A Qualitative Study on the Impact of Occupational Therapy Mentors on Children from Disadvantaged Homes and the Implications for Future Success

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A QUALITATIVE STUDY ON THE IMPACT OF OCCUPATIONAL THERAPY MENTORS ON CHILDREN FROM

DISADVANTAGED HOMES AND THE IMPLICATIONS FOR FUTURE SUCCESS

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Acknowledgements

ABSTRACT

Research into childhood development has shown that the impacts of a traumatic life event can have adverse effects on the development and future success of a child. Traumatic live events can be defined as any experience that varies from a typical pattern of childhood development, for example divorce, death of a parent, addiction concerns, domestic violence, or incarceration of a parent. Often a positive role model cannot be found in these children's lives, keeping them from reaching success later in life. Researchers have studied the impact of a mentoring relationship on children from disadvantaged homes and have found the mentoring relationship to be a pivotal point in development, especially in the transition from childhood to adulthood (Ahrens, DuBois, Richardson, Fan, and Lozano, 2007).

Given the importance of a mentor, it is imperative for a child to have a positive adult in their life during transitional phases. In cases of children from disadvantaged homes, an occupational therapist can often be this positive adult. Given the nature of the profession, occupational therapists are at a particular advantage to impact these children at a young age. Occupational therapists naturally look at a person in a holistic manner, allowing them to be more inherently involved in a child's life. Although an occupational therapist may seem like the natural profession to fill this role, not all occupational therapists find themselves assuming on mentoring roles with this population. What characteristics are needed in those therapists who become a mentor?

The focus of this qualitative study was to identify critical mentor characteristics through the experiences and opinions of occupational therapists who have worked with children from disadvantaged homes. The study explored the degree to which occupational therapists can work to mentor these children and the mentoring roles that occupational therapists are currently experiencing with their child clients. The study was constructed around the Psychosocial Development Theory created by Erik Erikson, and was intended as an exploratory study that will provide a baseline for future research for occupational therapists to actively serve as mentors for children from disadvantaged homes.

CHAPTER 1

INTRODUCTION

Rationale

The concept of using mentors to affect change for children from a disadvantaged home is not a new one. Researchers in the past have studied the correlation between mentorship and successful life outcomes across a wide context. A majority of the studies of show a positive correlational relationship between mentoring and outcomes. However, research in previous occupational therapy literature had focused almost exclusively on the subject of mentorship between practicing therapists and occupational therapy students who are making the transition to entry level practice. Currently there is no identifiable occupational therapy research examining occupational therapists who mentor for effecting life changes in child clients from disadvantaged home.

This subject is relevant to the occupational therapy profession when one takes into consideration the current statistics on success outcome rates for children from disadvantaged homes. The Children's Defense Fund (CDF) statistics for 2011 state that 45.3% of children living in the United States live in poverty; this statistic qualifies nearly half of the nation's population of children age 18 and under as being disadvantaged. Further statistics from the CDF identify that 1,706,600 of the nation's children have at least one parent who is currently incarcerated. Finally one third of all children in the United States are victims of some form of abuse.

Ahrens, DuBois, Richardson, Fan and Lozano (2008) state that children who are from disadvantaged backgrounds have less successful outcomes in adult life. These outcomes are reflected in employment, rates of sexually transmitted disease, incarnation rates, and education completion. With a

high percentage of the countries youth facing negative odds even before they are given a chance to succeed in adulthood, the need for effective interventions in childhood is apparent.

Occupational therapists are in the unique position to see these children in a number of settings and see them for extended periods of time. Given the nature of the occupational therapy profession and the holistic viewpoint about the client, the researchers believe that therapists are in a prime position to create an effective mentoring relationship with their clients, and help lead children to more successful outcomes in adulthood.

Theoretical Framework

The theoretical framework that is used to guide this research is Erik Erickson's Psychosocial Developmental Theory. This framework is chosen because of its ability to look at the development of humans throughout the lifespan. Erickson's theory is applicable to the development of the child client, as well as applying to the development of the therapist participants themselves. The potential participants for this study will represent a range of ages and each participant will need to be considered at their specific developmental stage.

This theory will also be used to develop relevant questions for the interview portion of the data gathering section of this study.

Statement of the Problem

The researchers arrived at the statement of the problem through thorough research of the available literature. As a result of the statistics presented, research that will be presented in the literature review, and an understanding of the underlying theory used, the following problem statement

was developed; children from a disadvantaged home often experience less success throughout their lifespan. Often these children do not experience a positive role model and are left to navigate through life without the supports that a child from a non-disadvantaged home may experience.

It is the researcher's assertion that an occupational therapist can act as this role model to children from disadvantaged homes. Because the profession of occupational therapy trains practitioners to look at the whole person and consider all aspects of function in a client's life, the education and training for occupational therapists gives them the opportunity as well the skills to effect positive change for these children.

Hypothesis

As a result of the information found in the literature review concerning outcomes for children from a disadvantaged background, studies on the positive impact of a mentor, and the impact of an occupational therapy mentor on occupational therapy students, the researchers believe that an occupational therapist can serve in the mentoring role with an at-risk child from a disadvantaged home, and lead them to a path for future success.

The researchers plan to test the hypothesis by performing qualitative interviews with several occupational therapists who have worked with pediatric populations for at least five years. It is anticipated that the outcomes from these interviews will point to a positive correlation between the use of occupational therapists as a mentor and positive outcomes for at-risk youth.

Assumption

29.6% of occupational therapists working in school settings; statistically it is likely that school-based occupational therapists are working with a significant number of at-risk youth or child clients from disadvantaged homes. The profession of occupational therapy is in a prime position to mentor child clients from disadvantaged homes.

Scope and Delimitation

The principle variables within the study include the occupational therapists: their years as practicing therapists, the years they practice as a pediatric therapist, and the social environment that was determined to be acceptable when they became therapists.

The interviews were conducted in the hometowns of each individual therapist, in a location they designated to be appropriate. All of the interviews were conducted within a 4-week time frame. The entirety of the study was approximately 1 year.

Based on the literature review, and the statistics of children living in a disadvantaged situation, this study was designated as important due to the need for mentoring to impact successful outcomes in the lives of at-risk youth. 45.3% of all children 0-18 were living in poverty in 2009. This figure comprises half of the nation's youth, who therefore already qualify as members of a disadvantaged home, based on the operational definition of "disadvantaged" developed for this study. The statistics from the CDF in 2011 further indicate that 20.8% of the children living in poverty qualified for an extreme poverty classification (at half the poverty level or below). Further statistics from the CDF (2011) also addressed single parent homes: 23.1% of children live only with their mother, 3.4% are living with their father only, and 4.1% of children live with neither parent. The researcher's then investigated the incarceration rate of a parental figure United States; according to the CDF, in 2011 more than 1,706,600 children had at

least one parent currently in the prison system. Abuse statics were also researched, including physical abuse, sexual abuse, and psychological abuse. In 2011, the CDF reported that 1/3 of all child abuse victims are age 3 and younger. Of all maltreated children, 78.6% suffer from neglect, 17.8% experience physical abuse, 9.6% are sexually abused, 7.1% suffer psychological abuse, 9.8% are subject "other or unknown" maltreatment, and 40% received no services after the investigation into their abuse report. Substance abuse and dependencies were also researched, and found to be present in the homes of 49.4% of children within the United States.

Importance of the Study

This study will help provide a foundation for further research that needs to be conducted on the mentoring role of occupational therapists with children in general, but more specifically children from disadvantaged homes. This study delineates the need for occupational therapists to become more involved with children from a disadvantaged background. The study also provides a basis for the opinions and feelings of currently practicing pediatric occupational therapists about the prospect of mentoring this population. This study will be useful for therapists wishing to make an even more significant difference with their children from disadvantaged homes, researchers wishing to study the impact of mentoring therapists on children from a disadvantaged home, and students wishing to better understand the role they can undertake with their pediatric clients.

Definition of Terms

Disadvantaged: Any child who has come from, experienced, or been exposed to single parent homes, cohabitating homes, poor/low socioeconomic status, parents without education, parental incarceration, exposure to drug, physical and or sexual abuse, and neglect or abandonment.

Mentoring: A deliberate pairing of a more skilled or experienced person with a lesser skilled or experience person, with the agreed-upon goal of having the lesser skilled person grow and develop specific competencies. (Murray 1991, pg xii)

CHAPTER 2

LITERATURE REVIEW

Introduction

Typical social development throughout childhood is hallmarked by many important milestones. Erikson defined these milestones as being; trust, autonomy, initiative, industry, and identity (Cole & Tufano, 2009). While these milestones are traits and characteristics, they have a lasting affect throughout the lifespan. According to Erikson these developments were determine how healthy a child will turn out in adulthood. When these milestones are disrupted then the outcome can be disastrous. A disadvantaged home can be defined as any home that consists of factors that contribute to the disruption of typical social development. These disruptions have been linked to the high risk for a disastrous outcome for the children coming from these disadvantaged homes. Research shows that children who have endured a violent, neglectful, or otherwise unfit upbringing often have worse outcomes in their future, in terms of experiencing success in their personal and professional lives, then those who are fortunate enough to come from a home meeting none of these stated criteria for a disadvantaged home (Ahrens, DuBois, Richardson, Fan, & Lozano, 2008). The researchers define worse outcomes as being incarceration, drug use, unemployment, and criminal activity (Ahrens, DuBois, Richardson, Fan, & Lozano, 2008). Often times the simple change of growing up with a single parent, rather than in a typical two parent home, can have an impact on a child's social development. The researchers pose the question: How can occupational therapy assist a child from a disadvantage home to achieve success within their personal and professional life? It is important to rise about their negative beginnings in order to research success. Research has shown through a variety of examples regarding

experiences and firsthand accounts that the intervention of a positive mentor is that difference. In today's society not every child is given the opportunity to identify with a positive role model. The researchers believe that occupational therapy can play the mentoring role with children.

According to the Institute of Education Sciences (IES) in 2012, 49.8 million in the United States are able to attend a public school no matter how destitute the home. Additionally, the IES identifies that 6.5 million children were receiving some type of special education in 2010. Approximately 21.6 % of occupational therapist or occupational therapy assistants work in public schools in 2010 (AOTA, 2010).

Disadvantaged Homes. For the purposes of this study the researchers used the following definition to guide the study: Any child who has come from, experienced or been exposed to single parent homes, cohabitating homes, poor/low socioeconomic status, parents without education, parental incarceration, exposure to drug, physical and or sexual abuse, and neglect or abandonment. Many researchers have developed their own definition of "disadvantaged home" to guide their personal studies due to a lack of a universally accepted definition of the concept. Waldfogel, Craigie, and Brooks-Gunn (2010) utilized the term "fragile families" within their study. They define a fragile family as one where a child is growing up in a home with a single mother or cohabiting parents. Nuru-Jeter, Sarsour, Jutte, and Boyce (2010) focused solely on the socioeconomic aspect that classifies a child as disadvantaged. They, however, provided no specific qualifiers or parameters for poverty or socioeconomic status. Smokowski, Reynolds, and Bezruczko (2000) specifically studied disadvantaged children but, like the other studies, they provided no concrete definition of what they considered to be a disadvantaged child. Unlike the other identified studies, however, they did specifically site situations that would classify a child as disadvantaged, which criteria that included poverty, single parent homes, and having mothers without a high school diploma.

From the literature reviewed the researchers determined that a child may experience a disadvantaged home if any factor significantly disrupts social development. The themes identified in the above mentioned literature still a need for more research on the subject. The identified gaps in the literature include areas such as parental incarceration, exposure to drug use through parents or peers at an early age, physical or sexual abuse, and parental neglect or abandonment.

Why should this population be of specific concern? According to the Child Defense Fund [CDF] (2011), 45.3% of all children ages 0-18 were living in poverty in 2009. This figure comprises half of the nation's youth and then qualifies them as members of a disadvantaged home based on the researchers' definition. The statistics further indicate that 20.8% of the children living in poverty qualified for the extreme poverty classification (at half the poverty level or below). Further statistics from the CDF (2011) also addressed single parent homes: 23.1% of children live only with their mother, 3.4% are living with their father only, and 4.1% of children live with neither parent. The researcher's then investigated the incarceration rate of a parental figure and, according to the CDF, in 2011 more than 1,706,600 children had at least one parent currently in the prison system. Abuse statics were also researched to include physical abuse sexual abuse and psychological abuse. In 2011 the CDF reported: 1/3 of all child abuse victims are 3 and younger. Of all maltreated victims 78.6% are victims of neglect, 17.8% experience physical abuse, 9.6% are sexually abused, 7.1% suffer psychological abuse, 9.8% are identified as victims of other or unknown maltreatment and 40% received no services after the investigation into their abuse report. Drug abuse was also researched and found to be 49.4% of children living with parents experience some type of exposure to substance abuse and dependencies (CDF, 2011).

