has not been explored with the same vigour, and few suggestions on how it can be fostered were found.

The aim of this study was to explore the determinants influencing the development of professional confidence of final year occupational therapy students. The broad research question was: 'What circumstances, situations, events and personal characteristics do students, and their lecturers or clinical supervisors identify as contributing to, or affecting the development of their professional confidence prior to graduation?'

Literature review

Professional confidence has been defined as "...a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences"[23]. The sources or determinants of professional confidence lie in certain personality components and the circumstances, situations, activities, events and relationships that an individual engages in on a daily basis[24]. A qualitative study[1] undertaken at McMaster University School of Nursing sought to investigate what influenced or hindered professional confidence with a group of baccalaureate nursing students. This study identified personality traits and behaviours before admission to undergraduate study and elements within the educational programme as forerunners to the development of professional confidence.

In terms of determinants prior to admission into a programme of study, a tendency to 'be involved and to take initiative' and 'venturing out', nurtured and evidenced during childhood years were reported as positively impacting on personal and later professional confidence[1]. Positive feedback from significant others during this developmental period and a general ability to cope with stress were further identified[1]. The determinants of professional confidence during the educational experience were identified, firstly, as the supervisor/student relationship, secondly as actual experience gained and thirdly, as feedback received from peers, lecturers, clinical supervisors and patients[1].

One of the understood purposes of supervision in clinical practice situations is to increase the professional confidence of students[11,13,22,25]. The close professional relationship that develops between a student and supervisor is assumed to be conducive to creating a positive learning environment, which in turn is understood to promote professional confidence[1,25]. While research undertaken in nursing[26] concluded that the supervisor-student experiences do raise student nurses' confidence levels, others have cautioned that the role played by supervisors in either fostering or hindering students' professional confidence was mostly speculative, with little empirical evidence to substantiate this claim[3,27].

The most significant determinant enabling professional confidence during an educational experience was considered the opportunity to gain experience[1,3]. Atkinson and Steward[19] explored the experiences of occupational therapy students both before and after leaving university. Their sample was acknowledged as being small (n=25 pre-qualification and n=3 post-qualification) and represented students from only one training centre in the United Kingdom. It was, however, noted that new practitioners reported heightened levels of ability through increased professional confidence, brought about, in part by, the experience gained to date, increased knowledge, the opportunity to practise certain skills and realising that they did not need to know everything. In a study undertaken with the first group of clinical psychologists performing community service in South Africa, 90% of the sample (n=52) reported increased professional confidence levels as they gained experience working[28]. While it is acknowledged that these studies were done with post-qualification professionals, most final year occupational therapy students undertake some independent practice as they near course completion. Perceptions of professional confidence also arise from feedback from peers, tutors, clinical supervisors and/or other colleagues. Continual self-evaluation undertaken through reflecting in and on practice, was also reported to foster professional confidence[3].

Certain personally held beliefs, strategies and identity issues were further reported as impacting positively on professional confidence. These included low anxiety levels[12], a comprehensive knowledge of self[1], enjoying a strong belief in one's abilities[3], being prepared for any experience[1], internalising the values, knowledge and skills of the profession[2], feeling competent and embodying a growing professional identity[2].

Overstated expectations about clinical practice on a students part was reported as negatively impacting on professional confidence[29,30], as there was a disjuncture between expectation and reality. In addition, while clinical practical might provide a necessary sense of reality to students, expectations from clinical supervisors perceived as unrealistic were reported as leaving students feeling vulnerable and under threat[31]. The image of a profession, perceptions of the programme and certain identified tutor behaviours were also noted as hindering confidence development[1].

International studies report determinants that influence the development of professional confidence in the nursing[2] and chiropractic[3] professions. However, there appears to be a gap in the literature in terms of the determinants influencing the development of professional confidence in occupational therapy students. By implication there appears to be limited understanding of how the development of professional confidence in occupational therapy students could be fostered, despite an acknowledgement that "now more than ever, it is important for us to educate not only competent but also confident therapists to meet the demands of a changing work world"[13:5].

Method

Study design

The research question was approached from within the qualitative paradigm with reality assumed to be socially constructed, recognising that there were possibly multiple truths. One South African educational facility was selected for the study, as it has a diverse student and staff population which was considered important, as diversity issues have not always informed research into professional confidence[32-34] or occupational therapy[14,35]. This facility served as the selected case, as Stake[36] noted that case study research could be used to choose that which is studied rather than as a methodology per se. Case study research offers a way of understanding complex human encounters in a particular context, important for the exploration of, and subsequent development of discipline knowledge in that same context[37,38].

Purposive sampling was used, and an invitation was extended to a group of 21 final year occupational therapy students to volunteer to participate in the study. Participants' ages ranged from 20 to 26 years and the group included two male students. The students came from different racial, cultural, religious and socio-economic backgrounds representative of the South African population. Participants' school experiences ranged from education received in under-resourced government schools, ex Model C government schools (well resourced) and private schools. A variety of languages were identified as the participants' first language, including English, isiZulu, SeSotho and Afrikaans, with the majority speaking English at home. All students took a semester course in conversational isiZulu (and an overview of Zulu cultural practices) to prepare them for their engagement with their service users, the majority of whom were isiZulu speakers. The participants either lived at home during the year, or made use of university hostel accommodation, having originated from the local municipal district which included both urban or peri-urban

settings, or from more rural environments further afield in the province and adjoining countries.

The purpose of the study was explained, and students were invited to volunteer to participate in two ways; through participation in focus group interviews and/or through submission of their reflective journal undertaken during their first clinical practical block of the year. The voluntary nature of participation was explained and volunteers were requested to sign an informed consent statement for their involvement in each of the data gathering exercises.

Nineteen students volunteered to participate in one or two of the five semi-structured focus group interviews[39] held during the year. Focus group interviews, consisting of three to eight students were arranged on the basis of the students' availability, and were scheduled for a time and place mutually agreed upon by the researcher and the participants. The first focus group of three students was held just after the first clinical practical block ended in April, with the last focus group, consisting of eight participants, taking place after the final examinations in November. Between these two groups, three more focus group interviews consisting of three (two groups) or six students were held. All the focus group interviews were audiotaped and transcribed verbatim.

Similarly, clinical supervisors and lecturers, actively involved in supervising this cohort of students were invited to participate in the study in a focus group interview held mid-year. An open invitation was extended to clinical supervisors and lecturers. Six supervisors and five members of the university's lecturing staff participated in two focus groups, one with each staff grouping. Similar to the student group, the lecturers and clinical supervisors represented a diverse cross-section of the South African population, and while the majority was female there was one male lecturer in the sample.

Reflective journals containing descriptive information and the students' reflections on practice, undertaken during their first clinical practical block of the year, provided additional data. Professional confidence as a phenomenon was not introduced to the student participants during the presentation of reflective journaling methodology before their clinical practical block, as the reflective journals were produced with another purpose in mind. However, the researcher had concurrently met with the student group to appraise them of the study and invite them to participate. Seventeen participants volunteered to submit their journals by mid-year, after they had been graded. Each journal, generally handwritten, was copy typed to facilitate data management.

Ethical clearance for the study was obtained from the Humanities and Social Sciences Ethics Committee of the University concerned (HSS/0156/2010), and internal gate-keeping imperatives regarding ethical protection of participants were met in both the Faculty and the School where the discipline was housed.

Data Analysis

Data analysis occurred concurrently with data collection which took place from April until the academic year drew to a close. The method of data analysis used to explore the experiences of the research participants was thematic anlysis[40]. As the researcher was guided by theoretical interests and preconceptions in the broad topic, having read widely in the area before and during undertaking the data analysis, theoretical or deductive analysis[40] was undertaken. Data across the data set was initially coded taking the broad sources of professional confidence, identified during the literature review, into consideration.

In order to enhance trustworthiness in this study, the following methods were used. Credibility[41] was achieved by employing research participants specifically chosen to represent the experiences of as diverse a group of occupational therapy students, lecturers and clinical supervisors as possible. Verisimilitude[42] will have been achieved if an occupational therapy student, lecturer or clinical supervisor (as the reader) recognised the situations, events and personal characteristics described and could relate to them, and if the account provided rang true. Finally, the process employed throughout the study was consistent, for example, the focus groups were conducted by the same researcher, using the same introduction and broad interview questions, thereby increasing dependability[41].

Findings

Two broad themes, namely external determinants and internal determinants emerged from the data. Participants perceived and experienced the external determinants that influenced the development of their professional confidence as: Opportunities for vicarious learning – not just doing as they said, but doing as they did. Opportunities for practice – practice makes perfect. Marks awarded – they do matter. Clinical supervision – a critical relationship. Peers – very important people. Feedback – hearing it like it is from others. The competence – confidence link and I can do it. Professional identity issues – green pants people, and lastly the current health care scenario – the way things are today. The internal determinates that played a similar role were perceived and experienced as: Locus of control – it is inside. Anxiety stress and coping – next time I can, and language and cultural issues – do you speak my language.

