

ATHABASCA UNIVERSITY

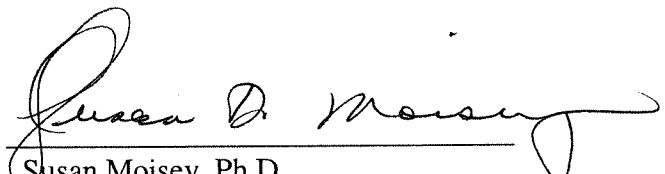
SUPPORTING MENTORING RELATIONSHIPS
THROUGH
DISTANCE EDUCATION TECHNOLOGY
BY
ELAINE FINSETH

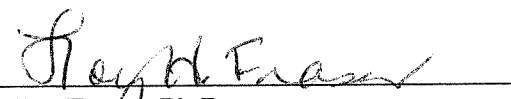
A thesis submitted to the
Athabasca University Governing Council in partial fulfillment
Of the requirements for the degree of
MASTER OF DISTANCE EDUCATION


Athabasca, Alberta
April, 2002

ATHABASCA UNIVERSITY

The undersigned certify that they have read and recommend to the Athabasca University Governing Council for acceptance a thesis "SUPPORTING MENTORING RELATIONSHIPS THROUGH DISTANCE EDUCATION TECHNOLOGY" submitted by ELAINE FINSETH in partial fulfillment of the requirements for the degree of MASTER OF DISTANCE EDUCATION.


Susan Moisey, Ph.D.
Associate Professor, Supervisor


Joy Fraser, Ph.D.
Associate Professor


Martha Cleveland-Innes, Ph.D.
Assistant Professor

Date: April, 2002

DEDICATION

This thesis is dedicated to my family. To my husband, Keith, for always lending a listening ear, showing incredible patience and understanding of the time needed to complete this process. To my three children, Nathan, Nicole, and Naomi, they too have been very helpful and understanding with the sacrifices needed along the way. Nathan your help with "computer glitches" or was it "mother glitches" saved me hours of headaches; also thank you for your help in data entry. Nicole, your help with data entry, reference checks and the much appreciated back rubs have helped me keep going. Naomi, the never-ending supply of fresh tea helped me persist with the many hours required by the computer. Thank you all!

I would also like to thank my mom and dad, and sisters, Leanne and Joanne, and brother, Dwayne, for your ongoing support, encouragement, and prayers. Together your support has helped me believe in the words of T.F. Buxton, "I hold a doctrine to which I owe much, indeed, but all the little I ever had, namely, that with ordinary talent and extraordinary perseverance, all things are attainable"(as cited in Engstrom, 1982, p.51).

ABSTRACT

The purpose of this study was to explore the nature of mentoring and the reasons why individuals seek mentoring relationships, and to examine how mentoring may be supported through distance education technology. This study utilized a combined, qualitative and quantitative research design. In this design, the two paradigms were clearly separate, yet associated developmentally.

In Phase One, a qualitative approach was utilized to identify key themes and questions. Four focus groups were conducted with a non-probability sample of occupational therapists who have supervised restricted practitioners. In this role, occupational therapists agree to be a mentor to the restricted practitioner. Two focus groups were conducted in rural Health Authorities and the other two in urban Health Authorities. Ethnograph v 5.0 software was utilized to code and analyze the focus group discussions. Common themes and patterns were identified and interpreted.

In Phase Two, a quantitative approach was used to answer the research questions and construct knowledge surrounding the themes identified in phase one. A questionnaire was administered to a stratified random sample of occupational therapists to elicit their perceptions of mentoring relationships, mentor and protégé roles and behaviors, reasons for seeking a mentoring relationship, barriers to mentoring, and the feasibility of using distance education technology to support mentoring relationships. SPSS software was utilized to analyze the data.

The findings of this study support previous research that indicates mentoring is a complex, multi-dimensional activity, which is complicated to define and categorize. Rather than

having only one type of mentoring relationship, it seems that occupational therapists may experience a continuum of mentoring experiences throughout their career.

There were three key factors identified as mentor functions: encouraging communicator, practice advisor, and career guide. These three functions comprised twenty-two behaviours, which reflect psychosocial functions and instrumental functions.

Previous research is also supported by the findings related to precipitating reasons for seeking a mentoring relationship. The key factors identified in this study align with being new to the profession/practice area, isolation, and role strain.