In the face of these statistics, it was clear to the researchers that something needs to be done to help reverse the effects that negative influences that can have on these children who are already

vulnerable. When considering a child's development, it is important to use a holistic view of the whole child. This includes looking into their past experiences, their school environment, and above all, their home life. The home is where children spend the most time, especially during the pivotal points of their youth, as Erikson pointed out within his Psychosocial Developmental Theory. To better understand the disadvantaged child, one must look into their home life and the influences, both positive and negative, that a child has and will experience on their path to success from the disadvantaged home.

Psychosocial Developmental Theory. As a child grows and learns social skills within their context, they unknowingly enter and exit stages throughout their life. Psychosocial Developmental Theory has been used for years to explain how children grow and what leads them down their own unique paths in life. Development can be defined as "process of change: the process of changing and becoming larger, stronger, or more impressive, successful, or advanced, or of causing somebody or something to change in this way" (Bing dictionary, 2012) and theory is defined as "a coherent group of general propositions used as principles of explanation for a class of phenomena (Unknown, 2005)." One could conclude that developmental theory is a coherent group of general propositions about development that explain the phenomenon of growing up.

The predominant theorist used as a guide for the explanation of pediatric development by many occupational therapists is Erik Erikson and his psychosocial developmental theory (Cole & Tufano, 2009). Erik Erikson examines the child from the beginning of life all the way to the end of the lifespan. Erikson identifies eight stages of development. Each of the stages build upon each other, so if there is a disruption/dysfunction in an earlier stage, this will affect the child for the rest of their life unless they are able to correct this dysfunction.

For this study the researchers focused on stages 1-5. Erikson specifically identified "biological and social factors in identifying sensitive periods within which a set of crises must be resolved" (Cole & Tufano, 2009). The first stage identified by Erikson is trust vs. mistrust for birth to one year of age (McLeod, 2008). In this stage the child must develop trust, and this happens by having their needs consistently met. If the needs are not met by the context that child is in, then mistrust is developed. It is important for the adults within the child's life to provide the support, safety and consistency that will allow the child to naturally reach the performance range appropriate for this age.

Autonomy vs. shame and doubt is the sensitive period that is faced between the ages of 2-3 (McLeod, 2008). At this point the child should begin to develop a sense of self and self-control which will build the foundation for a healthy development that allows for typical interaction in social situation. If a child does not receive the adequate amount of support when the reach success with a task they can constantly experience failure which can lead to a lack of confidence and a feeling of inadequacy.

Erikson identified the third stage of development as falling between the ages of 3 and 5. This stage is considered to be initiative vs. guilt. In this particular stage a child is starting to take the initiative. If the parents are to punish the child or make the child feel that they are trivial they will have feelings of guilt. Allowing the child to explore, but an also setting a reasonable boundary for the child is vital for normal development within this stage in order to allow for the child to develop a conscious and self-control (McLeod, 2008).

Industry vs. inferiority appears at 6 to 12 years of age in Erikson's fourth stage of development. At this point in development peers and other adults in the child's life, besides the parents, are a guide for the child. It is important that the adults and peers allow for the child to grow their self-esteem. If the

child does not develop a healthy self-esteem they may not reach their full potential. They can begin to feel inferior to those around them if they are not encouraged (McLeod, 2008).

The final stage the researchers focused on for the study was Erikson's fifth stage of development. The fifth stage is identified as the identity vs. role confusion for ages 13-18. Identity is based on the responsibilities that the adolescent has to cope with. This is the stage where they are reflecting over their past to decide who they are. This stage is where the development of person takes place. The disruption occurs in this stage, when the adolescent cannot figure out who they are based on their past.

It is obvious that in each of these stages there is potential for both negative and positive outcomes. The earlier the disruption within the stages, the greater the affects later on in the developmental process. Taking a retrospective look at their past it is not unrealistic to believe that if the child only sees the disruption they will likely feel inadequate and will not reach their potential for success. Cole and Tufano (2005) believe that OT interventions can facilitate the successful resolution of each age related crisis and can assist in achieving successful outcomes. When a child comes from a disadvantaged background they are more likely to experience the disruptions throughout their roles because of inadequate parenting, lack of needed resources, lack of support or lack of experience on the parents' part for positive role modeling.

Effects of Home Life. Children spend a varying amount of time within the home throughout their development. A majority of time their time is spent at home at the beginning of their development. However, as they enter into school age they will begin to spend more time at school. According to Smokowski, Reynolds and Bezruxzko (2000), **"social relationships among family members are by far the**

best predictor of behavioral outcomes in children (pg. 427)". If this is true, then it would appear that children from disadvantaged homes can be destined for negative outcomes from the beginning if the relationships with family members are not positive. There are five years of critical development where a child is likely heavily exposed to their disadvantaged circumstances and negative influences within the context of their environment.

There are many studies documenting the effects of the disadvantaged home life on children throughout their life span. Many of these articles discuss the positive and negative outcomes that can occur when a child begins their experience of the world from a disadvantage. One article discusses the long term negative effects of maltreatment and focuses on the child's social adjustment (Knutson, DeGarmo, Koeppl, & Reid, 2012). The researchers specifically focused on single parent homes (both single mother and single father homes). This research study found that in order for these parents to be successful they needed to be more aware of the basic needs as well as wants and desires, of the child. If this supervision is not present before and during the first grade, then the neglect directly relates to aggression and antisocial behavior. Stadelmen, Perren, Groeben, and Klitzing, in 2010, discussed the negative impact of parental separation and how the child's emotions and behavior are affected. When family conflict is within the home, children are more likely to be emotional and behaviorally problematic. When a child from a disadvantaged home experiences a variety of conflicts within their home life, they have no models of healthy relationships and lack conflict resolution skills. Without this model of healthy behavior and social relationships, the child is still destined to failure at an early age.

While negative outcomes are widely researched, there is also research supporting a factor that can lead to positive outcomes. This supporting factor allows the children to overcome their disadvantaged background and is known as the "resilience factor". An article by Werner and Smith

(1982) found caregiving in the child's first year of life to be the most powerful predictor of childhood resilience. If a child has a first year of high warmth, without disruption, they are more likely to have a strong resilience factor as they age. The resilience factor was also mentioned in an article by Harvey and Delfabbro (2004), who stated that "counterbalancing the effects of risk factors are what are commonly termed protective or resilience factors which enhance the individual's capacity for resilience"(pg. 4). Even as researchers identify this resilience factor, it is obvious that not every child possesses it. "Given sufficiently severe stressors, it appeared that even presumably resilient youth would succumb to psychological and physical distress (Harvey and Delfabbro, 2004, pg. 4)". Once a child has progressed passed the first year of life, there seems to be little chance of developing this trait; they either have developed the resilience factor or they do not. Even if they have the resilient factor, they may not be able to cope with the situations that come before them throughout their life. This can be attributed to not having developed strong enough resilience factors to cope with specific situations. Some of the most commonly seen outcomes with children without resilience factors who have come from disadvantaged homes include; poor school performance, higher dropout rate, incarceration, drug use, high risk health behaviors, unemployment, poor mental and emotional health, and many more negative outcomes. (Ahrens, DuBois, Richardson, Fan, Lozano, 2008)

Researchers have discussed resilience, and positive beginnings and how they affect overcoming the harsh reality of a disadvantaged home. Children from the disadvantaged home have the factor of not necessarily ever receiving positive reinforcement to help them develop this resilience factor. These children often times display behavioral problems at home which make the home situations tense and more dangerous for the child. How do these children overcome this despairingly harsh reality?

Literature has suggested that one way to help these children to achieve success is the implementation of a mentoring relationship.

Effects of Mentoring. Overall, the effects of having a mentor intervene in a child's life are mixed. Less than half of the research indicates the intervention of a mentor results in little to no significant difference for children than those children who did not have mentoring intervention. Additional studies suggest that it is the mentoring intervention that plays a role in whether or not a child succeeds later in life. Although older evidence is contradictory, more recent studies have focused on the exact factors that influence a successful mentoring relationship.

According to a study conducted by Ahrens, DuBois, Richardson, Fan and Lozano (2008), mentored youth are more likely to report favorable overall health. They state that these youth were less likely to report suicidal ideation, have received a diagnosis of a sexually transmitted infection, and have hurt someone in a fight in the year prior to the study. With the literature providing information about a difference in outcomes, the researchers wanted to investigate more into what factors were causing this variance. Spencer (2006) discusses the importance of the quality of the mentorship relationship as well as the overall duration of the relationship. The researcher states that mentoring relationships that terminate prematurely, less than 3 months, lead to feelings of low self-worth and decreased school performance. Clearly, relationship duration plays a significant role in the success of the mentoring intervention.

While there is some debate regarding the minimum necessary duration of the relationship, a review of literature indicates that researchers have reached similar conclusions regarding the necessary components for a successful mentoring relationship. Ahrens, DuBois, Richardson, Fan, and Lozano

(2012) identify the potential for some of the most successful mentoring relationships to be provided by non-parent adults. It is thought that this allows the mentor to have a degree of separation, and to a certain extent, be able to view the child objectively.

Grossman and Rhodes (2002) discuss how youth from disadvantaged backgrounds are more likely to develop feelings of rejection and less likely to form a close relationship with a mentor. If a child is unable to trust an adult due to a traumatic past experiences, and then a mentoring relationship is unsupportive and cut short, it is more likely that the child will internalize this and this experience will continue to reinforce their already negative self-worth.

Duration and the non-parental relationship are not the only factors to consider when developing a mentoring relationship; the quality of the relationship and whether or not the relationship is organic or contrived seems to play a role in the success of the mentoring relationship. Past studies have suggested that the use of a contrived relationship is less successful than an organic one. A contrived relationship is one where the mentor is assigned to the mentee; an organic relationship is one where the mentor and mentee relationship is formed through a friendship or other naturally occurring event. It is thought that the mentee will be more willing to work with the mentor and be more willing to develop that trusting relationship if the relationship is organic. In a contrived relationship, the child is often assigned to the mentor, and in this case the child as no control over the initiation of the mentoring relationship or who the mentor is.

More recent studies have suggested that this is not true. In fact, more than 50% of the literature that the researchers accessed studied contrived relationships, and all of these studies showed positive effects. So, if the origin of the mentoring relationship is not a key factor, then what is? The

majority of the selected studies isolated key factors that should be present in the mentor. Anda (2001) performed a study which examined successful mentorship programs using assigned mentors from the perspective of the mentee. Characteristics that were identified as being essential for a mentor to possess were developing a friendship that was of a different quality than the ones youth had with their peers, viewing the mentor as non-judgmental, and having a mentor who worked to help foster positive characteristics in the mentees. Given these characteristics, a strong argument can be made that the mentees are seeking a supportive role model in their lives.

Other qualities that were identified by Spencer (2006) as being important in a mentor were authenticity, quality of presence, relational responsiveness, empathy, collaboration, and companionship. In the review of this article it is apparent that the qualities of a good mentor are highly associated with an altruistic and holistic personality. It is important to note that the research not only identifies important qualities of a mentor but the qualities of the mentee as well. Often a mentoring relationship fails because of a lack of fit between the mentor and the mentee. In some cases it has been found that if the mentee is aggressive, it can lead to poor outcomes in both the mentee and the mentor (Faith, Fiala, Cavell, and Hughes, 2011). Throughout the literature, it has been shown that there are different reasons for failure; however Faith, Fiala, Cavell and Hughes (2011) specifically look at how an aggressive child can cause a barrier that the mentor is unwilling to cross.

Taking the importance of duration and the use of a non-parental mentoring figure into account, a clear picture is formed of the importance of this mentoring role. This positive impact provided by the mentor relationship allows for a window of positive change in a child from a disadvantaged home. The qualities stated in the literature bear a resemblance to those same qualities that are considered essential to

successful occupational therapists. These characteristic requirements suggest the usefulness of an occupational therapist in the mentoring role.