A. External determinants:

1. Vicarious learning: Not just doing as they said, but doing as they did ...

Participants reported that watching a supervisor successfully engage in practice was an important confidence booster: *"I think what improved my confidence ... was when I watched an OT* [occupational therapist] *... so the next time I was with the patient, I just thought of like, let me try this. I found that it worked and then.... my confidence was boosted ... just having somebody there to show you and then trying it out and finding that it actually works for you, helped me a lot"* (FG[1]). A clinical supervisor with years of experience noted: *"... where they see the OTs doing things, and they kind of then model your behaviour ... that builds that confidence"* (FG), acknowledging that she understood that vicarious learning was an important source of professional confidence in students: *"... you'll see them trying out what you were doing ... I think that's important because that's how we all learn"* (FG).

2. Opportunities for practice: Practice makes perfect ...

The participants all appeared to understand and appreciate that with practice comes greater competence which led in turn to enhanced professional confidence: *"... because you know, like the more you practice the more you get confidence in things ..."* (FG). The link was repeatedly made by the participants, who also noted that with more experience and concomitant confidence they also engaged more. This evolving professional confidence acquired through practice in one area, also positively infused their anticipated engagement in subsequent blocks: *"...I feel so confident walking out of that school. But not only confident about Paeds but the rest of the pracs..."* (JE). What they engaged in also needed to be perceived as successful, as success was an integral aspect of this cycle. Staff were also aware of this, with an academic participant noting: *"I think if they have repeated successes, it might be a major [boost] of their confidence at the end"* (FG).

A constant refrain from many of the participants was a reference to time, and the relationship between time, repeated practice opportunities and confidence: *"I mean you don't have time obviously to have practised three times ... three times ... to get that confidence"* (FG). Time, acknowledged as being limited, impacted on their ability to gain enough experience and practice certain skills and techniques sufficiently.

3. Marks awarded: They do matter ...

The participants reported that with respect to actual experience, the marks or grades awarded for performance aided or at times hindered their perceptions of competence and confidence. *"... knowing that you have a good mark, it just boosts your confidence much more..."* (FG). Good grades therefore, appeared to contribute to

1 The source of any direct quote included in the findings as evidence has been indicated as either a FG -focus group or a JE - journal entry

fostering professional confidence. However, the belief a supervisor displayed in a student was noted as ameliorating the negative effect low marks could have on professional confidence, as described in the next section.

4. Clinical supervision: A critical relationship ...

Participants were clear that: *"... our supervisors can build our confidence ..."* (FG). The importance of first impressions setting the tone for the ensuing relationship was raised by the participants in a number of the focus groups and in individual journal entries: *"If you're able to win your supervisor on the first place, she will be confident about you"* (FG). How the two parties perceived each other on the first meeting was noted as generally setting the tone for the ensuing relationship, with participants describing this resulting in their supervisor then either believing and/or having confidence in them or not. A unique insight offered by a male student related to how on first meeting with a supervisor, *"... we're going to use our charms..."* (FG), suggested that gender relations were perceived as a resource for male students to manage the supervisory relationship within this historically female working environment.

In terms of the personal qualities of supervisors, knowing the student, believing in them, being supportive, encouraging them, being there for them, understanding and helping were all identified as being important by the student participants: *"They encouraged us and didn't break us down. This gives us confidence in ourselves and allows us to grow and improve..."* (JE). Supervisors with these qualities were acknowledged as making students feel more confident: *"... like a supervisor who understands – I mean you can work so much better, you feel comfortable, you're at ease with your patient ... you just need encouragement sometimes, yes, it boosts our confidence ..."* (FG). The converse was noted by the participants as having the potential to adversely affect a student's confidence: *"I don't know how to say it, for the first time in OT... but my clinical supervisor, I felt like she did not like me ... she had a negative attitude towards me"* and the student concluded: *"...and that really brought down my confidence"* (FG). A positive and supportive relationship was viewed as ameliorating concerns around grades and perceptions of confidence: *"My marks are the worst prac marks I got in my three years of OT, but I feel the most competent and I have confidence in myself, all because of my supervisors. They believed in me, and so I can believe in myself"* (JE). A supervisor, reflecting back on her own experiences as a student, related her ideas on what she thought important for a supervisor to offer: *"... it's the support that we're giving building it [confidence], that really helps"* (FG).

5. Peers: Very important people ...

The group model of supervision raised some important pointers for developing confidence. The two most frequently voiced benefits for developing professional confidence, according to the participants, were reported as firstly, that students experienced support and encouragement as they felt that they were in this together: *" ... people are experiencing the same things, it's such a good support, like it's such a good way to like boost your confidence also because I think, you know, you're down and you don't know what to do and everything like that, and then that person kind of lifts you up and encourages you ..."* (FG). Secondly, the participants reported that they learnt from one another. In situations where it was reported that students were afforded very little opportunity to observe qualified therapists engaging in actual practice for a variety of reasons, working with peers served as an important foundation for learning and raising confidence: *"...it was really nice to have that kind of support. It just boosted your confidence more because you actually reassured each other in a way"* (FG). The participants also noted that peers were viewed as being of more value than other sources of knowledge and assistance at time: *"... because even if you can go to the book sometimes, the books will not give you that direction in as much as it can be given by someone* [referring to peers] *who has that experience ..."* (FG). One participant voiced disquiet about the potential of being placed alone at a site: *"... I could imagine if I was alone, wow, there are things that would be difficult ..."* (FG). This mutual sharing and observing allowed students to draw strength from the experiences of their peers, and allowed comparisons to be made between peers. This form of group clinical practice does however come with some risks, as some participants expressed concerns about 'getting on' with their peers, and others felt that not all peers were that supportive at times.

6. Feedback: Hearing it like it is from others ...

Feedback from clinical supervisors was acknowledged by the student participants as one of the main determinants that boosted confidence. A participant reported that: *"...what also played a big role in our confidence is the feedback we got from her* [referring to a clinical supervisor]*"* (FG). Another important determinant arising from feedback was the comments of patients (service users): *"... because a patient would say thank you or whatever ... yes, that would be a huge thing that is boosting my confidence"* (FG) and the family members of service users: *"... when the parents* [of a child being seen during an clinical practical experience] *start making comments you know ... like it just boosts your confidence, it really helped"* (FG).

7. The competence – confidence link: I can do it ...

Competence, knowledge and confidence are inextricably linked to one another, and it appeared well understood by the participants as this excerpt from a focus group interview demonstrated: *"...you know, I'd basically lost confidence in myself because I don't think I was competent. ... so because I wasn't feeling confident in my ability, my competency actually did generally decline"* (FG), and it was further described as a cyclical process: *"...it was like a vicious cycle"* [in this instance]. At times, competence was recorded as influencing confidence, for example, a student participant noted that: *" you have to know your stuff to feel confident initially"* (FG), with a supervisor concurring: *"I felt that like the lack of confidence of the students that I've had, has been directly proportional to the [their] lack of knowledge"* (FG). However, the converse was also perceived as true by the participants: *"... confidence went hand-in-hand with knowledge"* (FG).

8. Professional identity issues: "Green pants people ..."

The participants appeared acutely aware of the role professional identity and the image of the profession had on professional confidence. Participants reported: *"... it just helps to know that your profession stands out somewhere and it's making a difference. That health professionals know that you exist, not as when you [have to] tell someone 'I'm doing OT"* (FG).

The participants noted that deciding what occupational therapy essentially was, was difficult at times: *"... often I feel like 'is this my role? isn't this my role?' and then you don't feel confident"* (FG). Student participants and supervisors alike commented on, what they termed, a jack-of-all-trades notion to being an occupational therapist, and the impact that had on professional confidence.

Concern was also raised about expressing or voicing their professional identity: *"you know what I find difficult, to voice how I'm, what I'm thinking, ... that's when I lose my confidence"* (FG). This reported inability to succinctly define their role had detrimental consequences, as the participants perceived that occupational therapists were often misunderstood by other professionals, who found it difficult to understand the broad scope of the profession: *"Oh, you guys are what? Green pants people, right ..."* (FG). The speaker in this instance appeared to equate profession to uniform colour, as opposed to actual practice.

A supervisor, possibly better equipped to comment on the image of the profession noted: *"It's the image that's created .... we are seen as the lesser profession"* (FG). This was noted by the participants in general as affecting professional confidence levels: *"... because you think what does everyone else think about OT?"* The qualified therapists were very conscious that what happened in the work-place had a definite impact on students' confidence levels: *"... it has an impact on the confidence of us therapists that are in that setting, so there's no way that it's not going to affect the students that are coming in, because you're fighting to do your job on many levels, ... and*

every time you lose a battle the confidence dips" (FG). The interplay of professional confidence, professional identity and the image of the profession was critical, and it was noted by a participant that: *"... when your profession's not really recognised ... you sort of maybe hide-away"* (FG).