Many barriers impact the initiation and maintenance of mentoring relationships. The top four identified in this study are heavy workload, large client caseload, communication problems, and lack of willingness to mentor.

Although many therapists feel a need to have some face-to-face contact with their protégé, the potential of distance education technology appears to be a realistic means of enhancing communication and support within a mentoring experience. The media of choice is email, followed by the telephone, and Telehealth videoconferencing.

ACKNOWLEDGEMENTS

I would like to acknowledge and thank, Susan Moisey, for her tireless efforts in supporting me amidst the evolving phases of this program. Your advice and encouraging comments have been so helpful, particularly through the development of this thesis, when agonizing over the shaping of words into sentences, and sentences into paragraphs.

I would also like to thank my brother, Dwayne, for acting as my sounding board, listening to me talk out problems, and offering not necessarily the answer, but facilitating further reflection. As well thank you for your assistance with the data analysis, and the many phone calls to review this "just one more time".

Thanks also to Joy Fraser and Martha Cleveland-Innes for reviewing this study and facilitating the thought-provoking discussion during my oral defense. As well I would like to acknowledge all of the faculty and staff of the MDE program, for the guidance and reassurance provided throughout the last three years. I thoroughly enjoyed this program and appreciated the people involved.

Further I would like to thank my co-workers at Rosehaven and in Beaver County, for your ongoing support, encouragement, and belief that I would finish this thesis.

Finally, I wish to acknowledge those who helped organize the focus groups, Anne Tucker, Sheila Smith, Susan Murray, Val Hilario, and Johanna Kwakernaak. I would also like to thank the occupational therapists who participated in my study, I appreciate the time, effort, and careful consideration taken in the focus group discussions and the responses to the questionnaire. Your participation was essential to the success of this study.

TABLE OF CONTENTS

	<u>PAGE</u>
CHAPTER I – INTRODUCTION.....	1
Purpose of the Study	1
Importance of Study.....	2
Research Questions.....	4
Assumptions.....	5
Limitations and Delimitations.....	5
Conceptual Definitions	5
CHAPTER II – REVIEW OF RELATED LITERATURE	8
Mentoring and the Mentoring Relationship.....	8
Forms of Mentoring	15
Models of Mentoring	17
The Role of a Mentor.....	21
Mentor Behaviors/Attributes	22
Protégé Behaviors/Attributes	24
Protégé Needs	24
The Need for Mentoring in the Occupational Therapy Profession.....	25
Supporting Mentoring with Distance Education Technology	26
Barriers to Mentoring.....	29
Outcomes of Mentoring	31
Summary	33
CHAPTER III – METHODOLOGY	36

Research Design.....	36
Sample.....	36
- Phase One	37
- Phase Two.....	38
Instrumentation - Phase One	39
- Phase Two.....	40
Data Collection Strategy - Phase One.....	41
- Phase Two.....	42
Data Analysis.....	43
CHAPTER IV – RESULTS.....	44
Phase One.....	44
Question 1: Characteristics of Successful Mentor/Protégé Relationships	45
Essential Elements	45
Peer Mentoring Versus Hierarchical Mentoring.....	48
Dyadic Mentoring Versus Group Mentoring.....	49
Single Mentor Versus Multiple Mentors	51
Mentoring Relationships Across Regional Boundaries	52
Mentoring Relationships Between Different Facilities/Practice Areas	54
Mentoring Relationships Among Different Health Professions	58
Characteristics of a Successful Mentor.....	59
Characteristics of a Successful Protégé	62
Question 2: Precipitating Reasons for a Mentoring Relationship.....	63
Question 3: Barriers to Initiating and Maintaining a Mentoring Relationship.....	65

Question 4: Supporting Mentoring Relationships through D. E. Technology	69
Question 5: Feasibility of Using D.E. Technology to Support	
Mentoring Relationships	72
Phase Two	75
Characteristics of the Respondents	75
Gender	75
Age	76
Work Status	76
Regional Health Authority	76
Work Setting	78
Length of Service	78
Prevalence of Mentoring	79
Theories of Mentoring	80
Precipitating Factors for Seeking a Mentor	80
Initiation of a Mentoring Relationship	82
Functions/Behaviours of a Successful Protégé	85
Nature of Mentoring Relationships: Protégé's Perspective	86
Functions/Behaviours of a Successful Mentor	88
Nature of Mentoring Relationships: Mentor's Perspective	91
Development of Mentoring Relationships	94
Barriers to Initiating/Maintaining a Mentoring Relationship	100
Supporting Mentoring Relationships Using Distance Education Technology	105