Occupational Therapy Mentor. "Mentoring is a powerful tool... it can enhance professional skills, keep careers alive and growing and strengthen reputations and influence" (Scheerer, 2007, pg. 18). Literature on mentoring in occupational therapy has focused almost exclusively on seasoned occupational therapists mentoring new graduates of occupational therapy programs. The relationship between the occupational therapy mentor with the occupational therapy mentee is described by Scheerer as "shared responsibility as both value, learn and grow each from the other" (2007, pg. 19). This relationship's success is highly depended on the communication style and makeup of both the mentor and the mentee as similarly seen in the relationship between mentor and youth mentee. It has been found that the greater the amount of communication and planning for future communication, the great amount of change attributed to a mentor's participation (Provident, 2005).

Within the literature there are distinct qualities that have been assigned to occupational therapists when participating in the mentoring role. In order to meet the role requirements, Scheerer (2007) suggests that these qualities include; an ability to listen, being open-minded, using good communication skills, being a strong team player, giving good positive and negative feedback, having knowledge or resources, being a good teacher, having a high level of self-confidence, and being a positive person. It can be understood that these skills are expected to be at the core of the general practicing occupational therapist. In order to meet the needs of their clientele, an occupational therapist needs to have strong communication skills, as well as be a team player, making sure the therapist puts the needs of the client before their own. Through giving feedback, listening, remaining open minded and

sharing the knowledge they have gained, an occupational therapist communicates with his or her clients respectfully and productively. With these qualities being honed in a classroom and then again in the clinical setting, why aren't more occupational therapists becoming mentors?

There is one barrier that has been recognized throughout the literature as the reason for decreased mentoring among occupational therapists, the factor of time. Milner and Bossers (2005) identified that barriers to the mentoring process included lack of time, and inadequate contact time with the mentor. Time is precious for an occupational therapist, especially in most settings where occupational therapists interact with disadvantaged populations. When working with clients in many settings, the focus is on productivity. Because occupational therapists generally carry such heavy caseloads, actively serving in the role of a mentor would be one more stressor for therapists to allocate time for in their day. Despite this temporal challenge, Milner and Bossers (2005) found that a majority of their participants believed the mentorship program to be a positive, inspiring or valuable experience. People, not just occupational therapists, take pride in knowing that they have mentored someone to positive outcomes, and helped them to achieve the success that they have had in life. Teachers experience this joy on a regular basis. Teachers are even more limited on time than occupational therapists. They have an average of 30 students at a time where occupational therapists often work with children one on one. This one on one time with children puts occupational therapists in the optimal position for mentoring. This does not necessarily mean "that all supervisors should assume such a role" (Scheerer, 2007), because they may be lacking in other specific qualities.

Conclusion

What are the qualities that make a mentor? What are the qualities that make an OT a mentor? How does an Occupational therapist mentor relate to a child from a disadvantage home? While the parents are the primary resource for promoting a child's early development (Lawlor, & Mattingly, 1997), it is the researchers' belief that occupational therapists have the qualities (i.e. an ability to listen, being open-minded, using good communication skills, being a strong team player, giving good positive and negative feedback, having knowledge or resources, being a good teacher, having a high level of self-confidence, and being a positive person) to become mentors. The following study was conducted to delve deeper into the idea of occupational therapists expanding their specific role of mentor into a more vulnerable population that could use the mentoring perspective. The researchers' found considerable gaps in the literature that directly addressed occupational therapists stepping into the novel situation and playing the mentoring role for vulnerable youth clients.

Due to the lack of researcher on occupational therapists specifically playing a mentor role with youth from disadvantaged homes, the researchers felt it was necessary to delve deeper into the subject. The researchers believe that occupational therapists are in a prime position to provide the mentoring role with this population. This prime position comes from the schooling therapists receive that nurtures the qualities that mentors possess, as well as the focus in school on psychological development. Schooling also prepares occupational therapists to focus on all aspects of the context in which persons interact with their environment. The literature has shown that children from disadvantaged homes are in need of a stable adult to guide them on the path to success. The researchers aim to share the experiences of occupational therapy mentors in an effort to express the crucial role an occupational therapist mentor can and should play in a child's life. Given the unique qualities that are ingrained in

the very core of the profession, it is the researchers' belief that an occupational therapist can effect a dramatic change in the life of a child from a disadvantaged home and lead them to more positive outcomes. The most impactful way that occupational therapist can effect this population is by entering into the mentoring role. Mentors act as a guide, and as professionals skilled in the holistic view of the person and their context, occupational therapists would be the most natural fit.

CHAPTER III

METHODOLOGY

Research Design #1

Research Design. The researchers felt the most appropriate manner with which to research the

concept that Occupational Therapists serving as mentors would increase student success outcomes, was

to talk to the mentees who experienced Occupational Therapy mentoring first hand. We postulated that

examining first hand insight from mentees would give the most accurate description of possible success

outcomes with OT playing the mentoring role. The researchers chose a phenomenological qualitative

research design. Due to the subjective nature of interviewing unique individuals about their experiences,

logically understanding a person's feelings about a specific event that impacted them in a pivotal way

must include taking into consideration the subjective experience. Due to time constraints for data

collection, and the potential for limited access to the chosen population, a convenience sampling

method was selected. A convenience sampling method would grant the researchers a greater

opportunity to broaden their understanding of the target population's experiences. Informed consent

was designed at an eighth grade level in order to facilitate understanding for the target population

about the implications regarding participation. Informed consent was designed to be given verbally and

in writing before the completion of interviews, in order to inform the participants of their rights and

obligations, as well as the possible risks and potential outcomes of the study. A copy of the informed

consent would be given to each participant on the day of the interview, and include signatures by the

participant and the researcher.

Institutional Review Board (IRB) Certification. IRB forms were submitted in May of 2012 to the Institutional Review Board at the University of North Dakota. Verification of expedited approval for a human subject research study was obtained on June, 1, 2012.

Sources of Data. Locations for data collection were identified from the State of Wyoming. The regional areas included: Natrona County, Park County and Fremont County. The research population was narrowly defined due to the selected inclusion/exclusion criteria. The researchers decided to exclude protected populations due to time constraints, and lack of funding. No specific racial or ethnic demographics were indicated. Researchers chose to target the population over 18, who did not experience a lifelong disability or injury and had received occupational therapy before age 18.

Locale of Study. The study was never realized due to a difficulty in accessing the target population and the need to access this population through gatekeepers. The researchers planned for all semi structured interviews to take place in an area that was comfortable to participants i.e. home, coffee shop, public restaurant, where they felt at ease. The researchers believed that with the participants more at ease, honest dialogue would increase. Researchers wanted to be sensitive to not traumatize or re- traumatize the participants.

Population/Sampling. The population the researchers chose to study were required to be over age 18 (preferably over 25), with no comorbidities that would classify participants as members of a vulnerable population (i.e. pregnant, physical disability, incarceration, mental health diagnoses, etc.). Participants were required to have occupational therapy services between the ages of 9 and 18 and no longer be receiving any type of rehabilitative services that could classify them as vulnerable. This population was chosen because it reduces the potential psychological risks to the patient. By giving the participants chronological distance from the event and allowing them to choose the interview setting

the researchers were allowing participants greater control over the situation. Researchers acknowledge

they could not guarantee that re-traumatization would not occur; in light of this the researchers

included a clause within the informed consent to caution the participants of the potential risks. A

retrospective approach would ideally address participants' mature perspective when they look back at

their time in therapy. The researchers' initial projections for the study were to have up to 6 participants

in order to gain a wide variety of experiences.

To reach the target population the researchers contacted gatekeepers within the occupational

therapy population across a variety of settings, excluding psychiatric practice. Letters were sent to

occupational therapists within the State of Wyoming explaining the study and the participant

requirements. A follow up phone call was conducted with the potential gatekeeper therapists who had

received letters.   A total of 12 letters sent out in the identified regions. Researcher number one

received one email and two phone calls from the six letters sent. Researcher number two received 1

phone call and made three follow up calls with gatekeepers. None of the gatekeepers could assist in

identifying participants for the study. Although several identified possible participants, none of the

proposed participants were deemed acceptable due to the exclusion criteria. The study advisor also

contacted occupational therapists in the Casper, Wyoming area by phone and email in an attempt to

identify participants, but yielded no results.

Instrumentation/Data Collection. The researchers chose a semi structured interview format in

order to truly understand the client's subjective experiences in occupational therapy. The semi

structured interview format allowed the clients to elaborate on thoughts, feelings and share any type of

information that arose in conversation that was not originally anticipated by the researchers. These

interviews were designed as a two part process to include 2 one-hour interviews with the participants.

By utilizing an initial and follow-up interview format, the researchers anticipated better development of rapport with the participant before trying to obtain information of a more personal nature. Additionally, by separating the interviews, it could trigger the participant to recall more information between interviews that they would not have necessarily remembered in the time frame of a single interview. Interviews were to be audiotaped and transcribed; transcriptions were to be completed by the opposite researcher from the interviewer in order to eliminate bias. After transcriptions, all data was to be coded and analyzed by both of the researchers in order to establish common themes and patterns throughout of the participants' experiences, as well as identify critical experiences. Due to the difficulty in obtaining qualified participants as described in the population/sampling section, the study could not be realized, and therefore data collection was never completed.

Research Design #2

  Research Design. Given the previously stated difficulties that lead to the change of focus and the research design, the researchers have now designed and implemented a study to interview occupational therapists about their mentoring experiences with children from disadvantaged homes. The researchers believe that the occupational therapists are able to give a unique perspective on this population and what the therapist feels their impact was or could be, as well as the strategies they have used to help lead a child to a successful outcome as an adult. This revised study consisted of a retrospective phenomenological design. As previously stated, this research design provides the best insight into the subjective experience, although the new design focused on the occupational therapist experience instead of the client who received occupational therapy intervention. The retrospective insight allowed therapists to provide a perspective that has a certain amount of distance from the actual experiences with their clients, which allows them to look at the relationship in a different manner than they would if

they were still very involved with the client in treatment. For this design, a purposive sampling method was selected, however, rigor was increased by randomly selecting the actual participants from the total participant pool until the designated sample sized was reached. Informed consent was obtained and a copy provided to the participants before the first interviews were conducted.

IRB Certification. A protocol change form was submitted on August 30, 2012 to the Institutional Review Board at the University of North Dakota. Verification of approval for the modified study was obtained on September 11, 2012.

Sources of Data. Data was collected from across the state of Wyoming and Montana. Areas included: Natrona County and Fremont County in Wyoming, and Yellowstone County in Montana. Data for the literature review was also collected from articles obtained through the University of North Dakota Library of the Health Sciences and online search engines. The research population included occupational therapists who have worked with children for at least five years. No specific racial or ethnic demographics were indicated. Researchers chose therapists who had worked clinically for at least 5 years due to their understanding of the pediatric population; the researchers feel this gives the target population e a thorough understanding of pediatric therapy , and the opportunity to observe long term effects of treatment and the therapeutic relationships on former clients. In order to target the significant developmental years of the children from disadvantaged homes that the literature deems as critical for mentoring, a pediatric therapist target population is necessary for this study, as this population would have worked with pediatric clients at the time mentoring would have been most critical.

Locale of Study. The researchers conducted all semi structured interviews in an area that was selected by, and therefore comfortable to, participants (i.e. home, coffee shop, public restaurant, place

of work). Researchers felt that if the participants were more at ease, then truthful participation, without coloring the experience in a diplomatic way to change the true meaning of the experience, would occur. This decision was made due to the potentially sensitive nature of information that was disclosed.

Population/Sampling. Researchers contacted occupational therapists who have worked with the pediatric population for at least five years. In order to avoid vulnerable participants, the researchers assured that the sampling list included occupational therapists who had no comorbidities that would classify them as members of a vulnerable population, (i.e. pregnant, physical disability, incarceration, mental health diagnosis, etc.). The researchers felt that the occupational therapists involved in the treatment of the pediatric population would be able to bring a unique perspective to the thought process and approaches that can be utilized when working a as mentor with children from disadvantaged homes.

Ten occupational therapists were initially contacted by phone, and invited to participate in the study. Of the ten participants invited, two declined to be considered for the study. Each of the eight remaining participants were coded by researcher #1 and randomly chosen to comprise the 6 participants selected. This was done to eliminate any potential bias on the part of the researchers during participant selection.