9. The current health care scenario: The way things are today ...

Perceptions and experiences reported on by the participants in a number of the focus group interviews, were that occupational therapists suffered from burn-out, resources were limited, and that many health care professionals perceived a lack of success with their patients due to a high mortality rate or the quick turn-around of patients in a hospital settings. All these aspects were noted as impacting on professional confidence by the participants. *"I know every person that went to hospital X, the moment they entered through the boom gate, their confidence levels go all the way down, ... because that place, oh my goodness, I don't even know where to start, but it's burnt out OT's ..."* (FG). The high mortality rate in hospitals impacted on students' confidence levels, and was explained by a participant in the following way: *"... our patients die all the time, so you always get the feeling .... 'am I doing the right thing?', and then it impacts your confidence because you're not seeing that you're doing something right..."* (FG). This related back to an earlier point when it was noted that perceived success enhanced confidence. Supervisors were well aware of this situation: *"...like if they lose a patient as a student, they don't know how to handle it and it sort of brings their confidence down, like I can't, I couldn't do enough for my patient ..."* (FG). In other situations, participant patients were discharged prematurely, often well before the logical completion of any treatment intervention: *"... our patients are here for such a short time ..."* (FG), implying, once again, that students were frequently denied any feelings of success and by implication confidence.

B. Internal determinants: Doing it for myself. Me, myself, I...

1. Locus of control: It is inside ...

An important internal determinant that emerged strongly from the data was the reported need of students to take personal responsibility for their professional confidence. The participants raised issues around the locus of control and the their professional confidence: *"... so I think you must learn from inside yourself how to become confident, you can't always blame everybody because you're not confident – it comes from the inside ..."* (FG). Why confidence beliefs had to come from inside one was aptly summed up by another participant as follows: *"... because if you wait for other people to build your confidence, you're not going to get any better"* (FG).

2. Anxiety, stress and coping: Next time I can ...

Stress and anxiety were noted by the participants as negatively impacting on perceptions of confidence, with participants describing a number of coping mechanisms they used. Being prepared for clinical practical featured prominently: *"I'm going to practise again before Friday, because when I'm prepared I feel more confident"* (JE) and: *"I made sure I arrived on time, I got everything planned, prepared ... that helped my confidence in the end..."* (FG). Having faith in a power greater than self was raised by a number of participants: *"... my belief in God, and that kind of gives me my confidence"* (FG). Positive self-talk was also noted by the participants as aiding confidence: *"...I always do this and talk to myself, 'you know* [names self] *you can do it'"* (FG). Anxiety levels, stress, coping and feeling confident appeared linked and frequent references to trying to see things in perspective were made: *"... take a step back, ... I think when you get perspective then suddenly you're not as anxious and you have more confidence"* (FG). Reflecting back, either over a day or over a period of clinical practical, provided participants with feedback on their experiences to date: *"... as you realise you are improving, it helps you realise 'I can do this' and 'I am getting better at it' and when you know for sure your treatment is correct and beneficial to your patient ..."* (FG). The journaling exercise appeared to have provided participants with a valuable vehicle for reflecting: *"This journal was a good idea. It does take up time. But it's worth it. You get to vent, you get to think ..."* (JE).

3. Language and cultural issues: Do you speak my language? ...

Participants whose home language was not English raised language as an issue affecting their professional confidence. When they were obliged to use English, their second or third language, to interact with patients, they felt their confidence wane: *"... the language I think, it's also one thing which is bringing out the un-confidence a little bit in us"* (FG). However, these same students were acutely aware that when they used their home language with their patients they could justifiably feel confident: *"... if you use your language you are better, you have more confidence..."* (FG). An insightful participant noted: *"...I really need to be trained in a way that I can be confident in any culture"* (FG).

In conclusion, professional confidence was presented by the participants as a belief that arose wholly from within themselves. *"I'm feeling confident. ... But it comes from inside ... it's like a thing inside you, this confidence"* (FG) and locus of control, coping, language and cultural issues were inextricably imbedded.

Discussion and Recommendations

From the preceding results, it is evident that a number of these determinants are either within the control of educators, the students themselves or within the profession and the service sector as a whole.

Determinants within the control of the educators

Using a group model to supervise students was noted as encouraging the development of professional confidence by the participants. This finding supports previous research which reported that group supervision produced students who were more confident than those allocated to a more traditional 1:1 supervisory model[20]. Participants found that it gave them the opportunity to share and reflect with peers, who lent support and provided different types of learning opportunities. This study, therefore, supports previous nursing studies[1,2,24] which recorded that strength could be drawn from peers and professional confidence fostered.

The participants noted that with experience came professional confidence, similar to other studies[1,3,28] but that opportunities needed to span a realistic period of time, during which the student could gain experience through repetition. This has implications for deciding what experiences students need to have during their 1 000 hours of clinical practical training. A one-size-fits-all approach to clinical practice might not be the ideal, as learning is strongly influenced by individual attributes, as individual students and student cohorts differ in their needs[42].

Thirdly, this study highlighted the fact that clinical supervisors, and the supervision they provided during clinical practical experiences, played an important role in influencing professional confidence which was similar to other findings[13,26]. In previous research[44], qualified therapists described their personal experience as undergraduates to be the most beneficial when their clinical supervisors saw it as their duty, and acted in a way that built their confidence. Certain personal qualities in clinical supervisors were noted as supporting the development of professional confidence; the actual relationship that developed was critical and feedback received enhanced confidence perceptions as well. These issues argue for careful selection of clinical supervisors and should inform the content of any clinical supervisor training programme.

Fourthly, feedback from a number of sources was noted as encouraging professional confidence, with positive constructive feedback being one of the most important confidence boosters.

Finally, individuals from diverse backgrounds need to be admitted and to serve as supervisors, to inform and shape the profession from within[45,46]. Language usage, an item not reported on in the literature, and its possible effect on professional confidence as presented here, is deserving of further exploration. As English is

often considered the language of business and education, it was not unexpected that none of the English home language speaking participants expressed any opinion about language or cultural groupings affecting their confidence. However, "practice becomes effective when appropriately matched to the cultural beliefs and values of individuals, groups and communities"[47:157] and fieldwork undertaken in under-resourced and multicultural settings can be a rewarding learning experience, in turn boosting professional confidence[48].

Determinants within the control of the students

In keeping with previous research[1,2,12], the research participants reported low anxiety levels, feeling competent, and being prepared as internal characteristics required to feel confident. In addition, they reported that an internal locus of control and language as issues they considered impacting on their professional confidence, lending credence to an opinion put forward by McLaughlin, Moutray and Muldoon[43] that the mere application of external confidence boosters would not necessarily work. Managing stress helps to build confidence, and this can be achieved by encouraging self-reflection in journaling exercises, positive self-talk and reflecting on past behaviour.

Determinants within the control of the profession and/or service providers

The participants described how difficult it was at times to explain what is was they were thinking or doing as occupational therapists, and the negative effect that had on their professional confidence. Two implications of this are immediately evident. Firstly, as the professional identity of a student is largely cultivated through identification with clinical supervisors, supervisors need to project a strong professional identity and be able to convey their thinking and reasoning to others. Secondly, clinical supervisors lacking professional confidence and a healthy professional identity may be unable to encourage their students to be more independent or confident than they themselves are, with detrimental consequences for the future of the profession.

The practice environments of health professionals in general, and occupational therapists in particular, are changing, requiring new sets of skills. This was raised by both the students and their supervisors, and necessitates a responsibility for the profession to deal with and set the pace for change through creative and innovative ideas.

Limitations

This study did not presume to explore or pronounce on whether this group of students was in fact professionally confident or to what degree they demonstrated professional confidence at any point in their final year at University. As data was gathered from a purposeful sample of students, their lecturers and clinical supervisors, it reflects the experiences and perceptions of what influenced their professional confidence in the particular context.

Conclusion

The aim of this study was to explore the circumstances, situations, events and personal characteristics influencing professional confidence of a group of final year occupational therapy students. This study has indicated that the determinants or sources of professional confidence emanated from both within the student and from outside, and ranged from having an internal locus of control, dealing appropriately with change and stress, undertaking clinical practice in a group under the guidance of a confident supervisor, experiencing success with occupational therapy interventions to being able to work in an environment where the purpose and scope of occupational therapy were understood and respected.

Professional confidence appears to underpin competence, both of which are linked to professional identity, and for this reason, professional confidence needs to be acknowledged as an important component of occupational therapy education and research and explored to the same extent as the other two.

The findings of this study are significant, as they have implications for broadening the intake of students, the design of the curriculum and planning of clinical practical experiences, the student/supervisor relationship, crafting opportunities for feedback and considering how the profession can best promote and positions itself within the health sector.

Professional confidence should be identified as a targeted outcome of occupational therapy education and training programmes, and must be consciously nurtured in students, rather than leaving it to chance.