Feasibility of Supporting Mentoring Relationships Through Distance Education	
Technology	105
CHAPTER V – DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS	108
Discussion of Findings.....	108
Characteristics of a successful mentoring relationship.....	109
Types of Mentoring Relationships.....	109
Commonalities within Mentoring Relationships	112
Characteristics of a successful mentor/protégé.....	113
Precipitating reasons for seeking a mentoring relationship.....	115
Initiating and maintaining mentoring relationships	116
Barriers to initiating and maintaining mentoring relationships	118
Supporting mentoring relationships through D.E. technology	119
Feasibility of using D.E. technology.....	119
Implications.....	122
Recommendations for future research	126
REFERENCES	129
APPENDIXES	137
A. Introductory letter to focus group participants.....	137
B. Introductory letter to survey respondents.....	138
C. Information sheet.....	139
D. Consent form.....	141
E. Follow-up reminder	142
F. Survey instrument.....	143

LIST OF FIGURES

	<u>PAGE</u>
1. Gray's Mentor-Protégé Relationship Model	18
2. The Mentoring Continuum	20

LIST OF TABLES

	<u>PAGE</u>
1. Age of Respondents	76
2. Rural Regions/Urban Regions	77
3. Work Setting	78
4. Precipitating Factors	81
5. Initiation of Mentoring Relationship: Protégé's Perspective	83
6. Initiation of Mentoring Relationship: Mentor's Perspective.....	83
7. Functions/Behaviours of a Protégé	86
8. Position held by Protégé	87
9. Position held by Mentor.....	87
10. Functions/Behaviours of a Mentor.....	90
11. Time Spent Mentoring	91
12. Reasons for Becoming a Mentor.....	93
13. Guiding Criteria for Developing a Mentoring Relationship.....	100
14. Career Pressures.....	104
15. Realistic Media for Supporting Mentoring Relationships	105
16. Comfort Level in Various Computer Activities	107
17. Ideal Mentor Functions/Behaviours.....	115

CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study was to explore the nature of mentoring and the reasons why individuals seek mentoring relationships, and to examine how mentoring may be supported through distance education technology.

Research to date provides accumulating support for the value of mentorship. In reviewing the literature however, it is apparent that most are anecdotal reports rather than empirical studies, and the majority are situated in the corporate or business sector. Articles reviewed addressed mentoring in the business, education, and healthcare field, reflecting a variety of meanings from one setting to the next. Vance et al. (1997), in a discussion of mentoring, notes that “for professional growth to occur in a systematic and effective manner, the mentoring process must be coordinated to produce an understanding of role expectation, role formulation, and role identification” (p.119). However, mentoring in general is not clearly defined and minimal information is available in the literature regarding the characteristics that make mentoring effective in the field of occupational therapy.

Further, a number of research studies suggest the possibility in developing mentoring relationships despite barriers of time and distance. The majority of studies refer to maximizing results by using technology to connect mentors and protégés within the business world and within the field of education. Very few studies reflected the use of distance education technology to support mentoring in the health field.

Within the occupational therapy profession, restricted practitioners and practicing clinicians have a need for reflection and collaboration with peers. Restricted practitioners are those

occupational therapists who have graduated from a recognized occupational therapy program but have not yet passed the national exam, or who are participating in a refresher program. As a restricted practitioner, it is a professional requirement to be paired with a mentor in order to legally work in Alberta. Mentoring is an invaluable tool for support and guidance, as the delivery of health and education services is ever changing with new information, increasing demands, and progressively complex issues. Therefore, clarification of the characteristics of mentoring relationships, mentor and protégé functions, the types of situations where such relationships may be beneficial, and people who may benefit from a mentoring relationship is needed to reduce potential confusion and uncertainty. The findings of this study may assist organizations in the development of mentoring guidelines and practices to support successful mentoring relationships among occupational therapists.

Importance of the Study

Mentoring is a complex activity with multiple meanings, depending on one's context and viewpoint. Debate surrounds many issues such as duration, formality, and degree of commitment within the mentoring relationship (Lee, 2000; Robbins, 1991; Shaffer, Tallarica & Walsh, 2000). Over the years, the mentoring concept has been extended to include other forms of relationships such as advisor, coach, preceptor and peer relationships (Gibb, 1999). As a result, the definition of mentoring has become even more ambiguous.