Instrumentation/Data Collection. The researchers chose a semi structured interview format in order to truly understand the participant's view of their role as a mentor working with a child from a disadvantaged home. With a semi structured interview format, the participants were able to elaborate on thoughts, feelings and share any type of information that came up in conversation that was not originally anticipated by the researchers. This semi structured interview format allows for rich detailed information about the participant's experiences. Due to the uniqueness of every experience, it was

important to allow for the participants to add their own perspectives. These interviews were designed to be a two part process to include 2 one-hour interviews with the participants. Utilizing a two interview format allowed the researchers to develop a rapport with the participant before trying to obtain information of a more personal nature. Additionally separating the interviews allowed the participant to recall more information between interviews that they would not have necessarily thought about in the time frame of a single interview format interview.

Chapter IV

Presentation, Analysis and Interpretation of Data

The researchers each conducted 2 one-hour interviews with the six participants. The opposite

researcher then coded the interviews they did not conduct to address researcher bias. Participants of

the study included 6 female occupational therapists, each at a different practice level. Inclusion criteria

required that all of the participants practice in the pediatric setting for a minimum of 5 years. According

to Erikson' Developmental Levels, the majority of the participants are within the middle adulthood stage

of Generativity vs. Stagnation. Participant #1 was the only participant who was in the Ego integrity vs.

Despair stage. Each of the participants were randomly coded and assigned numbers in order to keep

their information anonymous. To begin, each participant was asked about their time in occupational

therapy, what settings they had practiced in and their current practice area. They were also asked how

becoming an occupational therapy had impacted their lives.

Participant 1 has been an occupational therapist for 42 years. She retired from full time OT work

in 2010, but does teach part time in higher education. . Before retirement she practiced at a

developmental preschool for 21 years. Prior to that time she worked in a variety of settings

psychosocial, rehabilitation, long term care, home health, pediatric, specialty hospital, the school

system, the K-12 system and the preschool system. She has also worked as a consultant to a

psychologist and in programs for adults with developmental disabilities. This participant sees

occupational therapy as changing her life by making it more fun, and gave her life purpose. She felt that

she was made to be an occupational therapist.

Participant 2 has been an occupational therapist for 17 years. She has been practicing in pediatrics and early intervention for the full 17 years. She is currently working with birth to 3 years of age; however her average population age is 18 months. She has worked with more birth to 5 in the past. This participant identified Occupational therapy as changing her life by opening her eyes to the harsher reality of the world.

Participant 4 has been an occupational therapist for 36 years. She has been working in an outpatient pediatric setting for the last 15 years. The average age range of her clientele is 0-10. She has also practiced in child and adolescent psychiatry and the school system. She identifies OT as changing her life in a more clinical way. She specifically stated "I deal a lot with kids with Torticollis and when the grandchildren were born it was like ok let's make sure they don't have that, and what system are they in and stuff… so it's certainly made me more aware of therapy issues within my immediate family".

Participant 5 has been an occupational therapist for 35 years. She has been practicing for 22 years in the geriatric setting. She worked for 5 years with the pediatric population in a Kindergarten through 6th school system. She has also worked in rehabilitation, and home health. This participant identified occupational therapy as changing her life by "pushing her into her career choice".

Participant 6 has been an occupational therapist for 10 years. She is currently practicing in the school system and has been for the full 10 years. However this participant has the unique experience of contracting outside the school districts, and she is also working with spinal cord patients, geriatrics, home health, developmental delay, acquired brain injury and acute inpatients in the rehab setting. Participant 6 identified that occupational therapy has given her life more meaning and a purpose.

Participant 8 has been an occupational therapist for 35 years. She has been working with the pediatric population for 34years. She is currently practicing with the birth to 3 age range. She spent one year working with teenagers with psychosocial diagnoses. She identified occupational therapy as changing her life by giving her direction, purpose, focus and a reason for being.

Each of these participants were asked to share their thoughts about mentoring, the role of OT, the challenges of working with disadvantaged children, the challenges of working with disadvantaged families and the positive aspects of working with this specific population. The researchers coded each of the interviews thematically, and during the coding and analysis process, the researchers identified five main themes recurrent within the data. These themes included: working with disadvantaged children, occupational therapists perception of mentoring, how they individually acted as a mentor, how they feel the parents reacted to therapy, and lastly how the individual therapists perceived their impact on the child.

Within the theme of working with children from disadvantaged backgrounds, including the perceived effects of a disadvantaged background, boundary setting, working with pediatrics in general, and what the therapists perceive would have done differently in treating this population. The theme of perception of mentoring included interdisciplinary mentoring, perceptions of a contrived vs. organic relationship, how the therapist could have been more of a mentor, commonalities seen by the therapist between playing the role of a mentor and being a general occupational therapy practitioner and the qualities of mentoring. The theme regarding the act of mentoring included how therapists identified the therapeutic relationship and instances where the therapists could see themselves as playing a mentor with their patients. This theme also included the occupational therapists in the roles of mentoring students and mentoring parents of their clients.

Working with Disadvantaged Children

The first theme identified through coding and analysis was working with disadvantaged children. The researchers found that this question generated the most significant amount of thematic data. It was critical that the researchers understand the experiences each participant had with children from disadvantaged homes. At the beginning of each initial interview, the researchers operationally defined "disadvantaged" as developed for this study. If necessary, researchers took the time throughout either interview to reestablish the operational definition to the participants. The interview questions were designed to obtain a full understanding of what is necessary for an occupational therapist to work with a child from a disadvantaged home. The questions posed varied in type to elicit more in-depth data. As the researchers analyzed the data, they found that there were many aspects of the therapeutic relationship that the participants identified when working with children from a disadvantaged background. The researchers found that the participants considered the boundaries, their own judgment of the client and their family, and the effects that the disadvantaged background had on the children when they were working with their clients. When asked to retrospectively review their time working with these children, all of the participants agreed that there were aspects of their earlier work that they would have handled differently had their practice experience been greater.

Disadvantaged vs. non-disadvantaged backgrounds. Each of the 6 participants had different views on working with children in general, as well as working with children from disadvantaged backgrounds. Participant 8 described this difference:

> I think that children that come from nuclear families, intact families, feel safe and I think children that are not, do not feel safe and that has a huge impact on their learning and their social emotional development and their development of all sorts of concepts about their world and themselves.

Participant 1 had a similar view of working with disadvantaged children: "So those kids especially have social emotional needs that you as a therapist you have to look at first." Participants 5 and 6 had similar opinions of working with children from a disadvantaged home:

> Participant 5: I first had to get over my horror at the fact that these thing were happening to these children and the difficulty that I experienced when I would like meet the parents or the people who had perpetrated some abuse against the children like in an IEP meeting.

> Participant 6: I feel that is very challenging and I feel that you um you have to grow some pretty think skin, to deal with some of these factors that you know have been in these childs' lives, you know children who have parents in prison, parents who have died, I mean kids who don't even know who their parents are you just have to, my experience with it has just been to just really care about them and show them that, I'll be there for them the best that I can be and just that.

It was clear that the therapists felt that working with the children from this specific disadvantaged background was drastically different from their average experience of working with children who did not meet the criteria for "disadvantaged". All of the participants stated a belief in the importance of taking into account that a child is from a disadvantaged background. The participants identified a variety of ways that they change their techniques when working with these children. Participant 1 specifically stated:

> I think it is important to keep it in the back of your mind because it may be a good informer of things you are wondering about which, things may have had more of an impact because of the situation.

The challenges faced by participants included avoiding burnout and focusing on the child no matter how challenging the relationship. The most commonly identified reason for burnout that the participants had heard about or experienced included not having follow through when the children go home at night. Participants also identified that when the parents have a negative attitude about therapy, the child tends to feed off of this reaction. It was noted that children

from disadvantaged backgrounds typically have behavioral issues that can interfere with therapy that other children do not. When specifically asked how to avoid burn out, Participant 8 stated:

> You hate to say it but, its complicated it is, it's terribly complicated and I don't know how you would keep from getting burned out if you had a whole series of them (disadvantaged children with behavioral problems). I mean you would just dread the day.

The researchers wanted to know more about the differences between working with children from disadvantaged homes and the non-disadvantaged child the participants work with. The researchers were curious to know what the major differences were; did disadvantaged background automatically imply increased difficulties for the practicing therapists?

> Participant 1: Sometimes we have to change our plan… kids change from moment to moment every day so we have to be where they are, we always have to start where they are, which I think with almost anybody should.

> Participant 2: It's heartbreaking at times, and it's joyful, and I love celebrating the little baby steps that they make. When they do something and it might seem minuscule to the outside observer but you know how hard and all the little steps that build up to the little baby step.

> Participant 5: I think it was really rewarding as far as being able to see the changes in them, um, to be able to see that what I was doing was making a difference.

> Participant 8: It's rewarding every day, I learn something every day from the families that I work with, from the kids, I have to be creative I have to be open minded.

Overall the participants identified working in the pediatric setting to be rewarding and a learning experience. When asked about working with children in general, the responses were very positive, in contrast to the answers regarding working specifically with the children from a disadvantaged background. Because the answers were considerably different between the two contexts, researchers thought it would be interesting to look at how the participants adapted themselves to the children from disadvantaged backgrounds in order to better meet their needs.

Use of rapport building. For any occupational therapy practitioner, the minute they first meet their client they are trying to build a rapport, to develop sometime of therapeutic relationship. Many occupational therapists would say that the therapeutic relationship is the backbone to the whole progression of therapy provided by an occupational therapist. While therapeutic relationship is one skill that carries over from one practice area to another, regardless of the clientele, the researchers were interested to know if changes in rapport building occurred with this specific population. The researchers found a category within the data that discussed how developing a therapeutic relationship with a child from a disadvantaged home can be the key to success throughout the time in therapy.

> Participant 1: The most important thing to give to a child would be the child's awareness of the connection, relationship which has to be based on acceptance and interests, you have to demonstrate acceptance and genuine interest then you can have a relationship and everything else flows from there. So I think that's the foundation.

> Participant 2: It's just trying to build rapport (to get the parents to buy into therapy) and find that common thread or that just something that you have in common and again it could be minuscule you know it could be very minuet but it might give you the tip of your big toe in the door to their lives.

> Participant 4: I think a sense of accomplishment, a sense of feeling like they can do it, they can succeed, they need to work differently they need to do it slower, but they will be able to do it.

> Participant 5: I think that giving them a listening ear for the most part, and children if you give them the opportunity will confide many things in you that you would be surprised and so those types of things where you allow them to feel safe enough to be themselves and feel safe enough to make mistakes and feel safe enough to tell you some personal things that are going on in their lives.

> Participant 6: When you have someone who comes from a truly disadvantaged family giving her that sense of self and that sense of importance and esteem and confidence, this is a kid who anticipates failure and that is what she has been taught or expects and so when you start giving her the idea that no you are not a failure you can do this, it gives you a sense of pride and it feels good and it's fun to see her step up.

> Participant 8: Depends on your environment but yep absolutely. And the lower income ones and the drug ones or you know those kind of things a lot of times those parents are

young and they have been addict or they have been abused and they don't trust me or anyone and so I think those bonds are the closest ones and I think I help those families probably the most because they watch me and they don't trust me and they watch me interact with their kids and how their kids love me after a while and look forward to me and how they start to opening up to me about their background…so they I think that they really have to feel safe and trust me with their child, with their prized possession.

It is reasonable to assume then that the rapport necessary for development of a beneficial therapeutic relationship is also a requirement for establishing a successful mentoring relationship. The researchers examined this theme in more detail further in the interview process.

Boundary setting. One thematic aspect when working with disadvantaged children that occurred frequently was the idea of boundary setting. As the researchers analyzed the boundary setting theme, they found that the answers were vastly different between the participants. When analyzed further, the practice settings that each participant worked in was found to have a significant impact on the boundaries that needed to be set. Another theme that impacted the boundary setting for the participants was their individual personalities and where they felt they were in their life. The researchers found this variance to be puzzling. In school, occupational therapy students are taught to maintain professional objectivity; however a majority of the participants could identify areas where boundary setting was not nearly as significant a concern, especially with this disadvantaged population. For Participant 1, the researcher asked her about the significance of the setting or the boundary in trying to connect with the child. Participant 1 responded:

Probably, so if you have a good team working with that child I think you will see progress no matter what the setting is, I think it's easier, if you have a strong team you're going to see progress. If it's a fractured team… then no.

Participant 4 felt that she bent the rules at the request of the parents.

I think that you establish boundaries and those are guidelines, they are not hard and fast rules and that there are some families that you do a little bit differently or provide

them something else and you go that extra for…If the parent asked and was honest and, um, very forthcoming about what they needed then you go the extra mile for them, it's not based on anything else for me.