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PAPER 3

RESEARCH ARTICLE

Professional Confidence: Conceptions Held by Novice Occupational Therapists in South Africa‡

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Abstract

This study aimed to explore how novice occupational therapists conceptualized professional confidence. Professional confidence is a dynamic personal belief that matures over time. It is closely linked to both competence and professional identity ensuring fitness for practice. Although professional confidence has been defined and a number of its attributes have been identified, how practitioners understand or conceptualize the phenomenon is not clearly understood. Eight novice occupational therapists undertaking their community service year in South Africa during 2011 participated in the study. Data, collected during semi-structured interviews, were analyzed using phenomenographic methodology. From the participant's descriptions, three qualitatively different ways of understanding professional confidence emerged from the data, namely knowing as an occupational therapist, believing you are an occupational therapist and being an occupational therapist. The outcome space was also described. The study did not purport to gauge whether the novice therapists were in fact confident. As professional confidence is a maturing self-belief, the findings are limited to novice occupational therapists. The findings contribute to a growing understanding of professional confidence in occupational therapy. Further research is needed in terms of what informs the conceptions held by novice therapists and how professional confidence can be assessed in graduates on completion of their educational programme.

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Keywords

occupational therapy education; phenomenography; novice occupational therapists

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Introduction

Professional confidence has been defined as a personal belief maturing over time with exposure to determinants that positively influence this growth process (Holland et al., 2012a). But do novice occupational therapists, community service therapists in the South African context, have an awareness of their professional confidence and how do they understand it? Previous research has noted that competence, professional identity and professional confidence are interlinked and work together ensuring fitness for practice. A number of international studies exploring this readiness for practice have been undertaken over the years and demonstrate that novice practitioners reflect on and can articulate their competency experiences and needs (Nordholm and Westbrook, 1981; Rugg, 1996; Tryssenaar and Perkins, 2001; Lee and Mackenzie, 2003; Cusick et al., 2004; Morley, 2006; Robertson and Griffiths, 2009). Entry level competence for novice therapists is also understood

through the application of minimal standards of training most often prescribed by statutory or regulatory bodies (HPCSA, 2003). Professional identity has also been explored (Tryssenaar, 1999; Björklund and Svensson, 2006; Mackey, 2007), especially in terms of the shift from being a student to a qualified practitioner and what this implies, and therapists have considered their professional identity. But to date, professional confidence has not been researched to the same degree within the profession.

A concept analysis of professional confidence yielded a definition (Holland et al., 2012a), and the sources or determinants of professional confidence in student occupational therapists have been identified (Holland et al., 2012b). Studies undertaken in nursing (Brown et al., 2003; Crooks et al., 2005; Haavardsholm and Nåden, 2009) have explored the meanings of professional confidence within that profession, with Brown et al. (2003) noting that the conceptualization of professional confidence was unclear. Knowledge of how novice occupational therapists understood their professional confidence would highlight how these practitioners perceived their growing confidence for themselves and describe their awareness of, and learning about, it. This learning is important, as Pang (2003) noted, as it signified a change in an individual's ability to experience a phenomenon, discern aspects of the phenomenon and remain mindful of it. As there is a reciprocal relationship between professional confidence, competence and professional identify, it would be beneficial if practitioners not only considered their competence and professional identify, but their professional confidence as well.

The aim of the study, therefore, was to explore the qualitatively different ways that community service occupational therapists described, experienced, understood or made sense of their professional confidence, that is, how they conceptualized their professional confidence.

Background

Novice practitioners in South Africa are required by law to undertake a year of remunerated community service in a National Department of Health facility immediately after graduation. In their fourth and final year of study, students are required to nominate five sites of choice for their community service year, and their placement to a site is then arranged by the Department. The period of service covers a calendar year commencing on 1 January, with new graduates registering with the Health Professions Council of South Africa as community service therapists. In the province of KwaZulu-Natal, placement sites include long-established occupational therapy departments, sites being re-established or brand new departments that have not been serviced by an occupational therapist. Therapists are placed as single-handed therapists or in a department staffed with one to five colleagues. There are generally other practitioners such as physiotherapist(s) and speech-language therapist(s) at the site, but frequently, these practitioners are also undertaking their community service year. In the province, an informal network of support and mentoring is offered by members of the profession, and some peer mentoring is evident, but the Department of Health does not offer any formal mentorship, as the novice practitioners are regarded as qualified and are, therefore, viewed as competent to undertake their role.

Professional confidence is a "dynamic, maturing personal belief held by a professional ... (that) includes an understanding of and a belief in the role, scope of practice, and significance of the profession, ... based on their capacity to competently fulfil these expectations ..." (Holland et al., 2012a, p. 222). New graduates have expressed the need to feel confident in their role (Morley, 2006), but according to Morley, the same novice practitioners experience a crisis of confidence within the first 6 months of working, whereas Toal-Sullivan (2006) noted that occupational therapists, in particular, have problems with this transition and ascribed it, in part, to a lack of self-confidence. Thus, although the transition from student to graduate professional was acknowledged as being a difficult period, during this period, novice therapists shape their self-beliefs, including their professional confidence.

Preliminary work undertaken with baccalaureate nursing students by Brown et al. (2003, p. 166) yielded the following meanings of professional confidence: feeling, knowing, believing, accepting, doing, looking, evolving and becoming. These students explained the meaning of professional confidence as an internal process evolving during their student years, commencing with a sense of *feeling* good about one's self and *evolving* over the 4 years of training to *becoming* a professional nurse. In another study, undertaken with post diploma baccalaureate nursing students (Crooks et al., 2005, p. 361), four themes emerged as to what professional confidence meant for this group. These were as follows: defining confidence as an internal feeling of self-assurance, developing confidence

through becoming informed and finding one's own voice, knowing when you have confidence, and that the outcome of being confident was described as feeling like a professional. Both these research endeavours used thematic content analysis methodology and also sought to explore the sources of professional confidence. In other research, Haavardsholm and Nåden (2009, p. 488) defined confidence as a "qualitatively good bodily experience characterized by feeling comfortable and relaxed". The research studies cited did not use a phenomenographic approach, and all three studies reported on meanings of professional confidence as only one of the outcomes of their research.

Phenomenography has been described as a research orientation or approach (Bruce and Gerber, 1997; Svensson, 1997) primarily aimed at understanding the experience or awareness of a group of people about a phenomenon. According to Sjöström and Dahlgren (2002), it is a set of assumptions about people and how researchers can acquire knowledge about how people experience the world. Phenomenography argues for assuming a second-order perspective, where instead of being interested in how something actually is from the researchers' perspective (i.e. a first-order perspective), the researcher wishes to understand how a phenomenon is conceived of and understood by the people involved or in the know, in other words, how these people make sense of their world (Sandberg, 2000; Sjöström and Dahlgren, 2002). Accordingly, the aim of phenomenography is to discover and describe the qualitatively different ways that the phenomenon of interest is experienced, perceived and made sense of, thought about, understood or conceptualized, and it is further accepted that there are a only a finite number of distinct ways that the phenomenon can be understood (Barnard et al., 1999; Sjöström and Dahlgren, 2002; Stramouli and Huggard, 2007). This emphasis on discerning the nature and variation of personal experiences and perceptions is important, as professional confidence has been defined as a *personal* belief (Holland et al., 2012a) held by a professional. The categories of description that are identified in a phenomenographic analysis are not phenomena in their own right, but rather "people's various ways of thinking about their experience" (Sjöström and Dahlgren, 2002, p. 342).

Method

Data were collected from a small, purposive sample in keeping with phenomenographic principles (Stramouli and Huggard, 2007). Eight community service occupational therapists specifically chosen to represent the variation prevalent in community service therapists in the province were invited to participate. In phenomenographic sampling, a range of demographic characteristics are sought, as opposed to frequency, as the researcher seeks variation, not frequency of understanding, from as diverse a group as possible (Åkerlind, 2008). Variations identified included educational institution (alma mater), cultural background, working environment (single handed vs. small team), urban versus peri-urban settings and the field of practice. All the research participants were female, with five working in small departments with occupational therapy colleagues, whereas three worked as single-handed occupational therapists. Six worked in predominately physical settings, whereas two worked in the psychiatric or mental health arena. The settings encompassed both previously advantaged and disadvantaged hospitals or clinics, and five of the settings were situated in large towns. Graduates from three educational institutions were represented in the sample. On initial contact with each research participant, they were informed via telephone or email about the broad topic and were afforded the opportunity to ask questions or request a copy of the research proposal. This helped set the scene for the subsequent interview, with many of the research participants bringing brief notes to the interview as their interest had been piqued prior to the interview.

During the semi-structured personal interviews, held at times and places that suited both interviewee and interviewer, two broad questions were posed: 1) "what does professional confidence mean to you as a community service occupational therapist?" and 2) "what are the characteristics of a professionally confident occupational therapist?" In keeping with phenomenographic principles (Entwistle, 1997), the interviews were conceived to encourage the therapists to reflect on their experiences. Further prompts included "can you explain that some more?" or "paint a (word) picture". The purpose of the interviews was to allow the interviewees to reveal as much as possible about their understanding. The conversation was not directed in any way other than posing the broad questions, each interview being allowed to unfold naturally. All interviews, which lasted between 25 and 60 minutes each, were audio-taped and transcribed verbatim. The transcripts were then checked against the original digital recording to ensure accuracy.