To further complicate the task of clarifying the nature of mentoring, there is no widely accepted explanation or theory of mentoring. A number of theorists agree that mentoring has an evolutionary nature and have defined specific stages within the mentoring relationship (Kram, 1983; Krupp, 1983; Gray & Gray, 1985; Egan, 1990; Valdez & Lund, 1993; Morales-Mann & Higuiche, 1995), while others suggest that developmental models are no longer meaningful due to

the ever-changing workforce (e.g. Darwin, 2000). Clinton and Clinton (1991) propose nine types of mentoring categorized along a continuum of involvement. The types are: discipler, spiritual guide, coach, counselor, teacher, sponsor, contemporary model, historical model, and divine contact. Rather than one individual mentor fulfilling a number of roles to fulfill the needs of a protégé, the protégé may have a number of mentors each fulfilling only one or two needs.

Concurrence of behaviours and attributes between the mentor and protégé are important for optimizing the mentoring relationship (Rogers, 1982, Shaffer, Tallarica, & Walsh, 2000). There are numerous reasons for a potential protégé to seek a mentor. The most common reasons are related to psychosocial support and help in developing professional expertise, otherwise known as the instrumental function (Pan & Mutchler, 2000). The *instrumental function* is the external value of the relationship whereby protégés benefit from their mentor's knowledge, contacts, support, and guidance. The *psychosocial function* is the internal value of the ongoing interpersonal dialogue, encouragement, collaborative critical thinking, planning, inspiration, reflection, and feedback (Galbraith & Cohen, 1995). Research has focused primarily on the need for mentoring therapists new to the profession, therapists in remote area practice and therapists experiencing professional role strain (Alberta Association of Occupational Therapy, 1998; Bohannon, 1985; Rogers, 1986).

Numerous studies have shown the effectiveness of distance education in facilitating learning and collaboration despite barriers of time, distance and diversity in setting. Telementoring is an approach utilized to foster mentoring relationships using technology to overcome time and distance barriers. Contact between the mentor and protégé is supported through telecommunication media such as e-mail and list serves. A number of studies have described online mentoring services, which facilitate instrumental and psychosocial functions (Galbraith &

Cohen, 1985; Shaffer, Tallarica, & Walsh, 2000; Rodriguez & Brown, 2000; Boreen & Niday, 2000).

Despite the success of mentoring, there are barriers to initiating, maintaining, and terminating these relationships (Pan & Mutchler, 2000, Smink, 1999, Owens, Herrick & Kelley, 1998). If these barriers are overcome, protégé's, mentors, and organizations may benefit (Smith, 2000, Little, 1990, Weiss & Weiss, 1999, Shaffer, Tallarica, & Walsh, 2000).

Further research is required to study the characteristics of successful mentoring relationships, the attributes and behaviours of effective mentors, and protégés, and the occurrence of intentional mentoring within the healthcare field. Research is also needed to identify the barriers to mentoring relationships and the potential mechanisms to overcome these barriers. This study sought to explore the nature of mentoring, to determine why individuals seek mentoring relationships, and to examine how technology can support this relationship. Toward this end, the study addressed the research questions listed below.

Research Questions

1. What are the characteristics of successful mentor/protégé relationships?
2. What are the precipitating reasons for an occupational therapist to seek a mentoring relationship?
3. What are the barriers to initiating and maintaining mentoring relationships among occupational therapists in Alberta?
4. How can a mentoring relationship be supported through distance education technology?
5. Is it feasible to use technology to support mentoring relationships among occupational therapists in Alberta?

Assumptions

The study was undertaken with a set of assumptions that may have influenced the researcher's perceptions. These assumptions are outlined below.

1. Mentorship is a professional requirement to enable restricted practitioners to work in Alberta and therefore an important reason for studying mentorship.
2. It is assumed that mentoring relationships currently occur through face-to-face interactions; however, barriers of time and distance may impact the effectiveness of these relationships, particularly in rural regions.
3. Distance education technology is effective in overcoming the barriers of time and distance.