Participant 2 had a vastly different idea about the boundary line between working with a child and the family. The researcher found this to be an interesting dynamic and asked if the participant felt that there is a line that can be crossed for becoming too involved in the client's life. Participant 2 felt that the disadvantaged aspect of a child's life can be a factor causing a boundary crossing; however she felt that personalities are the major factor for her:

I'm probably on the other side more than not, oh well I think when it comes down to it you have become somebody that makes them (the child or family) codependent, I think that's too much, I think that's how you cross the line.

Participant 5 was asked if she felt that there are any boundaries that need to be set, especially with children from a disadvantaged background, or if she felt the environment should be less formal than it would be with an adult. The researcher felt it was important to distinguish how this participant felt between her extensive work with adults and her time with children.

I think definitely you have to still have boundaries because you're not their parent and you're not their buddy, you know, you have an authority figure to a degree and so which is part of why the relationship evolves.

Participant 5 was later asked if she felt that it was important to keep clear boundaries within the specific setting and she felt that she never really had the experience of having to set the boundaries more clearly within a pediatric setting because the bell rang at 3:30 and the students were gone. She felt the boundaries were more likely to be crossed when she worked in the rehabilitative setting.

Participant 6 felt she kept her boundaries pretty even across the board, no matter what kind of home life her clients had. She felt that boundaries needed to be set rigidly to a degree, but with room

for exceptions. Participant 8 felt that the boundary is different for every child, and for every relationship the therapist will have with the parents.

> I've gone to birthday parties, I've gone to Tupperware parties, I've gone… I've been like party down, I've brought every candy bar and popcorn around. It doesn't matter, it's all relational. It's however you think you can best help the family… you do have to draw boundaries, you know… but I just think that the boundaries come from being a seasoned therapist.

> *Effects of disadvantage.* A significant aspect of the interviews related to the effects that the participants felt they had to address from working with children from a disadvantaged background. It was the researchers' opinion that it was critical to understand the participants' opinions of what the effects of a disadvantaged background can have on the child. Each of the participants had a unique perspective about the effects of this disadvantaged background. None of the participants stated that the disadvantaged background was irrelevant, and none consider background in a way that would affect the intervention. All felt that it was important to have the history at the back of their minds when working with the child.

> Participant 1: I think it is important to keep it in the back of your mind because it may be a good informer of things you are wondering about… things that may have had more of an impact because of that situation, so you just keep it in the back of your mind.

> Participant 2: Every child is unique, their background experience all those types of things factor into that and it wouldn't be the truth if I said you don't have preconceived notions or something about when you get a child with a specific diagnosis. I mean in your mind you kind of go through your little file cabinet and you're like "maybe this is what I am going to see", but you know I mean they are all just little…just this little unique individual and you just kind of take them as they are and try and build them up from there.

> Participant 4: I don't think it has any impact on how I treat the child, their home life certainly has a major impact on whether or not there is follow through on a home exercise program and that has an impact on them and if there has been drug or alcohol in utero then that has an impact, so I think that sometimes I think it's hard to know what things impact what you are doing and it lessens the benefits.

Participant 5: I think that's huge. I think that environmental exposure, you know in today's world, it seems like they have a lot more preschool programs and the school systems are actually providing those, so that's catching and the Head Start programs but for those kids who are not… transportation is a problem, money is a problem getting those kids to and from picking them up, those kinds of things, maybe everyone is working and also maybe just a general neglect of the child to not make that a top priority, so if the child doesn't have somebody that is reading to them and monitoring what they are watching on TV or making sure they have correct nutrition, warmth, all the basic needs we need in order to develop from there and then they are at a disadvantaged almost from day one.

Participant 6: What you see is not always what you get, you might be the most disheveled kids but you have the best family to help them and then you might see the girl, who would be very nicely dressed, her hair would be done, but she had some real behavior issues, who ended up, she was being severely abused.

Participant 8: I think those kids have not been given enough structure growing up they don't know where their boundaries are, they don't know so they push them all the time… you know kids that don't have to eat in a high chair, at a table, they can graze in front of the TV, they don't have any boundaries, any structure, they hit their parents, even little ones, you know, and so I think… that's what all the behavior is that.

Changes to previous approaches. After asking the participants to discuss their opinion on the effects of a disadvantaged background, the researchers wanted to understand how the awareness of these effects had impacted the therapists' treatment approaches. Once the participants had been warmed up to the memory of working with disadvantaged youth, it was time for the researchers to ask what the participants thought they could have done differently when examining their practice with children in this population. This question appeared to be the most difficult question posed by the researchers, requiring a great deal of reflective time for response. The responses from the participants revealed:

Participant 1: Back in the early 90s when the word "autism" and "PDDD" and "structural disorder", you know, were not really in our vocabulary, but there was a little boy I probably could have done more for, although I did do some matching with him, but I saw his picture and letters from his mom because they left the state and I did kind of think to myself "you know knowing what I know now could I have done a little bit more for that one"?.

Participant 2: I wish we would have had more of a community, like OT association, with the school therapist, the hospital therapists and the clinic therapists that would have been beneficial for me just working with the kids and being so new.

Participant 4: It's kind of cliché, but I would tell my patients to keep trying, don't give up, and I have to admit, I've learned as much from them as they have learned from me, find a different way if that way does not work.

Participant 5: Even as we have talked, it's like "you know, why couldn't we have some kind of like lunch group?", you know, those types of things or more group kind of activities would have been ideal or after school clubs, yeah, those types of things would have been really, really nice. And asking the parent, inviting the parent, having parent day, or you know, having those types of things so that they are more involved and so we could have been much more proactive back then.

Participant 6: I think at this point I would have been more assertive (When reporting suspected abuse) because I have more experience, but in the same sense it's a tricky thing because you want to advocate for the kid but you don't want to speculate and you don't want to assume things because you know it was true there were some serious problems at the home but we didn't know that for a fact.

Participant 8: Even though it might hurt or I might think about it all night or might kind of think about what is going on in their life what or how I could help better it always leads me to be a better person personally, so yeah, I think you know you have to do what's in your heart and that's what you kind of have to let guide you, so I think I could always do better, you know?

All of the participants identified ways they could have practiced differently in the past, although most felt that current experience would have indicated changes in past practice. The data indicates that while the participants understood at the time that disadvantages existed for their clients, that due to lack of experience, information, or support, this awareness was not a priority in the relationships with the children. The participants' responses lead to the conclusion that with more knowledge and support, the backgrounds of these children could be significant in successful outcomes to the relationship. These child clients are different in many ways than their developmentally appropriate peers, and therefore need additional guidelines and resources in the therapeutic relationship. In retrospect, the participants were aware that they changed their own attitudes and approaches to the relationship, but not many did it consciously.

The participants all identified how they perceive disadvantaged populations, how this affects their therapy, how they set boundaries and ways they would change how they had worked with clients in the past.   With a clear understanding of how the participants viewed disadvantage as it relates to their work with child clients, the interviews then moved to their view of mentoring. How did the participants view the concept of mentoring? Did they feel that occupational therapists should play the mentoring role? Did the participants feel they had ever played the role of a mentor?

Perceptions of Mentoring

For any occupational therapy practitioner, the minute they first meet their client they are trying to build a rapport, to develop sometime of therapeutic relationship. Many occupational therapists would say that the therapeutic relationship is the backbone to progression of therapy provided by an occupational therapist. This therapeutic relationship is one that carries over from one practice area to another, regardless of the cliental. The researchers found a category within the data that discussed how developing a therapeutic relationship with a child from a disadvantaged home can be the key to success throughout the therapy. The researchers asked a variety of questions that led to answer that fit this category. To participant #1 a question regarding the most important thing to give a child yielded a response about relationships. Several of the participants answered questions about positive experiences with answers about relationships. This was a recurring theme that did not depend on the question to be asked directly, the participants would answer with different versions of using a therapeutic relationship with the child. Mentoring in general is a complicated subject. There are diverse definitions of what mentoring is and what constitutes a mentor. A mentor is defined as "a trusted counselor or guide" (Merriam-Webster, 2012). This definition is very broad and leaves

a lot of room for interpretation. Each participant had their own idea of what a mentor is and

what a mentor does. When the researchers asked the participants for their opinions of

mentoring, many of them were thrown off guard and needed time to develop a definition.

Participant 8 felt that mentors come in all sizes and shapes and they can be somebody you met

for 5 minutes or somebody you have known your whole life. Several participants indicated that

occupational therapists should act as a mentor more in their daily practice with disadvantaged

youth and/ or their families. Several of the participants, especially those working with younger

age groups, saw themselves acting as mentors to the families or the parents, more than with the

children.

> Participant 1: You can't be a mentor if you are thinking about yourself, because mentis is a Latin word that means thinking and this mentalis muscle is the thinker so to be a mentor you have to be thinking about the person you are mentoring, not yourself and it is not easy to do that sometimes.

> Participant 2: OT mentor to a client mentor; I just think having that nice give and take just knowing that you don't know it all especially when I work with parents I know how to do all this stuff with their kid, but they still know their kid the best. And so respecting their knowledge even though it's not of child development or its not of sensory techniques or whatever but really respecting their knowledge and taking what they tell you at whole, face value and incorporating that into the way you work with their child has been very helpful.

> Participant 4: I guess mentoring to me is like teaching someone how to do it, I mean when you have a student therapist who comes in an watches to see how you deal with not only the nuts and bolts but the emotional part the families all of the different aspects and you kind of help them learn what it is like to deal with all of that stuff regardless of what job they are going to have and when I think of mentoring its different than being a therapist.

> Participant 5: I think the child who would need more of a mentor would be someone who doesn't have a strong parental person at home, especially in the late afternoon to evening hours, I think that would be an ideal position for us (occupational therapists) to try and help that child be it, um, getting them involved in Boys and Girls Club working on transportation issues um like I say having some kind of a set outing that you would do

with a couple other children, and I think it would be better to do with more than one child to eliminate that overstepping personal bounds.

Participant 6: I think I have been a mentor because some of the kids that I see have said to me that they feel comfortable with me that they are excited when I come to see them for OT that they um you know they have asked me about how long does collage take um what do you have to do to graduate high school, what does it take to get an apartment, all kinds of stuff.

Of all the participants, participant 6 was the only subject who identified the role of mentor as outside of

the scope of OT practice, although she previously identified herself as a mentor to clients:

No I don't think OT should focus more on playing that mentoring role, I think it is a very nice idea and I think it is very complementary thing to OT… but I can also see it if there were to be I mean I would think to be a mentor would be a pretty big job and I think it would be hard.

Participant 1 also struggled to think of herself as a mentor:

Oh, how are you measuring mentorship? If mentorship means as a facilitator for the child to learn a new skill…maybe they did not learn a new skill but they participated and choose to participate, then absolutely, every child.

As the participants struggled to define what a mentor was, additional questions were asked

throughout the interview to assist the participants to develop their personal ideal of mentor qualities.

Time was the one quality that all the participants identified as being critical to playing the mentoring

role. Other qualities consistently identified in the interviews were: flexibility, empathy, playfulness,

positivism, holistic sense, strong sense of self, acceptance, openness, honesty, multitasking, and

attentiveness. Participant 1 responded with the following additional qualities:

Listening, being nonjudgmental, being inquisitive, asking kids, asking parents, asking teachers, being willing to listen to parents especially if they are a single parent working and they have all kinds of stress, asking them if there is anything going on at home or somewhere we can give them extra support in while they are at school, you have to ask extra questions to learn what the needs are and to ask questions you have to have time and allow the time to ask the question and if you ask the question you are saying to them indirectly, you know I'm asking you this question but I'm really also saying that I'll have the time to help if I can.

Participant 4 also identified more strongly with her position in the psychiatric setting, where

she feels she was more of a mentor, than in her current pediatric outpatient setting:

> I think in many ways when I was doing psych I was mentoring the patients and when I'm
> doing pediatrics I'm mentoring the parent um when I was psych I saw the kids daily and
> they saw you in a variety of different settings because they saw you all day so you really,
> they got to watch as well as just talk to you. When I am talking to the parents and
> mentoring them I'm seeing their child for 45 minutes once a week and I'm trying to help
> them in situations where to a certain degree they get to match what I do but more often
> than not they will have a question for me and I will try to give them an answer or some
> suggestions whereas in psych the kids got to see me walk the walk and talk the talk and
> um so it's just a little different that way.

Perceptions of Occupational Therapists as Mentors

While the participants discussed the qualities necessary in a mentor, a pattern began to form in

the qualities they listed which applied to both occupational therapy and mentoring. Because mentoring

and occupational therapy have so many common characteristics, the researchers wanted to better

understand what qualities the participants thought identified someone as capable to serve as a mentor.