The following iterative steps, originally proposed by Dahlgren and Fallsberg in 1991 (Sjöström and Dahlgren,

2002; Larsson and Gard, 2006; Widäng et al., 2007), were used during data analysis:

- Familiarization with the transcribed interviews through repeated reading of the transcripts;
- Condensation, through searching for statements that were related to professional confidence. Patterns, related to understandings within each transcript were noted;
- Comparison of the statements for similarities and differences was then undertaken to find agreement and variation;
- Similar statements were then grouped together;
- Articulation, through which, in each group, the essence of the similarity was described;
- Labelling, in which each category of description was assigned a name or label; and
- Contrasting, where the categories were compared in a more abstract manner with regard to their similarities and differences.

Neutral discovery, as opposed to an imposed framework for analysis, was employed during the analysis phase, and categories were allowed to emerge progressively as the analysis unfolded. All the generated data were used as proposed by Morris (2006). Data analysis was guided by three considerations, namely bracketing, consciously employing a descriptive focus and assigning an equal value to all descriptions. Bracketing (Ashworth and Lucas, 1998; Morris, 2006) involved the researcher, firstly, setting aside her existing knowledge and understandings, and secondly, not questioning the validity of the research participant's reports. It was acknowledged that a tension existed between trying to put aside personal assumptions about professional confidence and grounding the results squarely in the data. However, according to Morris, "researchers who use a discovery approach will already, consciously or unconsciously, be implementing some degree of bracketing, despite the difficulties involved" (2006, p. 10).

The outcomes of the analysis process are conceptions, or "basic unit(s) of description" (Marton and Pong, 2005, p. 336), and these conceptions were confirmed and named when it was decided that there was enough evidence that a certain meaning had been expressed. Within each of these units, the structural aspects of the conception were then highlighted and confirmed.

Credibility was ensured by employing a purposive sample, and all the interviews were conducted by the researcher using the same format, thereby increasing dependability. Rigour would be achieved if an occupational therapist recognized the categories of description and could relate to them. In phenomenographic research, replication of the categories of description is not considered necessary to ensure rigour (Brammer, 2006).

Ethical clearance was obtained for this undertaking as part of a larger study on professional confidence, and approval for this portion of the study was further sought from the KwaZulu-Natal Department of Health. This approval process included obtaining the support of the facility (hospital) managers where each of the research informants was employed, as well as obtaining the informed consent of each participant prior to the interview. In some instances, the support of relevant line managers was also required prior to commencement of the study.

Results

Three qualitatively different ways of understanding professional confidence emerged from the analysis. Professional confidence was described by the respondents as *knowing* as an occupational therapist, *believing* you are an occupational therapist and *being* an occupational therapist, the first two being internal to the person, with "being" the external manifestation. The different conceptions were raised numerous times within any single interview and were identified in each interview. Each category is described in more detail later, using excerpts from the interview transcripts to illustrate the conception. A diagrammatic representation of the relationship between the three categories of description is also provided, in what is termed the outcome space.

Category A: Knowing as an occupational therapist

Knowing encompassed how these novice practitioners felt they now knew themselves, their skills and knowledge (their competence), and their role and how these three worked together to create an innate internal feeling of knowing, or "I know . . .". This was evidenced in just[1] doing it (engaging).

[1] "Just", in a South African context, is frequently used in everyday speech to mean/imply not hesitating, going over to action, now. Almost without thinking; getting involved, making it more pointed.

Knowing myself

There was an acknowledgement by the respondents of growing self-knowledge and understanding of oneself as a person, for example how to cope with stress and how to manage themselves in various situations. This was described as "Knowing yourself in terms of your own strengths and weaknesses and managing your strengths and using them to the best . . . but at the same time looking at your limitations and looking at how you can . . . reduce that . . .". It was a general "confidence in yourself", which the respondents likened to self-confidence.

Knowing and understanding my professional skills and knowledge

Self-knowledge was further reinforced, according to the respondents, by knowing and understanding their skills, and an understanding and an acceptance of their competence and what they were capable of as occupational therapists. " it's like your knowledge, your skill, your ability . . .". Knowing the theory, where to look for help, and knowing in a practical sense, where to start with interventions, were all presented as forming part of this knowledge component. Accordingly, a confident occupational therapist was "somebody who has very good skill". A strong link between competence and confidence was made: "feel(ing) competent increases your confidence".

Knowing and understanding my role as an occupational therapist

Words used by the respondents to describe this knowing of their role included knowing what their role was as an occupational therapist within their employment settings and within their teams, knowing their obligations, responsibilities and their professional boundaries. An apt description that described this knowing was as follows: "knowing that I've chosen the right treatment modality or way of treating them (the client). . .". Knowing and understanding their role was presented by the respondents as a merging of knowing themselves and their professional skills and knowledge, and then using these to the best of their ability as occupational therapists.

(Just) Doing it

Providing evidence of the knowing was described as "(you) just go in with a patient and just like start straight away and there's no fiddling around to try and find what they need to do. . .". In other words, the respondents understood that they (just) know.

Category B: Believing you are an occupational therapist

Believing, also an internal feeling, was described variously by the respondents as being certain and trusting, and was evidenced by not second-guessing themselves as practitioners.

Being certain of yourself, your competencies and your role

As with knowing, believing was described as believing in themselves, believing they could undertake the task at hand because of their skills and knowledge, and believing in their role. These beliefs were acknowledged as standing firm despite the outcome and were further described by the respondents as trusting themselves and their competencies, for example saying " . . . you believe it's going to work . . .", " . . . being secure and certain in whatever . . ." and " . . . even if things don't go according to plan . . .". A certainty was demonstrated in the following statement: "This is what I've done and I am sure that what I have done is right"

Trusting

"Ok, I'm an occupational therapist, this is what I do" was how this trust was voiced by one of the respondents. Again, it was described as an internal feeling, ". . . like a trust in yourself . . .".

No second-guessing

The notion of not questioning themselves, that is, being sure and trusting, brought the issue of not second-guessing oneself constantly in treatment situations to the fore. Professional confidence was understood as ". . . it comes . . . without doubting yourself . . ." and " . . . not kind of second-guessing myself . . .". This led to these novice practitioners acknowledging that, at times, they believed that they had to fake confidence. "I won't go there and say 'oh my gosh I don't know what to do'. . . if you see a patient and you don't know what to do, you assess the patient and give him another appointment.

Don't tell him 'I don't know what to do . . .' ". This quote is provided as evidence of pretending (faking it) so as not to appear uncertain when dealing with a patient.

Category C: Being an occupational therapist

Being spoke to how confident therapists presented themselves professionally, in terms of their appearance, body language and speech, further evidenced in being assertive and able to advocate for themselves or the service. What was inside each individual, the knowing and believing, translated into the professional image they portrayed to the outside world, that is, how they presented themselves.

Body language – portraying the professional

A number of components of body language were raised by the respondents, including the tone and content of speech, coming over as positive, happy, calm and in control. It was described as "you have that . . . aura about you . . .", portraying the therapist as "she looks confident, the physical characteristics are there, . . . the posture, the smile, the radiance . . .".

An assertiveness

Professional confidence was described by the respondents as being outgoing or assertive. Putting themselves out there and being able to explain their role led to actively engaging and not shying away from encounters, either with colleagues or patients. Being confident was described as " . . . would make you assertive . . . being able to tell people to back off . . .".

Advocating for

In keeping with being assertive, being confident was understood by the respondents as being able to ". . . advocate for themselves . . .". It was described in various ways as putting themselves out there, approaching other health professionals and marketing themselves and the profession.

Discussion

The aim of the study was to describe the qualitatively different ways community service therapists made sense of, experienced and understood their professional confidence as novice practitioners. Three interlinked conceptions of professional confidence emerged from the data, namely knowing, believing and being. According to Åkerlind (2008, p. 243), the various ways that a phenomena are understood that arise during data analysis are not established independently, but rather in relation to one another, as indicated in the outcome space.

The outcome space

According to Han et al. (2009), the outcome space is a diagrammatic representation of the relationship between the categories of description that emerged during data analysis and can be viewed as a synonym, in this instance, for professional confidence (Figure 1). The outcome space illustrated herein represents the internal components, namely knowing and believing in yourself, your professional knowledge and your skills, with the external manifestation of then presenting yourself confidently, that is, being the professional, acting assertively and advocating for yourself and the profession. All three conceptions are interlinked, and the internal factors not only inform one another but both contribute to the externalization.