Limitations and Delimitations

The limitations to this study centered primarily on the response from potential respondents. "Willingness of individuals to respond at all, respond in a timely fashion and to respond accurately" to the survey will affect the study (Mauch & Birch, 1998, p.105). Another limitation is that the findings are based primarily on 'perceptions' of practitioners.

As the population for this study is registered occupational therapists, generalizations to other health professionals may not be valid. In addition, since the focus of this study is on occupational therapists registered in Alberta, the ability to generalize these findings to other therapists across Canada is limited.

Conceptual Definitions

Mentoring Relationship: A mentoring relationship is a "relational process, in which someone who knows something, the mentor, transfers that something (the power resources, such as wisdom,

advice, information, emotional support, protection, linking to resources, career guidance, status) to someone else, the protégé, at a sensitive time so that it impacts development” (Clinton & Clinton, 1991, p. 2-4).

Mentor: A person who shares knowledge, experience, and time with another individual (protégé), often supporting psychosocial function and instrumental function within the protégé. The role of a mentor is challenging, complex and may involve advising, affirming, counseling, encouraging, facilitating, guiding, listening, seeking input, helping with career directions, role modeling, and helping the novice develop to an expert (Alleman, 1982; Galbraith & Cohen, 1995; Kaye & Jacobson, 1996; Haney, 1997; Shaffer, Tallarica & Walsh, 2000).

Protégé: A person who is guided and helped, especially in the furtherance of her/his career, by another, often more experienced person. The protégé often exhibits positive qualities such as a willingness to learn, respect for the mentor, openness to feedback and advice, and effort.

Regional Health Authority: The province of Alberta is divided into seventeen Regional Health Authorities. These regions are responsible for planning, implementing and evaluating health care services within their region.

Urban Regional Health Authority: For the purpose of this study, urban regions are identified as those regions employing over 100 occupational therapists. The occupants of these regions are primarily city dwellers.

Rural Regional Health Authority: For the purpose of this study, rural regions are identified as those regions employing fewer than 100 occupational therapists. The occupants of these regions comprise city, town, and village dwellers, acreage dwellers, and the farming community.

Registered Occupational Therapist: A therapist who meets all criteria to be registered with the Alberta Association of Occupational Therapy.

Restricted Practitioner: A therapist who has graduated from an accredited occupational therapy program; but who has not yet passed the national exam; or a therapist who is currently involved in a refresher program.

Role Strain: A role is a "position in society that contains a set of expected responsibilities and privileges"(Kielhofner, 1997, p.73). Role strain occurs when two or more incompatible sets of responsibility and time commitments conflict.

Sole Charge Therapist: A therapist who is working as the only therapist for a particular organization. The sole charge therapist has administrative responsibilities together with clinical responsibilities.

Telehealth: A network which links people at various remote sites using audio and video communication, enabling real-time and/or prerecorded interactions.

Caseload: Refers to the number of clients currently receiving occupational therapy services.

Workload: Refers to all work related activities such as caseload, committee work, administrative duties, teamwork, and research.

CHAPTER II

REVIEW OF RELATED LITERATURE

This study analyzed mentoring relationships among registered occupational therapists in Alberta. Over the years, the term mentor has had multiple meanings in the literature and the composition of mentoring relationships has varied. Cunningham (1995) notes, "There has been little documentation regarding the specific nature, extent and perceived or real benefit of these encounters"(p. 12). Barriers pose limitations to the initiation and development of mentoring. Can distance education technology support mentoring relationships thereby reducing the impact of some of these barriers? The purpose of this study was to explore the nature of mentoring relationships among occupational therapists and the reasons why mentoring was sought, and to determine the feasibility of distance education technology in supporting these relationships. This literature review focused on the complex nature of mentoring in general, the need of mentoring within the occupational therapy profession, the barriers to mentoring, and the potential of distance education technology to support mentoring relationships.

Mentoring and the Mentoring Relationship

The mentoring relationship is so complex that it seems to defy definition. Gibb (1999) suggests, "no word in use is adequate to convey the nature of the relationship... words such as 'counselor' or 'guru' suggest the more subtle meanings, but they would have other connotations that would be misleading."(p. 1056). The term "mentor" is generally used in a narrower sense, to mean teacher, advisor or sponsor.

The mentor-protégé relationship is mutually beneficial; the mentor's work benefits from the protégé's energies and talents, while the protégé benefits from the mentor's experience and the

opportunities provided. The relationship is helpful in making the transition to “achievable dreams”; the term mentoring means all these things and more (Levinson et al., 1978).