The majority of the questions in this section of the interview focused on whether the participants

thought that occupational therapists, on the whole, are capable of being mentors for children from

disadvantaged backgrounds. The researcher's wanted to know if the participants thought that

occupational therapists should specifically serve in the mentoring role, and what capabilities are needed

for them to be effective in this role. Children from disadvantaged homes have people constantly in and

out of their lives. The researchers asked the participants what they felt occupational therapists could do,

to be different from the other adults entering and leaving these children's lives. Participant 1 stated

that occupational therapists are different because they have been trained to look at the whole person

and see the person within their context at the same time. Participant 2 felt that occupational therapists

could be a mentor for these children through advocacy. Participant 5 felt that the one-on-one time with the client is what "ups the ante" for occupational therapists compared to other disciplines. Participant 6 identified the consistency of seeing the patients and knowing that you, the therapist, are providing them with some structure that they can count on. Participant 8 thought, from her experience, that the best way to help a child is by coaching the parents, loaning them toys, and teaching the parents how to make toys.

The areas identified by the therapists were varied; however each of them did identify the capabilities that one would need to possess in order to be an occupational therapist mentor for children from disadvantaged homes. These perceptions of occupational therapists presented by the participants are the backbone of the study. When asked, the participants identified their belief that occupational therapists could act as a mentor or a child from a disadvantaged home:

> Participant 1: I think there are many opportunities to be a mentor, you just have to know what is going on and evaluate the situation and you can be a mentor by mentoring a caregiver or another professional, maybe they (the child) have moved to working with another therapist or another teacher and your advocating for the client by mentoring the new person who is going to be giving the direct service, there are probably opportunities that arise all the time as long as we have our eyes open and are willing to survey the environment.

> Participant 2: I don't necessarily think that each OT has to be a mentor, I would say It would definitely have to be to their personality and their comfort level…I mean some people are just cut from a different cloth and it might be more natural for them to take on a mentor role versus other people might prefer to take a different type of supportive role.

> Participant 4: I know when I worked with psych 16-16 years ago I think that as a therapist, they were more older children adolescents, and I certainly think you are able to give them more of a mentoring experience then.

> Participant 5: I think probably even more so (giving patience and time) because kids from a higher socioeconomic background typically have more time with their parents because they are not involved in whatever activities they are involved in so I think that would up the ante as far as having a teacher spending one on one time with you and

encouraging you and maybe not saying that you know that you're stupid or that you can't do these things and you never will and those kinds of attitudes to always encouraging and always having a positive outlook and a lot of you know "atta boys" and "look how much better you are doing in school now because of this" and that kind of thing.

Participant 8: Do I think it would be harder to act as a mentor? Um I don't think so at that age because at that stage in their development you are really teaching them to be their own advocate if their still in therapy after that long and you are teaching how to talk about their disability how to advocate for themselves as far as maybe a job or those kinds of things, so actually I think that is a really ideal age, the teenagers, to be a mentor advocate.

Contrived vs. organic context. In the literature available about mentoring there has been some discrepancy between whether a mentor should be from a contrived or organic context. As an occupational therapist assigned to a pediatric client in their caseload, the relationship would be considered contrived. It is suggested that no matter what the capabilities of the mentoring adult, there will be no long lasting effects from a contrived context. The researchers addressed with the participants whether they believed that their mentoring relationship with clients would make a difference because the relationship was contrived? As with many of the other questions, the answers related to the issue of contrived versus organic relationships were varied, as any of the participants had never thought of mentoring in the contexts of "contrived" vs. "organic". Many of the participants agreed that organic relationships could possibly be more effective in some instances; however none of them believed that the relationship between the mentor and the child would be weaker and less effective simply because it was contrived. Many of the participants felt that the contrived context was a way to "get the foot in the door". The participants indicated that the characteristics and qualities that they had previously listed would be as effective in a contrived context in the long run.

Participant 1: I think OTs, a majority of the time, have contrived relationships based on their skills, but it's going to go into an organic relationship.

Participant 2: If you consider other relationships you have, that would be fairly true as far as more natural, but I think depending on that goodness of fit that the therapist has with that child that they might not have that initially, but it can definitely build into more of an organic type relationship.

Participant 4: I guess that's it I don't worry about whether its organic or contrived, it's like did you make the connection… In this particular thing I don't have a choice it has to be contrived but I don't think it makes it any less when it works, it's no less important than the other… I would say that the contrived wouldn't be as affective it would not be as good, but my experience says that isn't true.

Participant 5: I don't agree with that (organic being more effective)…say that child of a friend where you can have those types of a relationship maybe fun, but I don't think the child is quite as focused on the fact you're there for them, as you would be in a direct therapy relationship where you are absolutely focused on their needs…you have something that you are doing together that is goal directed and so they know that you are there specifically for them, you're not just like taking them with a bunch of other family members to a park or a movie. So I think you have almost an increased mentorship type of a situation.

Participant 6: No, I think it is dependent upon the person, I think it is dependent on the OT…I don't think how I'm going to be with them is going to be any different.

Participant 8: I don't necessarily agree with that, I think that sometimes the ones you trust the most that come up through can do the most damage, I think sometimes you meet one person in your life and it changes your life forever.

While the participants saw the logic behind the literature findings, none of the participants agreed with the literature and some even felt that it was more productive to be in a contrived rather than an organic relationship due to the unique talents and abilities of occupational therapists. Whether or not these participants had ever seen themselves as a mentor, this question caused very strong reactions. They felt that if they were mentors coming out of contrived relationships, the impact they had was as great as that produced by an organic relationship. Even participants who were hesitant to label themselves as mentors argued very strongly in the defense of the contrived relationship.

Parents Reactions to Therapy

A common theme that was mentioned by all of the participants was how the parents reacted to therapy. Although the researchers did not specifically ask the participants about the parent's reactions, it seemed to come up naturally when the population of disadvantaged children was brought up. Overall, the participants seemed to believe that the parent's interactions had a significant impact on the success or difficulty the child experienced. Participant 8 discussed how the parent's interactions affect the child:

> I do. I really do… the way they play with their children, this is going to make a difference for the rest of their lives… I think because a lot of them want to raise their kids differently than the way they were raised, but they don't have the tools and so I think particularly in disadvantaged …I think that that population needs more mentoring. I mean I have some 15-16 year old parents, they are just kids.

Participant 2 spoke about how she sees the parent's interactions when working with a birth to three population:

> I am thinking my birth to 3 year olds, because we actually go into the homes and so we see their living situation, or we have families where sometimes we are working with one parent and the next time we are working with the other parent and depending on the family there might be good communication or there might not be good communication…I think that it may on some level impact how much carry over you get with the family, but I have had fabulous single parents, divorced parents, parents that have been through abusive situations or those types of things that are in it for their child and they are willing to do whatever it take to get what they need. Um but then again in that same breath, I have the families that are only doing it because DFS said they had to and so um you know you get the full spectrum…I mean it just really it's just very individualistic depending on the family.

Participant 1 discussed a positive situation where the child had very good follow through on the part of the parents, and how that positively affected their child's therapy:

> His parents, they were there, they wanted to know what was going on. Of course mom had an advantage, she was not working, so when they got him into school they always came and were visiting him…my taking the time as well as the parent having the time, the collaboration.

Situations like the one described above were not common during the interviews, and served as the sole

example of a primarily positive parental interaction from the participants. Many participants spoke

about the frustration they felt when working with parents who were less likely to follow though:

> Participant 4: You know, I thought of a couple instances where you were where you
> working with the child, and the parents, no matter what you give them, no matter how
> you try to do things. that the parents don't follow through, the frustration with that not
> being able to mentor them so to speak so that they understand the importance of doing
> this and it's not so much that they are incapable physically or mentally or whatever
> it…there is times that it feels like it's more important to me that their child improves
> then it is to them, that they just don't care, it's not part of their value systems, it's like
> "ok I'm not understanding that".

Participant 6 worked in the school district and discussed how she rarely saw the parents:

> Participant 6: I see them some times in a meeting, it's not usually the parents though, it
> is sometimes, actually we are all really pretty happy, a little surprised, when we do see
> the real biological parent. A lot of times we see foster parents, its grandparents or
> grandpa or auntie, or even the sister…a lot of the kids I have, parents are both dead or
> they're in jail or they're in prison, or who knows where they are a lot of the times, is not
> the parents, but a couple of the times it's the parents and we get to see them and talk
> to them.

Several of the participants identified the outcomes of poor follow through at home; typically the child

would not make progress in therapy, and clients would stop coming to therapy or the therapist would

have to discharge the child because they were not making progress. Participant 4 talked about how she

had to place clients on "therapy breaks" due to a lack of progress,

> …you kinda have to back them out gently but it's like… you can't say you're not doing
> this…it's kinda like, "you know I've been looking at their chart and seeing where they
> are, it appears that they are just kinda stuck right now" and you say that happens,
> making sure that they don't feel like you are pointing a finger at them. Because at some
> point they may figure out that they want to do this… so often the child is in the room
> when you are talking to them and you don't want the child to feel bad about anything
> so.

Participant 2 described a situation where she worked with a parent who she perceived as difficult, and how therapy services eventually stopped:

> So we did have a family where there were two therapist that were seeing twins …it was one of those situations where mom just felt they were doing good enough, they weren't up to par, but they were doing good enough and so she just kind of slowly stopped making appointments and then we just asked if she still wanted services and she said no.

The last major area that seemed to involve a discussion of parents was the client or family reaction to discharge from therapy. This was the only question asked by the researchers that directly related to parental reactions. Some participants discussed how the family has relied on occupational therapy as an emotional safety net, whereas others discussed parents being relieved when their children discharged from therapy. Participant 1 discussed transitions from services for the birth to age 3 population:

> …sometimes there are some families you know, kinda nervous about moving to the next stage, who the therapist and the teachers, who have done it in the same team for many many years, and it's the fear of the unknown. But again in that situation, if you do sense that then that is where it is natural to move into that mentor piece…that is something that we did all the time at CDC was teach the parent and caregivers how to be advocates for the child. It was a huge piece when they were transitioning… teaching to be advocate. I think that is a big mentoring role and the parents would even occasionally come back and say so and so went to school and they are really having trouble with this and this and so then again we can go into a mentoring role and give them some tools.

Participant 4 discussed the emotional context of discharge:

> I think it's a good thing its harder on the family then it is on us, most of them it's a good thing that the child graduates and I think it is harder on the family because they perceive us as a safety net and now they are not going to have that safety net and it's really important to tell them "give me a call, let us know…positive or negative, let us know", but there have been some where we have literally have had to say ok we have seen them every day it's time to start working toward…and we try to give them a couple months like you know ok school is going to be starting in august, let's use that as our jumping off date and start backing off of therapy…we try to prepare them for that, because it is hard for them…especially we have kids, we see for years and you want the parents to be prepared for that because they need to see it coming.

The emotional connection was echoed by Participant 8:

> Yes it's always hard to discharge, everyone gets attached and the family relies on you to come…Absolutely without a doubt they cry in the meetings sometimes. Yeah, the parents cry, the mothers cry. I mean think about it, you're in someone's home for three years, every week. You don't even see your best friends every week, I don't, so and you love their children and so they love you because you love their kids…we are with them during the very worst time in their life and if their kid is testing out that means they have done so well…still that that post-traumatic stress thing, from having that preemie that weighed one pound…they are still trying to get to that fact that they can accept that they are going to test out.

All participants recognized that the parental reactions to therapy had an impact on the child's outcomes in therapy. How they reacted to therapy differed amongst each participant's experiences, but a common theme was the level of follow through from the parent and the impact of that level on successful outcomes.

Mentoring of Parents. As noted during the interviews, a recurrent theme of mentoring the parents kept appearing. This theme was most predominant with participants who had worked with the birth to age 3 population, and with participants who did not work inside of a school system. The majority of participants appeared to feeling strongly about the participation of parents in the therapeutic relationship, and many expressed a belief in the need to increase parental inclusion:

> Participant 1: There was a huge advantage with the parent learning what skills the child should be demonstrating so that the parent could work on those skills with the child, because many parents just are not aware of how kids develop normally and if they don't get their information from wellness checkups from the nurse, they just don't get the information, so there is an advantaged for the parent working with the child and the client progresses.