The conceptions link very well with the identified attributes of professional confidence synthesized in a concept analysis undertaken by the researcher (Holland et al., 2012a, p. 219). Professional confidence was described as consisting of four attributes, namely higher cognitive functioning, affective, action and reflective components. The reflective component, informed by self-reflection and feedback from others, in turn influenced the other three components in a never-ending widening spiral of impact. In the current

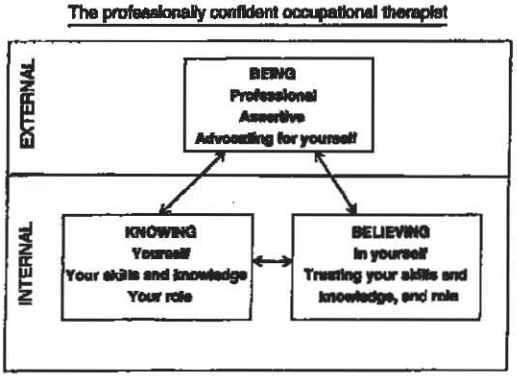

Figure 1. Outcome space

study, the respondents (novice therapists) spoke of knowing – a higher order cognitive ability and believing – the affective component. This was evidenced in a going over to action – being – including presenting themselves as confident therapists. In concept analysis, attributes are the critical components or characteristics of a concept, and may be found in a definition of the phenomenon or in the words used to explain the concept.

Presenting the 14th Vona du Toit Memorial Lecture, Crouch (1994) identified confidence, conviction and courage as fundamental elements for the survival of occupational therapists in South Africa. She linked the three elements to assertiveness, viewing them as integral to assertiveness, but noted that assertiveness came with a number of negative connotations in the profession, based as it was in the health and welfare sector and being female dominated. This research, while exploring the understandings and experiences of novice therapists in terms of professional confidence, supports the links Crouch made, as confidence includes the notions of conviction (knowing and believing), courage (believing and knowing) and being assertive. Crouch (1994) noted that self-confidence was the most important part of assertiveness and that courage and conviction arose from this confidence.

Being comfortable and relaxed, raised in the Haavardsholm and Nåden (2009) nursing study, related well to the conception of believing as an occupational therapist found in the current study. A second understanding of confidence raised in the 2009 study, feeling secure, linked directly to knowing and having mastered (the just doing) certain clinical skills and role expectations. This was termed control confidence by Haavardsholm and Nåden (2009).

The notion of faking until you make it as highlighted in this research was touched on by Crouch (1994). She noted that feeling something, for example confident, led to that feeling of becoming part of one's cognitive processes and then starting to believe it, exactly as these novice therapists described. This links back to the explanation presented by Pang (2003) that learning and thinking about how one understands and experiences a phenomenon signifies a change in the individual's ability to discern, experience and become mindful of the phenomenon. Another term in the literature for this notion of faking it was acting-as-if (Haavardsholm and Nåden, 2009), an apt way to describe the engagement.

Huntley (2008) investigated beginning teachers' conceptions of competence. One of the conceptions raised in that study was becoming a professional, and presenting oneself as confident. For this group of beginning teachers, competence conveyed or inferred confidence. In the current study exploring conceptions of professional confidence, the converse was noted as holding true for novice occupational therapists. Within the conception of believing you are an occupational therapist, viewing or understanding oneself as competent was highlighted as a necessary component of the conception. The interplay and relationship between competence and professional confidence was again foregrounded in both these studies.

Research in nursing has identified similar understandings of professional confidence to those raised in this research. Brown et al. (2003, p. 166) identified eight meanings of professional confidence, including knowing, believing and doing. These meanings that emanated from that research were described as amalgamating or merging in a students' final year and then seeing professional confidence described as having a sense of becoming a professional nurse. If this *becoming* can be linked to student years – the period of learning the ropes and professional induction into the ways of the profession – it equates very well with the conception these qualified but novice therapists held, namely *being* a professional. Further research in nursing (Crooks et al., 2005) confirmed that professional confidence was an internal feeling, whereby the research participants, graduate professional nurses, spoke of knowing and presenting yourself as a professional as meanings of professional confidence. This further supports the findings in the present study.

Conclusion

This research has assisted in addressing an important gap in the literature in terms of how novice occupational therapists understand, experience and describe their professional confidence. In contrast to a phenomenological study where a researcher would attempt to crystallize the essence of what professional confidence was, this study focussed on the conceptions or understandings held by these novice therapists undertaking community service in South Africa. Further, it must be noted that the study did not attempt to explore whether these novice therapists were in fact confident (or not).

A number of studies have reported that novice therapists enter the work force questioning their professional confidence and often experience a further loss of confidence during their initial period of employment. This study has highlighted that novice occupational therapists understand that knowing and believing in yourself, your professional skills and knowledge, and your role leads to presenting yourself as a confident occupational therapist, that is, being a confident therapist. This finding supports Barnett (2009, p. 437) who claimed that "the process of coming to know and to form an understanding (whether theoretically or more practically) – has implications for ... *being*".

It is recommended that further research explore how knowing, believing and being are informed, and what nurtures or threatens these understandings. The Department of Health, as the employer of these novice practitioners, assumes a level of competence by virtue of their employees having completed an educational programme. In research undertaken to explore what employers want when hiring occupational therapists, Mulholland and Derdall (2004) noted that confidence, amongst other personal traits, was also desirable. Understanding what fosters professional confidence would help guide both the profession and employing bodies as to what steps might need to be put in place to assist novice practitioners to consolidate their professional confidence. Previous research in occupational therapy (Tryssenaar and Perkins, 2001; Toal-Sullivan, 2006) has, for example, confirmed that the initial concern and doubt experienced by novice practitioners in terms of their knowledge and skills was gradually replaced by professional confidence, especially when there was support and mentorship during their initial period of employment.

Educational facilities and the profession should thus ensure that their graduates are not only competent but demonstrate an emerging professional confidence. Further research is, however, required as assessing this emerging professional confidence is also not well understood. Novice occupational therapist should commence their community service year consciously seeking opportunity to become a professionally confident occupational therapist.

This research has provided the discipline of occupational therapy with the kind of knowledge "that individuals and groups can use to increase the power and control they have over their own actions" (Polkinghorne, 1988, p. 10). The novice practitioners who participated in the study appeared to have a sound and consolidated understanding of what constitutes professional confidence, which provides a sound basis from which to explore the phenomenon further.

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CHAPTER 4: CONCLUSION

In this concluding chapter, I will respond to the research questions as presented in the introduction to the thesis and discuss the research in terms of the overarching aims and objectives of the study. Conclusions to the study will be drawn, and suggestions for further research offered. As spelt out in the introduction, the overall aim of the study was to establish a body of knowledge for the occupational therapy profession, and the research objectives were noted as: firstly to clarify the concept 'professional confidence', secondly to explore the understandings held by occupational therapist of professional confidence, and finally, to investigate the determinants or sources of professional confidence in occupational therapy students. The research objectives have been met. New knowledge has been generated and has been presented for the consideration profession through three published papers and as consolidated in this thesis.

INTRODUCTION

The title of this thesis, *'On becoming a confident occupational therapist'*, was prompted after reflection on a statement made by Watson and Fourie (2004, p. 20) where they noted that " 'becoming' is a life-long journey of discovery and adaptation that is realized through doing and influenced by being". Wilcock (1999) proposed that there needed to be a sound balance between doing and being, and that becoming was dependent on both. These three concepts were evident in the exploration of professional confidence. *Doing* was reported as an identified attribute or characteristic of confidence as well as a determinant of confidence beliefs. *Being* was an understanding that novice therapists had of their professional confidence, *being*, informed by knowing and believing, which had also been identified as attributes of professional confidence together with accepting (Holland et al., 2012a). *Becoming* was implicit in professional confidence as the definition, presented in paper 1, conveyed. Doing, being and becoming is about being transformed into an occupational therapist: one with a consolidated professional identity, appropriate competencies and a maturing professional confidence.

During the study, three broad overarching questions were posed, namely: What was professional confidence? Secondly, how do occupational therapists understand their professional confidence and thirdly? Finally: What contributed to becoming a professionally confident student and graduate?

THE MAIN FINDINGS

In summary, the main findings during the three phases of the study were:

PHASE 1: PROFESSIONAL CONFIDENCE AS A CONCEPT

Phase 1, which sought to address the first research question, saw professional confidence defined as "a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and belief in the role, scope of practice, and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences" (Holland et al., 2012a, p. 222). Unpacking this definition briefly, it was evident that professional identity (*the belief* in...) and competency (*competently fulfil...*) were intertwined and formed part of professional confidence, which strengthened the assumptions and inferences previously made by a number of authors (Björklund & Svensson, 2006; Creek, 1999; Toal-Sullivan, 2006; Withers & Shann, 2008). Further, it was a dynamic, maturing personal belief, supporting the notion that professional confidence involved a process, as it was confirmed to be a self-belief that grew over time in the context(s) that professionals found themselves in. In addition, confidence was noted as undergirding competence and expertise.

A number of attributes or characteristics of professional confidence were identified, and these were grouped as an affective (feeling at ease, feeling relaxed), active (taking the initiative, doing, experiencing success), reflective (feedback from others, reflection in and on action) or higher cognitive functioning (knowing, believing and accepting) component. Professional confidence was represented as a spiral process, with each component informing the next in a growing sphere of influence; the goal being to feel like a professional, i.e., being and becoming a professional. With hindsight, after conclusion of all three phases of the study, the higher order cognitive attributes of knowing, believing, gaining insight and accepting should be viewed as the critical ones, informed and moulded by the other three, namely the affective, action and reflective components. I.e., one has to engage, take the initiative and experience success, reflect using feedback from a range of sources, all while feeling relaxed and comfortable and from that one started to know, to believe and to accept.