Many theorists define mentoring within the context of the workforce. For example, Clinton and Clinton (1991) define mentoring as a "relational process, in which someone who knows something, the mentor, transfers that something (the power resources, such as wisdom, advice, information, emotional support, protection, linking to resources, career guidance, status) to someone else, the protégé, at a sensitive time so that it impacts development” (p.2-4). The authors highlight that mentoring is a process of empowerment.

Allman and Shannon (1988) describe mentoring as follows:

A nurturing process in which a more skilled or more experienced person, serving as a role model and teacher, sponsors, encourages, counsels, and befriends a less skilled or less experienced person for the purpose of promoting the latter’s professional and/or personal development. Mentoring functions are carried out within the context of an ongoing, caring relationship between the mentor and protégé (as cited in Kling & Brookhart, 1991, p. 40).

Auster (1985) emphasizes the dyadic character of the mentoring relationship, referring to this feature as fundamental and distinctive of the mentoring relationship. He also highlights the opportunities for clearer thinking, the worthiness of praise from a significant other and ultimately career success (as cited in Papalewis, 1991).

Clawson (1985) concurs, finding a positive relationship between mentoring and advancement in the workplace. He notes that the mentoring relationship is job-related, rather than the emulation of lifestyles and personal ideals (as cited in Papalewis, 1991).

Yoder (1990) stresses that both the mentor and the protégé

should share job involvement, well-thought-out career plans, ambition, valued peer relationships, and an open and teachable attitude toward learning...common goals and mutual emotional

commitment enhance the ability of the mentor in helping the protégé develop professionally. The “right chemistry” is important to maintain a long, caring, successful relationship” (as cited in Lee, 2000, p. 24).

Other researchers do not limit the mentoring relationship to the workforce. For example, some emphasize that a mentor is one who supports the dream of the protégé and helps the protégé to grow personally and professionally (Krupp, 1985; Levinson, et al, 1978).

Many researchers refer to the mentoring relationship as involving an older, more powerful individual guiding a younger, less powerful person. Nolinske (1995), in a review of the literature, concludes, “the traditional mentor nurtures a person eight to fifteen years younger and less experienced. The mentor provides information, wisdom, and emotional support to the protégé in an interactive relationship that includes political and socialization experiences” (p. 40).

This line of thinking suggests that the mentor has more career-related experience and knowledge than does the protégé. However, Darwin (2000) suggests otherwise. “Mid-career workers, at the maintenance stage, are now having to learn new skills; those in which younger workers may already be more competent. Career age, rather than chronological age, may be more important” (p. 205). She notes that a number of organizations are now moving away from the notion that mentoring is a hierarchal relationship.

The Professional Development Schools (PDS) approach exemplifies this new focus. Professional Development Schools strive to create learner-centered environments in which reflective practice and decision-making are part of their school culture. Weiss and Weiss (1999) note,

the PDS movement has led to an attitudinal shift away from the concept of mentor as veteran whose unidirectional role is to impart basic knowledge to an unknowing novice, towards

that of an experienced co-worker who, in relationship of mutuality with new colleagues, offers assistance and also learns from the experience (p.3).

This direction not only emphasizes the difference in moving away from the veteran mentor, but also stresses the connectedness throughout the different career stages.

Although research tends to focus on mentoring the individual new to a profession, mentoring may also be beneficial for individuals at different points in their careers. SLA Chapters (1999) states

a mentoring relationship is developed between someone who is new to the profession and a more experienced person in the field. However, mentoring relationships can also involve someone who has been in the field for a while but is changing career paths, or someone who is just looking for guidance and support (p.12).

Commitment within the mentoring relationship is often described as ongoing, emotional, and long-term. Shaffer, Talarica, and Walsh (2000) suggest the average mentoring relationship lasts five years. Smink (1999) suggests mentoring relationships should last at least one year. Rogers (1982) infers that it is difficult for a mentor to sponsor more than a few protégés simultaneously due to the intensity and continuity of the relationship. Such a relationship accounts for its restrictive and exclusionary nature. Pilette (1980) speaks of the spiritedness of the interaction in which both the mentor and protégé may feel intellectually and physically energized (as cited in Rogers, 1982).