> Participant 2: Yeah, I mean most of the parents definitely, they know their kids, I mean they might be rough around the edges but they do know about their kids and just to be able to try and take anything any kind of guidance or knowledge that they have as well as sharing my own and just letting them know that, I might be the one that comes in once a week, but really you're the expert you tell me what's working and when it's not working then we will brainstorm and we will come up with something else.

Participant 4: Oh certainly, I think a lot of what we do in the home exercise plan is teaching the parents how to parent, offering them styles of coping strategies. They need them as much as the children do, and being able to kind of offer them options of how to handle and in a way they have never even thought of and part of that is experience as a therapist and part is experience as a parent and part of it is being able to step back and look at the situation differently than the parent.

Participant 5: We would discuss with the parent during the IEP meetings, but to actually have a parent come in and really participate I can't remember that ever happening.

Participant 6: Um, no we don't try to get them more involve, the ones that are really involved I have you know made handouts and um exercise programs and all different types of things to do you now while they are on Christmas break or whatever.

Participant 8: Parent coaching, more help when they are struggling more family support services and when they are struggling to get gas so they can go to work they cannot work with their child you know or where they are living is so small and you're working on crawling and there's really not even a built environment for the kid to crawl in there is just a play pen.

Perceived Therapist Impact on the Client

A common theme that emerged through the course of the interviews was how the therapist felt that they impacted the clients they served. There were many factors that contributed to how the therapist felt they impacted clients, including their unique relationship with the client and family, how much time they invested in each client, the outcomes they saw when they encountered the clients later in their lives, how they felt the client impacted them, and how they felt that their work changed the lives of the clients.

Although this was a common theme amongst the participants, some of their perspectives on their impact differed. One of the most dramatic impacts came from Participant 4, described an incident where she worked with a client who had several sensory difficulties and the strain it was placing on his family, As a result of this strain, the child's parents were contemplating divorce, but of the occupational

therapist's intervention the family dynamic was restored. When participant 4 was asked if she felt like she had saved the parent's marriage, she responded, "which I had no idea I was doing, I was working with the kid and trying to make the kids life better and in the process you made the whole families life better."

In the case of Participant 8, she looked at her impact as being able to give hope: "Oh I think…I am very fortunate to be an OT because I am a giver of hope and just to be able to give hope to someone changes their lives."

Across the board, all participants felt that they had made an impact on the clients and families that they encountered, regardless of practice setting. The main difference in this area seemed to be the mode of change that the participants used; some used physical change to inspire growth, where others relied on both emotional and physical change to achieve the outcomes they observed. Commonly, however, the perception that they had made a difference was not understood until much after the fact. This can be attributed to the perception that the majority of the participants felt like they were "just doing their job", although they all recognized that therapy was necessary for these clients to have a successful life. When asked about a perceived impact, Participant 1 responded, "In general, the teachers would comment on the self-confidence and the initiative because of what they said was my intervention, my interaction." For other participants, the realization of their impact was not recognized until they were transitioning out of one setting into another. Participant 2 reflected on the impact she had when leaving her first job in one town to move to another:

> I'd like to think so, I mean when I left Gillette…pretty much all of my families
> that I was working with at the time gave me gifts or cards and you know notes
> of appreciation and those types of things, so um I hope that speaked (sic)
> highly of how they felt about what I was doing for them and their child.

Participant 4's point of view was unique in the sense that she was not able to see many of her clients post discharge to know what far reaching effects she had made. When asked if she felt that her interactions made an impact, she replied:

> You know, I don't know, because I don't necessarily know that much about the other areas of their life, I mean in know the kids where the parents have said you know I got one little boy now where the mom is saying this is amazing he is starting to go to day care now and he is starting to engage, but he has a sensory processing problem so it is logical therapy is helping with that um I mean you would expect it to help with those other aspects of life when its um dressing or some of that I don't know, it would certainly help at home but I don't know.

Participant 6 talked about an experience she had where she heard about the effects of her intervention after her client had been discharged from service:

> The special ed teacher called me, he was in tenth grade, so it must have been I discharged him in ninth grade, any way… [the special education teacher] called me and said he is reading, and I was like oh my goodness, I mean he could never read, he was so developmentally behind so so bad, but it eventually happened.

Overall the participants realized that their interactions with the clients had a positive effect, but in some cases, the participants did not realize that the child was benefitted in more than just the area addressed until it was pointed out to them by another person.

Some of the participants spoke about their opinion of why occupational therapy was able to have such a meaningful impact on the client as compared to other adults or other professions these children often had to interact with. Many of the participants identified the ability to give more time to the clients than others in their lives were able to. Often teachers had several students they had to work with at once or parents had other children or jobs splitting their time, where the occupational therapist on the other hand spent time with the client one on one. It was frequently stated by the participants

their belief that the children needed this specific type of interaction, because they were not receiving it elsewhere. Participant 4 discussed this idea at length:

> I don't have multiple kids in my therapy sessions, the teachers has multiple kids, she is a regular in the classroom and the teacher does not have to move so that's different um parents have multiple kids in the family they work you know low wage you know they are not physicians they are not electricians or whatever, so there is not a lot of money there is not a lot of time they are gone a lot…In addition to being a therapist the one thing that I give her [a client discussed earlier in the interview] that the other don't is one to one time with an adult who just is there for her. And I think as much as anything that is really what she needs, it's just her and me.

Other participants identified that occupational therapists were different from other adults or disciplines due to the specialized nature and unique knowledge base of occupational therapy training that allows therapists to see factors in the lives of the clients that other disciplines or other adults would not be able to see. Participant 1 stated:

> Because we are there, we have been trained to look at the whole person and see the person as, in the context they are in at that time. And what is the environment? What is going on in the environment that is influencing anybody's behavior? And I don't mean behavior like screaming or whatever, I mean behavior like moving forward on whatever skills they need to develop. So I think um a greater picture of the person and the person as, how they function in different environments around them, and people because that changes from minute to minute. I think we are a special skill for that.

Participant 6 felt that occupational therapy was unique because of the difference in expectations placed on the child and the child's reaction:

> I think as the OT, they see, the kids see you coming and they know you know, they know that you understand that their spelling is not going to be good, they reverse their letters and it's hard for them to stay on task and that you have a different understanding of what their abilities are and what their limitations are so I think they feel more comfortable with you because you don't have these outrageous expectations of them.

Participant felt that having this insight allowed them to provide the client with a type of treatment that was very different than any other adult in the child's life. This unique treatment, in the opinion of all

participants, was an important aspect in the development of the treatment and outcomes in the lives of these children.

Many participants also believed that the skills that they taught the children also applied to other areas of their life despite, any home situations they may be experiencing. The occupational therapist were able to recognize that if a child was from a disadvantaged home life, then some of the skills learned in occupational therapy might carry over differently once they go home because of the additional stresses this particular population must face. Participant 5 reflected on the change in attitudes afforded to the child through increasing function:

> Um well I think that like with all of our clients the more we can help them to be independent and function on their own the less likely they are to be running, having interference from people who may not be patient with that type of a thing, so the more we give them that ability to take care of themselves, the more they are able to move out from that and achieve more in different areas. I think that starting from their like ADL skills moving on to their academic skills and I think to we teach them a how to function better in the classroom too and so once they are able to better do that, then of course they have increased interaction with peers and their teachers don't perceive them as a problem, then their parents don't perceive them as much of a problem because they don't want to hear any more bad news.

When participant 5 was asked how often she saw parents look at their child as a problem she responded, "I would say probably more frequently than not." She looked at the impact she had on these children as more than just the skills they acquired, but also how those skills will help them with interactions with the rest of the people in their life. Participant 6 talked about how a simple skill like basic handwriting can have far reaching effects for a child from a disadvantaged home, beyond the skill itself:

> I think it is a skill that they need to know…when they are able to do something positive and you are able to give them that reinforcement and they have success in doing, I think that is more the deeper part of it.

Participant 1 spoke to the building of self-esteem and how that relates to the additional stresses these children go through:

> …I would teach the child to problem solve the situation, when they know they have solved the problem, I'm sure that would have to help their self-confidence and apply to other areas. It's hard to measure how kids feel about themselves…a lot of it is what you see non verbally… I tried to use this strategy in class when I would say "gee, I wonder what we ought to do, I wonder what would happen if we did this or we did that", so you are not asking them a direct question, but you are encouraging them to think and test out something that they are thinking and "oh gee how did that work?" … they just smile.

Participant 4 once again spoke to the family's perception of the child:

> It tends to be more of the social skill play kinds of things, like we can take them to Wal-Mart now; we can go to the store and they don't have a meltdown; they can sit thought their sisters concert at school without absolutely being berserk; we can take them places and the whole family is calmer. We have a fair number of kids where because of the sensory stuff actually hold the family captive and so those are kids where you definitely have the parents say this is so much nicer…in that instance you do feel like they have made the change though out their life environment.

Overall all of the participants were able to recognize that occupational therapy had far reaching implications for the clients, especially those from a disadvantaged home because of the additional stresses they, and the family or caretakers, typically faced. Often these children present problems across all of their life context and being given the skills to cope through occupational therapy transferred over to their other contexts as well.

All of the participants came to understand that they had a significant impact on the clients that they served. This was not a surprising finding to the researchers considering the training and experience of the participants. The greatest variances in this category appeared to be how the participants perceived that their interventions impacted the client. The variances in perceived impact can be attributed to differences in practice settings that the participants practiced in and the level of contact the participant had with the client post discharge. As the researchers analyzed the data they examined

commonalities between the participants' answers based on the professional and educational expectations at the time the participants graduated from professional school, and how long they have been in practice. However, all of the participants are highly unique individuals, based on settings they have practiced in and their own life experiences as a therapist.

The last category within this section was how the participants felt overall about occupational therapy playing the mentoring role. Throughout the interviews there was a significant emphasis placed on the participant's feelings about the role of occupational therapy, specifically the role of occupational therapy with children from disadvantaged homes. By the end of the interview process, the participants had each settled into their opinions regarding mentoring with disadvantaged youth. The first question participants were asked for this set of data was: Do you think occupational therapy should play more of a mentoring role with this population? Further asked questions are listed within the data. These questions were asked to further clarify the participants' feelings on the subject of mentoring within the occupational therapy profession.

> Participant #1: I think it depends somewhat on the age of the child like if you are getting an older student who is transitioning from um one school setting to another there is probably needs to be a mentor or moving from school to community" Do you think that during transition is the only time that occupational therapist should act as a mentor? "no I think um there are probable many opportunities to be a mentor you just have to know what is going on and evaluate the situation and you can be a mentor.

> Participant #2: Um I don't necessarily think that each OT has to be a mentor I would say it would definitely have to be to their personality and their comfort level … but I mean some people are just cut from a different cloth and it might be more natural for them to take on a mentor role versus other people might prefer to take a different type of supportive role if that makes sense" So then being a pediatric OT do you think that all those children actually need a mentor in their healthcare provider or in their OT? "well I think a lot depends on where their family as a whole is at you know if you've got your single mom or you've got other issues in the home or whatever um I think that's what is going to determine how much of yourself you need to give.

Participant #4: I think I always start out just being the therapist and then if perceive some sort of need or they ask then kind of gently flow into it I guess I would be reluctant to just put on the mentor hat all the time that's…I don't think that is why people come to a therapist is to have a mentor they come to have therapy but then if they start asking me those kind of questions um we did this it worked really really good what is the next step? How do we do that? At that point I feel like it is kinda both mentor and therapist… I have never thought of myself being a mentor it's like as you talk about it I guess or I'm like ok I've done that I do that and its without even thinking you just kind of shift into that mode as its needed.

Participant #5: Yes I think that especially if that were really delineated as a goal and with specific people you know I mean I could even see that there could be like a screening in place where this child is identified as needing a mentor and that do it according to specific parameters so that people aren't just out there you know wantonly getting into business that might not be theirs to get into and so it would have to be professionally guided" Do you think that every child that come through OT needs a mentor? "No"

Participant #6: No, I think it is a very nice idea and I think it is a very complementary thing to OT it kinda goes but I can also see it if there were to be I mean I would think to be a mentor would be a pretty big job and I think it would be hard right off the bat coming out of school and assuming that kind of a role" Do you think it is something that more older OTs who have been practicing longer should look more into being a mentor? "Maybe, I mean you know we have these people who run around and are kind of like old souls and they are very sweet.

Participant #8: Oh I think it would be wonderful, um, yeah. How do you think that an OT program can go about facilitating that in a student who is maybe going through the program? "Um you know I look at older the older kid population when I think about that because you know 0-5 its it is kind of hard except for mentoring them on coping strategies and skills and how to focus and those kind of things I think with the younger junior high and high school for sure.