The antecedents or precursors of professional confidence were also identified. These related to certain personality characteristics and general life experiences, mastery experiences, supportive and encouraging environments and relationships that validated the practitioner. Periods of transition, for example going from student to graduate professional were noted to be of concern, as were stressful events as these could impact negatively on confidence beliefs, with practitioners then questioning their professional identity, competency and professional confidence.

PHASE 2: CONCEPTIONS OF PROFESSIONAL CONFIDENCE

A second study (Holland et al., 2012b) was undertaken to explore the understandings novice occupational therapists held of their professional confidence. In the South African context, novice therapists are required to undertake a year of community service with the Department of Health straight after graduating from an occupational therapy school. While exploring the conceptions occupational therapists held of professional confidence, community service therapists as a group were selected, as the first year of employment, post-graduation, was considered as one where competencies were consolidated and where self-beliefs such as professional confidence were further shaped and nurtured. How would these novice practitioners understand and conceptualize their professional confidence?

Three qualitatively different ways that these novice therapists understood their professional confidence emerged from the data, namely; knowing, believing and being. Knowing and believing were understood to be internal manifestations of being the externalisation of their confidence. What was interesting to note, was that the knowing and believing components included knowing and believing in self, in their role(s) and in knowing and trusting their skills. Professional identity and competence were inherent in the conceptions and these components all worked together, and were evidenced in being the assertive championing professional. The knowing and believing translated into a professional image these practitioners portrayed to the outside world as the consummate professional.

As noted in the discussion in paper 2 (Holland et al., 2012b), the three conceptions conformed to and confirmed the attributes or characteristics of professional confidence identified in the concept analysis. Knowing and believing matched the higher order cognitive functions, and as noted earlier in the concept analysis, were informed by active engagement, reflection and a supporting environment. The findings in terms of attributes (Holland et al., 2012a) were thus confirmed in the findings of this phenomenographic study, exploring the conceptions of professional confidence held by novice occupational therapists.

PHASE 3: THE SOURCES OF PROFESSIONAL CONFIDENCE

What informed students' professional confidence? The study, undertaken with a cohort of final year occupational therapy students (Holland et al., 2012c) yielded a range of sources or roots for professional confidence beliefs, and these were ordered as determinants within the control of educators, the students themselves or the profession. While a number of determinants were identified as being within the control of their educators or the profession itself, the research

participants were very conscious of the fact that they needed to take personal responsibility for their professional confidence beliefs, as they were of the opinion that they could not always depend one other people, events or and circumstances to bolster their professional confidence.

Antecedents, or sources of professional confidence were the events, situation or circumstances that preceded or informed it (Holland et al., 2012a). The finding in this phase of the study, when compared to the concept analysis, confirmed many of the expectations as raised in the concept analysis, including particular personality characteristics and general life experiences before entering their educational programme and a firmly grounded belief in self, and their chosen profession. Further, mastery and success experiences within their educational programme and clinical fieldwork experiences generated positive feelings in terms of professional confidence, particularly if these occurred in supportive, encouraging environments. Relationships with peers, lecturers and clinical supervisors, other health professionals and clients were reported as fostering their confidence beliefs, particularly when these relationships were characterised by respect, constructive feedback and acceptance. This information became valuable through reflection before, during and after practice, as confirmed in previous research (Brown et al., 2003; Crooks et al., 2005). The research participants in the third phase of the study (Holland et al., 2012c) however added vicarious learning, fieldwork grades (the marks awarded) as a source of feedback, and language and cultural issues as additional sources of their burgeoning professional confidence beliefs. The participants in this study identified the current health care scenario and professional identity as negatively impacting on their confidence, aspects not explicitly generated in the concept analysis. In part, these two issues could be related back to unsupportive environments the students and their clinical supervisors found themselves in, and having to deal with being denied success in terms of treatment outcomes (Holland et al., 2012c), and contradictory information in terms of professional identity as perhaps presented theoretically in lectures and as observed in practice (Holland et al., 2012c). The concept analysis identified that practitioners required congruency between practice and what was recorded or reported on in the media, for example, in order to feel confident within a situation (Holland et al., 2012a).

THE VALUE TO THE PROFESSION INHERENT IN THESE STUDIES

According to (Weaver & Mitcham, 2008) a discipline was responsible for, and established itself by building its scientific research base from a set of well-developed key concepts, as concepts served the purpose of guiding a profession. Secondly, understanding a concept or phenomenon signified a change in an individual's ability to experience the phenomenon, discern aspects of it and remain mindful of it according to Pang (2003), and with a shared understanding of a concept,

communal identification of the phenomenon and communicating about it were encouraged (Baldwin, 2008; Weaver & Mitcham, 2008). Thirdly, concepts served as building blocks for theory within a profession (Kim, 1983; Mitcham, 2003; Morse, 1995~~) and as noted earlier, these needed to be clarified just as operational definitions might be.~~).

In addition, confident students or practitioners were more likely to benefit from learning opportunities that presented themselves (Spiliotopoulou, 2007). The interplay between professional confidence, which was noted as influencing competence in a mutually beneficial manner, which in turn impacted on professional identity, together make up the practitioner who ~~was~~is then able to offer an effective service (Holland et al., 2012a, 2012b).

This study has, therefore, contributed in a number of ways to the development of a body of knowledge the professional now has at its disposal, to better understand education and practice and on which to base further research.

MAIN CONCLUSIONS

The concept analysis undertaken confirmed that self-efficacy was a surrogate term for professional confidence, and that the terms were often employed as synonyms. It appeared that the use of either term was probably dictated by the discipline of origin, with confidence noted as being preferred in professional education literature and self-efficacy in educational psychology (Hecimovich & Volet, 2009). While this was not explored to confirm its veracity, I wish to confirm that (professional) confidence as a concept has presented itself frequently in occupational therapy literature over the years, implying that the profession appears to favour that terminology. It was, therefore, justified to explore how the phrase 'professional confidence' was used within the profession.

Professional confidence is a dynamic, maturing self-belief informed by, and in turn informing, professional identity and competence. Professional confidence, competence and professional identity are intertwined and interlinked, and worked together bolstering one another. However, a threat to one was an implied threat to the others. During periods of transition, for example, going from student to graduate professional, moving from one job to another or changing work place imperatives, perceived threats could impinge on, and make a practitioner question their professional confidence, competence and/or professional identity.

Novice practitioners were able to conceptualize professional confidence, and describe it in three qualitatively different ways, namely knowing as an occupational therapist, believing you are an

occupational therapist and being an occupational therapist, merging knowledge, beliefs and action. Again, while these were presented as different ways of understanding or conceptualizing professional confidence, the outcome space illustrated that they are inter-related, informing and contributing to each other.

The need for support and mentorship for novice practitioners was one of the conclusions drawn in the study exploring conceptions of professional confidence held by novice therapists (Holland et al., 2012b). In the literature, much emphasis has been placed on some form of supervision, mentoring or oversight of novice practitioners, particularly during their crucial first year in practice (Fone, 2006; Gaitskell & Morley, 2008; Herkt & Hocking, 2007, 2010; Morley, 2007). It was recorded that supervision was an essential element of an occupational therapists professional role development and professional identity, and it was necessary to foster professional confidence, with (Barnitt & Salmond, 2000) arguing for uniformity of support for practitioners during their first year of employment. However, as noted in that study the community service model in South Africa did not include any provision for formal supervision or mentoring.

Professional confidence beliefs had identifiable roots or sources, both within the student and outside of the student within the environment. In the majority of instances, the determinants identified by the students mirrored the antecedents raised in the concept analysis, but language usage was raised by English Second Language users as an important determinant that had not been identified during the concept analysis. The major sources of professional confidence beliefs in students were confirmed as mastery experiences, vicarious learning, encouraging and supportive relationships including those with peers, supervisors and service users, feedback from self, through reflection for example and coping with stress and anxiety, and feedback from supervisors, including the grades awarded for clinical practicals. Professional identity issues and the current health care scenario in South Africa were identified as negatively impacting on their growing professional confidence in keeping with previous research.

As peer support and feedback was identified as an important source for professional confidence beliefs, the current South African practice, frequently employed for a number of reasons, of placing more than one student at a clinical practice site with a clinical supervisor, was noted as holding great advantages for fostering professional confidence. This affirmed the use of the practice, which was often considered as a last resort, as a result of various resource limitations.

STRENGTHS AND LIMITATIONS OF THE STUDY

As noted earlier in the introduction, the study did not set out to explore if the research participants were in fact professionally confident or not, and did not presume to raise their professional confidence in any way. The research also did not seek to identify or to research interventions that could be put in place to encourage professional confidence.