Over the years, many theorists have extended the mentoring concept to include other forms of relationships such as advisor, coaching/peer coaching, preceptorships and peer relationships, to name a few. Gibb (1999, p. 1056) suggests such "elasticity leads mentoring to be characterized as everything from a grand name for 'coaching' to ...an intense, emotional

relationship, in which the protégé is not only interested in learning about work but is also willing to become a new person."

Lee (2000) describes mentoring as a "distinctive, interactive relationship between two individuals, occurring most commonly in a professional setting," and further notes that the distinguishing features between a mentor/protégé relationship and an advisor/advisee relationship are duration, formality, level of commitment, and scope of the relationship (Lee, 2000, p. 24). He concludes that the mentor/protégé relationship is generally a long-term, emotional relationship, which encompasses professional and personal dimensions that foster growth and development of the protégé.

According to Robbins (1991), peer coaching is a "confidential process through which two or more colleagues work together to reflect on current practices; expand, refine, and build new skills; share ideas; teach one another; conduct classroom research; or solve problems in the workplace." Robbins states that "coaching is not evaluative nor is it meant to suggest that one partner has a higher status than the other(s). Coaching involves the use of strategic questioning and probing techniques to facilitate reflection and analysis of what happened and what might be done differently next time" (as cited in LOTE, 1999, p. 1-2). Coaching involves behaviours that are also required in a successful mentoring relationship; however, "the mentor-protégé dyad appears to be most intense or emotionally charged, hierarchical, parental, exclusionary, and elitist" (Hunt & Michael, 1983, p. 476).

Clinton and Clinton (1991) note that

Coaching is a form of apprenticeship in which practice and feedback are essential... coaches impart skills, impart confidence, motivate a person, and model the importance of the learning the basics of a thing, a process that prove valuable in all of life ... almost anyone who has some skill and knows how to impart it

can be a coach as long as there is someone who needs the skill and wants it (Clinton & Clinton, 1991, p. 5-13).

Therefore, one might suggest that coaching in itself may not necessarily be mentoring, rather coaching is just one function within the complex role of mentoring.

The terms mentoring and precepting are often used interchangeably, although they too are conceptually different. Mentoring involves a long-term, committed, voluntary relationship. Precepting is short-term and faculty-assigned, and tends to be the dominant model for clinical education. Shaffer, Tallarica and Walsh (2000) found that

preceptors perform a formal, structured task with a narrow focus. Assigned by a manager, they usually help other nurses develop competence and socialize in a new work environment. The mentor's role has a much broader scope, including career introduction, guidance, and inspiration (p. 32).

Hayes (2000) suggests that precepting may be thought of as a sub-role of mentoring.

The nursing profession has asked the question, is it possible to have mentoring preceptors? Research has shown that students have benefited more from having a mentoring preceptor than a non-mentoring preceptor. In a qualitative study, Hayes (2000) explored the meaning of the preceptor/student relationship as experienced by the student. She found that students who were linked with a mentoring preceptor experienced a sense of commitment from the preceptor, and felt supported, protected, and encouraged as well as energetic and excited about their future. On the other hand, students who were linked with a non-mentoring preceptor did not feel a connection with the preceptor, nor did they feel that the preceptor was interested in them. The relationship frequently left the student's confidence shattered. Questions remain however about the Hayes study. Is this difference in experience truly mentoring or just good

coaching skills? Mentoring may evolve from precepting through time, mutuality of interest and shared aspirations and values.

Peer relationships may or may not involve an enduring emotional bond and may or may not involve individuals, in a junior/senior role. Peer relationships may be formed for different purposes, e.g., information sharing, career strategizing or for emotional support and friendship. Kram (1985) suggests a continuum, ranging from information- peer to collegial-peer to special-peer. The information-peer and collegial-peer relationships lack the emotional bond of the special-peer relationship. The terms special- peer and mentor are used interchangeably. Special rapport, trust, and mutual admiration are key features of a special-peer. The special-peer relationship provides intimacy, honest feedback, and a personal confirmation of worth. This relationship is often focused more on personal issues than on job-related performance and skills (Kram, 1985).

Other common themes of mentoring include the following:

- Mentoring is multidimensional in nature; it serves to facilitate growth in professional and/or personal development;
- Mentoring is an ongoing, committed relationship between two individuals. One of the individuals within the relationship is more skilled or experienced than the other;
- Reciprocity occurs at some point within the relationship.