As the researchers analyzed this data they found that only one participant responded with a definite "no". Half of the participants thought that it was situational and depended on the client and the therapist's comfort zone. The last two participants thought that the role of mentoring would be a good idea; however it would need to be formally monitored. This variance in answers was interesting to the researchers. Researchers felt that this finding could have been due to the perceived impact that each of the participants felt they had had on their clients.

Conclusion

After analyzing the data, the researchers found that almost all of the participants felt that occupational therapist possess the training and characteristics to serve as mentor for children from disadvantaged backgrounds. Similarly, all of the participants felt that occupational therapy and mentorship held commonalities. In the right situation, under the right circumstances, and with the right "goodness of fit" between the client and the therapist, a mentoring relationship could be developed.

Each of the themes that the researchers identified were unique yet organically flowed through the interview process. Questions related to working with disadvantaged youth contained the most significant amount of information. Within the information, the participants identified different experiences they had with disadvantaged youth. Participants discussed the impact on child who is from a disadvantaged home, with identified areas where these children may need more support, particularly to counterbalance a lack of follow up at home. The lack of follow up, or more specifically a lack of involvement by parents and caregivers, was identified by participants as being the most impacting effect on a child from a disadvantaged home. The participant's perceptions of what a disadvantaged home is and how it affects the child directly, as well as the expanded role that the therapist must assume in this circumstance, lends supports to the researchers' hypothesis that occupational therapists possess the knowledge and holistic orientation to serve in the mentoring role.

Within the data the researchers shared the participant's perception of what mentoring means to them. While each participant had a common foundation of understanding about the concept of "mentor", each also had their own individual idea of what mentoring should be in the practical application. These individual definitions of mentoring were seen throughout the examples provided of each participant's work with children or families from disadvantaged homes. Through the interview process, it became clear that the participants had each served as a natural mentor due to the

circumstances of their clients' backgrounds. One significant and unanticipated theme was that of the occupational therapists mentoring the parents for the benefit of the client. This was a commonality among participants who worked with the younger ages. All of the participants felt that they had a positive effect with their patients, but represented a wide continuum regarding parental involvement from a high need for increased participation to very little perceived need of increased participation by parents. To control for participant bias toward their clients, the researchers asked probing questions to force the participants to analyze their perception of their effectiveness with this population. The researchers also questioned the participants regarding any negative client outcomes. Overall, participants were very honest when describing the challenges of working with children they did not connect with. Another area where the researchers anticipated bias was in the perceptions toward the parents to the therapy their children were receiving. Many of the participants did identify negative parent reactions to therapy, and shared stories with the researchers about these negative experiences, but this data was largely offset by the examples of mentoring of the parents identified by the participants.

Overall, the participants were very forthcoming with information about their experiences. The participants were honest about their interactions with their clients and the families. From the analysis of themes, the researchers can conclude: the participants believe that children from disadvantaged homes are in need of extra attention; most of the participants feel that they can be an effective mentor, but only if time is allotted to provide support to that child or family; it takes special characteristics to be a mentor; structured and specific guidelines would need to be in place to avoid boundary violations; and while there are commonalities between occupational therapy and mentoring, it is not an automatic fit for every therapist. If an occupational therapist is comfortable with being a mentor, and they have the

time to dedicate to the client and the family, the therapist is in a prime position to be a mentor for a

child from a disadvantaged home.

CHAPTER V

Summary, Conclusions and Recommendations

Summation

Children from a disadvantaged home often experience less success throughout their lifespan. A mentor can be this link to lead to future success for a child who has experienced disadvantaged beginnings. In order to address this problem statement, the researchers designed a qualitative study in order to examine the retrospective viewpoint of occupational therapists who have extensive experience in working with children from disadvantaged homes. After analyzing the data and comparing participant responses, the hypothesis that occupational therapists can serve as mentors when working with a disadvantaged home, with specific expectations of time and relationship structure in place.

The significant findings that surfaced during the data analysis included therapists acting as a organically as mentors without the conscious decision to do so, and the recognition that children from a disadvantage home need special considerations and unique treatment. Factors in this consideration include the effect of the home life on therapy outcomes, and the need to mentor the parents, as well as mentor the child, with special emphasis on birth to age 5.

Hypothesis

The hypothesis for this study was: occupational therapists are in a unique position to provide the mentoring role with a child from a disadvantaged home and lead them to a path for future success. The results of this pilot study suggest that the hypothesis is true and occupational therapists can serve in the mentoring role with children from disadvantaged homes. More research needs to be conducted in order to define the contexts and in structures for occupational therapists to assume the mentoring role

within their practice. The majority of the participants stated that they believed that occupational therapists are capable of mentoring children from a disadvantaged home, with limits and conditions identified. Further research should consider the amount of time available, the setting and age groups, and the oversight structure necessary for occupational therapists to interact with clients in this context. Specifically, pediatric occupational therapists consistently interact with children from disadvantaged home and have the skills and knowledge to provide appropriate support for these children from disadvantaged homes.

Conclusion

Based on this study, the researchers can conclude that there is a strong correlation between the qualities of a mentor and the skills and abilities possessed by occupational therapists. According to Murray (1991) "mentoring is a deliberate pairing of a more skilled or experienced person with a lesser skilled or experience one, with the agreed-upon goal of having the lesser skilled person grow and develop specific competencies(pg, xii). The data collected supports the assumption that with the appropriate pairing and therapeutic use-of-self, occupational therapists can mentor the disadvantaged pediatric population for the purpose of helping them develop more successful life outcomes.

In other settings, mentorship is something that has to be purposeful. Within occupational therapist, the relationship is not "by chance". It is a relationship that if commenced in the school district, does not need an active seeking out on the parent's part; parents do not need a doctor's referral and there generally are no additional outside appointments. This is key to the formation of the mentoring relationship, given that the data suggests that poor parental follow through was a common outcome in a disadvantaged household. The relationship is more likely to have a chance at formation, due to the consistency that a school occupational therapist can provide.

Occupational therapists who serve as a mentor would not limited to the school practice setting, however. The data suggests that occupational therapists can also serve as mentors to parents who are living in a disadvantaged home, and may also have come from disadvantage. In a pediatric setting for children from birth to age 5, the participants suggested that when they act as a mentor, it is largely directed towards the parents. Acting as a mentor for the parents will help the children by providing the parents support, stability, and skill attainment. Consequently, the children will have a more stable home environment, and have the support they need from their home life. While therapist can act as a mentor for the children, with this population the outcomes will last longer and be more affective if the mentoring focused on towards the parents.

If occupational therapists are trained to recognize the signs of a child from a disadvantaged home and they are trained to use mentorship as a mode of therapeutic use of self, then they have the tools to affect the greatest change and possible help to lead these children to better outcomes later in life.

Recommendations

For further study, the researchers recommend using a more randomized selection process; use of a randomized selection process will allow for more reliability and validity within the study, and an increase in generalizability of the study outcomes. The researchers also recommend sampling one practice area at a time. By sampling one area at a time, the study can be tailored to better apply to focused populations. Also, selecting occupational therapists who have worked for similar amounts of time in the same field will allow for a comparison of setting specific data results. Further studies should also focus on mentoring needs from the client's perspective based on their perceptions of their time and relationships in occupational therapy and their opinions about being from a disadvantaged home. The

researchers also recommend that further research also analyze the role of occupational therapists as mentors for adult populations to obtain a broader understanding of the effect that this relationship can have across a wide variety of populations.

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Appendix

Interview Questions 1 &2

Interview #1

1.   How long have you been an occupational therapist?

2.   What field of occupational therapy are you currently practicing in?

a.   How long in this field?

b.   Where you in any other field before this

3.   Do you feel that occupational therapy could have an impact on a child from a disadvantaged home?

4.   How do you feel about your time as an occupational therapist treating children?

a.   How do you feel about treating a child from a disadvantaged background?

5.   Do you feel that you, as an OT have acted as a mentor in a child's life?

a.   How do you know this?

6. Is there a particular child that you mentored that sticks out in your mind?

a. If not is there a child you feel you could have played more of a mentoring role with?

7. Is there anything you could have done to make the child's experience better?

8. If you had to pick one thing what was the most important thing to give to a child in therapy what would it be?

9. How would you describe your experience as an occupational therapist with a child from a disadvantaged home?

10. What do you feel you could have done to be more to be a mentor in a child's life?

11. What made you different from other adults in the child's life?

12. What is one positive experience from your time with this specific child that really stands out to you?

13. Can you describe one experience that made you think, I am really making a difference here?

14. Do you think this experience was different then when you were with another patient?

a. If so why?

15. What are some of the qualities that make OT different from other people that interact with a child?

16. Some research suggests that an organic mentoring relationship is more effective than a contrived one, do you agree?

17. Did you ever give advice to a child that you knew they took to heart?

a. How did you know if they did or didn't?

18. Would you change anything about your experience as an OT?

19. Would you change any qualities that an OT would need to have in order to act as a mentor?

20. If you could go back and say one thing to your child patients to help their experience what would it be?

Interview 2

21. How did OT change your life as a therapist?

a. How do you feel you as a therapist have changed lives?

22. What did you learn from your patients?

23.   Did the skills you taught to your patient apply to their life?

a.   How so?

24.   Did participating in OT help the child in other areas of their life?

a.   How do you know or not know?

25.   Describe ways that you OT went above and beyond the job description for your patient

26.   Name some of the qualities that made you a mentor as opposed to just an OT

27.   Do you think OTs should focus more on playing the mentor role in young adult/children's lives

28.   Do you think there is a line that can be crossed from being a mentor to becoming too involved

a.   Do you think that line is easy to cross

29.   Do you feel that OT could fill that mentoring role

30.   How would you describe OT

31.   Describe one memory of you distinctly playing the mentor role

32.   Do you still keep in contact with any of your patients

a.   Specifically ones that you have mentored

33.   Do you think your patients life would be any different if they would not have had OT

a.   How

34.   Can you think of a cross road in their life that if they had not had OT they would have taken a different path

35.   Do you feel you could have done more/less as a mentor

36.   Did playing a mentoring role in the child's life, cause friction in other parts of their life

a.   Family, friends

b.   How did you handle it

c.   How did they handle it

37.   Why did they stop participating in OT

a.   If discharge did you feel they were ready for discharge

b.   Was it hard when your OT sessions ended

i.   For you or them?

ii.   In what way(s)

38.   How long were they in OT

39. How did OT change your life in general

40. Do you see your role as an OT, with children who are at risk, as a mentor?

Informed Consent Form

The University of North Dakota occupational therapy students are carrying out a research project looking at the effect of occupational therapy mentors on children from disadvantaged homes (any background that includes divorce, drug use, drug abuse, jail time, abuse, foster care, poor, homeless, and violence) and the effects for future success. The reason for this independent study is to explore the special characteristics that an occupational therapist as a mentor must have in order to be effective in creating change in a child's life.

In this study you will be asked to willingly participate in two one-hour interviews. In these interviews you will be asked basic questions about your experiences as an occupational therapist in working with children in this capacity. If at any point during the study you decide you do not want to continue there will be no consequences and you are free to stop at any time. The interviews will be scheduled 2 weeks apart. Each interview will be audio taped and transcribed word for word.

There are little to no risks associated with joining in this study. There will be questions that will refer to your professional experiences that may be stressful. The main benefit of the study is adding to the information available to occupational therapists who work with children from disadvantaged homes.

Your name will not be given out or used on any of the documents in this study. No information from the results will identify you. Results of the study will be shared with the University of North Dakota Occupational Therapy department. The final study will also be published, and the general public can see

the finished study. We greatly appreciate your willingness to join in this research. If you would like a copy of the finished study feel free to contact Jenni, Melinda, or Professor Lamborn.

Even though there is little of chance of any type of damages, physical or emotional, they are possible. If an emotional or physical pain were to occur, the Occupational Therapy Department and the student researchers cannot be held responsible. Every reasonable effort will be made to assist you in finding appropriate help.

If you have questions at any time regarding your rights as a research subject, or if you have any concerns or complaints about the research, you may contact Breann Lamborn, the research advisor, or the Institutional Review Board at the University of North Dakota. Please contact Professor Lamborn if you cannot reach the student researchers, or you wish to talk with someone else.

You will be given a copy of this consent form. If you have any questions feel free to contact any of the following.

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Participant Signature   Date

Interviewer Signature   Date

IRB Approval