A strength of the research was that it took an insider's perspective, and set out to a establish from 'those in the know' firstly, what conceptions novice occupational therapy practitioners held of their professional confidence, and secondly, what occupational therapy students understood as the determinants of their professional confidence. Purposeful groups of research informants were put together during the study, in which data were gathered from those best placed to present their experiences, views and perceptions. During Phase 2 data were gathered from a range of respondents in keeping with phenomenographic principles and in Phase 3, data were gathered during prolonged engagement with the students to ensure that a range of experiences informed what they had to contribute during the focus groups.

While the research undertaken in this study does not claim to have produced definitive answers due to the nature of the research, and generalizability of the results was not sought due to the uniqueness of the context, the innate value and interest of the study for those in the in setting is emphasized. It must, however, be acknowledged that there are lessons for other occupational therapy schools and for the Department of Health, both nationally and regionally in South Africa, as the employer of novice therapists.

RECOMMENDATIONS AND IMPLICATIONS FOR FURTHER RESEARCH

A study to explore the differences and similarities between self-efficacy and professional confidence would prove valuable in order to analyse and define the two concepts more finely. This would assist in ensuring that the appropriate nomenclature was employed, and that links could be made between research already undertaken involving both terms. Research confirming whether or not they could be used as synonyms for one another would, therefore, be beneficial.

Further research is needed to explore the nature and directionality of the relationship between professional confidence, professional identity and competence. The relationship is not linear and none of the concepts appear to be superior to the other. The reciprocal relationship between the three needs to be explored in greater depth.

In term of conceptions of professional confidence, further study is indicated with independent practitioners (as registered with the Health Professions Council of South Africa in South Africa after their year of community service), in order to understand whether more advanced practitioners would conceptualize their professional confidence in similar ways to that of novice therapists. This would assist the profession to understand professional confidence during the lifespan of a therapist. In similar vein, how would student occupational therapists make sense of their professional confidence? Professional confidence has been noted as being a maturing self-belief, and how this maturation is evidenced would be worthy of further exploration.

In order to understand novice practitioners professional confidence comprehensively, it would be valuable to explore the determinants of their professional confidence, firstly to determine if they mirrored those offered by the student group, and secondly to better inform their employing body, the Department of Health, of their needs in terms of fostering professional confidence and its concomitant professional identity and competence.

While there is some informal peer support and practitioner mentorship on offer in KwaZulu-Natal to novice occupational therapists, this needs to be expanded and formalized, and a proposal needs to be made to the South African Department of Health, both national and regional, highlighting the advantages of such a system, both to them as employers and to their employees. The difficulties of transition periods was acknowledged as being ameliorated by access to supervisors or mentors (Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001) and as a practitioner group we need to explore a model of practitioner mentorship suitable for the conditions we find ourselves in, namely one of limited resources, limited continuing professional development opportunities and a paucity of professional support on offer to novices. Literature offered a number of avenues for further exploration, including a model recommended by Gaitskell and Morley (2008) and Fone (2006), in which the three purposes of such a supervisory relationship were identified as being supportive, formative and managerial. The need for such a motivation to the Department of Health was supported by researchers engaged with another group of practitioners who also undertake community service, namely clinical psychologists. The researchers noted that in spite of community service being regarded as 'independent' practice and not an extra year of training, they strongly advised that a formal supervision structure and network be formulated (Pillay & Harvey, 2006). There was scope for collaborative work with other health disciplines on this aspect.

Recommendations for enhancing the clinical supervision of students were also made during Phase 3 of the study. This included, but wasn't limited to, exploring models for this kind of supervision, the developing training material for clinical supervisors and for preparing supervisees.

With the information now available in terms of the determinants of professional confidence in students, further research is indicated to understand the nature of interventions that need to be undertaken to create an enabling environment in which students could grow as practitioners and cultivate their professional confidence beliefs. For example, from the literature the following ideas were noted, all, however, are in need of closer scrutiny. (1) A School of Nursing had reported introducing a module, 'Professional Enrichment' in the final year. The aim is to assist students to build their confidence (Chickerella & Lutz, 1981). The purpose and content of such a module would need to be explored and research needs to be undertaken to establish its potential value. (2) Briefing and debriefing of students on clinical fieldwork experiences has received attention in the literature and needs further investigation (Copeland, 1990; Mackenzie, 2002). (3) 'Confidence-rich' learning environments have been proposed (Lundberg, 2008, p. 86) or what Mulholland et al (2006) termed 'positive learning environments', the nature of which were unclear and in need of research and development. (4) As noted during Phase 3 of the study, the manner in which educational centres establish their clinical training platforms required consideration. Placement sites and experiences encountered in such sites affect students' professional confidence, their interest in and appreciation for the profession (Mulholland et al., 2006). It has been mooted that a one-size-fits-all approach to clinical practical training might not be the ideal (Holland et al., 2012c) as was noted in other research (Kirke, Layton, & Sim, 2007). As educators we should not assume that students should all be treated the same or that they learn in the same manner, as learning (to be an occupational therapist) was an individual activity (Yerxa, 1991; Zuber-Skerritt, 1992).

CONCLUSION

One of our innate needs as human beings is to be viewed as confident and competent, and Occupational Therapy is specifically concerned with how engagement in occupation enables our clients to achieve competence and confidence. During the education and training of occupational therapy students, the educational journey should enable our students to achieve professional competence and confidence. During community service, professional identity, competence and professional confidence should continue to be fostered and encouraged.

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APPENDIX 1

ETHICAL APPROVAL FROM THE UNIVERSITY OF KWAZULU-NATAL

UNIVERSITY OF
KWAZULU-NATAL
University of KwaZulu-Natal
Research Office
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19 May 2010

Ms K E Holland
Faculty of Health Sciences
School of Audiology, Occupational Therapy and Speech Language
WESTVILLE CAMPUS

Dear Ms Holland

PROTOCOL: "On becoming a professionally confident occupational therapist"
ETHICAL APPROVAL NUMBER: HSS/0156/2010 M: Faculty of Health Science

In response to your application dated 12 March 2010, Student Number: **991240795** requiring Gatekeeper's permission which has been received on 19 May 2010, the Humanities & Social Sciences Ethics Committee has considered the abovementioned response and the protocol has been given **FULL APPROVAL.**

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

SC/sn

cc: Dr L Middleton (Supervisor)
cc: Prof. L Uys (Supervisor)
cc: Mr. S Reddy

APPENDIX 2

GATE-KEEPER PERMISSION: KWAZULU-NATAL DEPARTMENT OF HEALTH

HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM069/10
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

06 May 2010

Dear Ms K E Holland

Subject: Approval of a Research Proposal

1. The research proposal titled **'On becoming a confident Occupational Therapist'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at the identified facilities in 2011.

2. You are requested to take note of the following:
   a. Obtain a *signed support letter* for your study from the facility manager once identified. Please submit the support letter to us once obtained. The study CAN NOT BEGIN without support from the identified facility manager.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi
Date: 12.5.10
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

APPENDIX 3

GATE-KEEPER PERMISSION: FACULTY OF HEALTH SCIENCES, UNIVERSITY OF KWAZULU-NATAL

SCHOOL OF AUDIOLOGY, OCCUPATIONAL THERAPY AND SPEECH LANGUAGE PATHOLOGY,
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University of KwaZulu-Natal

Mr S.M Phehlukwayo,
Chair: School Research Committee,
School of Audiology, Occ.Therapy and Speech-Language Pathology,
UKZN.

Mrs J. Lingah,
Academic Coordinator,
Occupational Therapy

26th April 2010.

Dear Julie & Stanford,

Use of Occupational Therapy Department for Conducting research into the Development of Professional Confidence in Occupational Therapy.

Please find attached letter and documentation from Mrs Kathy Holland requesting permission to have access to our students during phase 3 of her research in order to carry out three data gathering components i.e. to have a focus group with students (in final year); to access their reflective journals from their paediatric block and finally to access their clinical performance feedback booklets.

I have read the attached documents and am satisfied that the data gathering process is straight forward and in no way compromises the students. I would therefore approve the request on the following grounds:

1) That you both support my decision
2) That permission is given to Mrs Holland to approach the students to participate and obtain their consent directly from them, based on informed consent, such that we are in no way obliged to get involved in the data gathering process
3) The final decision for participation rests with the students
4) An electronic copy of the research is forwarded to the School upon completion thereof.

If you are both in agreement with my decision, please be kind enough to sign below.

Gatekeeper permission is granted to Mrs K. Holland, according to the conditions stipulated above.

Prof R.Joubert
HOS

Mrs T. Lingah
Academic Coordinator OT

Mr S.M Phehlukwayo
Chair:SRC

Department of Occupational Therapy, School of Audiology, Occupational Therapy and Speech-language Pathology, Faculty of Health Sciences, Private Bag x54001, University of KwaZulu Natal. Durban, South Africa. Tel (031) 2607953 Fax (031) 2607227.
Email Joubertr@ukzn.ac.za

Gatekeepers approval granted - Dco FHS

30/04/10