Despite these commonalities, ambiguity and debate continues. Is a mentoring relationship a power-dependent, hierarchical activity, or is it a democratic, mutually empowering activity? Should mentoring relationships be homogenous, or can they be heterogeneous in nature? Is mentoring restricted to a dyadic relationship, or may it involve a group of individuals? Is the mentoring experience an active or a passive learning process? Is mentoring a committed

relationship or a relational process? Darwin (2000) concludes “How mentoring is defined and used appears to depend on one’s point of view” (p. 199).

Forms of Mentoring

Gibb (1999) describes the growth and acceptance of mentoring, noting that “the nature and number of activities linked to the concept and practice of mentoring seems to be growing everyday” (p. 1055). Mentoring is multi-dimensional. It may be formal or informal. Mentoring may involve face-to-face visits, or it may be supported through technology. Mentoring varies with the purpose and may include a traditional mentoring relationship, group mentoring, multiple mentors, peer mentoring, network mentoring, or corporate mentoring (Smink, 1999; Kaye & Jacobson, 1996; Loeb, 1995; Rogers, 1982; Le Moal, 2000).

Traditional mentoring involves a one-to-one, ongoing, committed relationship. According to Darling (1985), a mentor is “a person who leads, guides and advises a person more junior in experience” (p. 42). Smink (1999) defines a traditional mentoring relationship as involving regular contact, with a commitment for at least one year.

Group mentoring involves the mentor as a learning leader of a team or “learning group” within a learning organization (Kaye & Jacobson, 1996). This group of individuals has regular contact with one another. The terms “group mentoring” and “multiple mentors” are often used interchangeably.

Loeb (1995) suggests multiple mentors may be considered as a “board of advisors” within and outside the organization. These mentors provide a wide range of expertise and advice about specific organizational politics and culture as well as broader trends in a profession or field. He justifies this approach by suggesting, “one-on-one mentoring is becoming less viable as competition increases and people change jobs frequently, becoming less identified with one

organization” (as cited in Kerka, 1998, p. 2). Horgan (1992) also supports the concept of multiple mentors. He describes multiple mentoring as a situation in which several mentors collaborate with several protégés, learning from many perspectives, while minimizing the risks incurred in an exclusive relationship. The benefits of multiple mentoring include the following: a) protégés have access to several experienced, knowledgeable practitioners; b) protégés have multiple role models; c) a team approach is utilized; and d) the process creates an awareness of diversity and sensitivity.

Peer mentors differ from traditional mentors in terms of their egalitarian quality. Each participant may, at times, be the leader and, at other times, be the follower. Peer mentoring is based on the premise of complementary talents; it fosters a collegial relationship, allowing more people to be involved. Peer mentoring is less exclusive than a traditional mentoring relationship (Rogers, 1982).

Networks involve a broader power base and a larger group of people than peer mentoring. There is less emphasis on the development of specific vocational or professional skills, and more emphasis on upward career mobility. Networks are similar to peer mentoring in that competence is assumed. Generally networks are based on the premise that “it is who you know, not what you know, that gets you ahead” (Rogers, 1982).

According to Le Moal (2000), “corporate mentoring can offer a means of fostering competitive growth in the Canadian capitalist arena” (p.19). He suggests that mentorship is a mutually beneficial arrangement; however, he further notes that larger corporations have the obvious advantage. Using the example of oil, forestry, mining and utility companies as corporate mentors, and aboriginal businesses as corporate protégés, Le Moal cites benefits such as management training and expertise, technical training, and efficiency coordination. He highlights

mentoring characteristics as follows: companies develop a strong relationship, which lasts over a number of years (3+ years), providing guidance and clarifying objectives of the relationship for both sides. Le Moal uses the terms “mentoring” and “partnership” interchangeably throughout his study.

One might ask the question, are all these forms truly mentoring? As the work environment continues to change and career paths are less predictable, the traditional form of mentoring is also being questioned (Kram & Hall, 1995).

Models of Mentoring

There is no widely accepted explanation or theory of mentoring. Numerous theorists agree that mentoring has an evolutionary nature, and that the mentoring relationship goes through various stages from initiation to redefinition/termination (Kram, 1983; Gray & Gray, 1985; Egan, 1990; Valdez & Lund, 1993; Morales-Mann & Higuiche, 1995). Such models are termed developmental models of mentoring.

A well-known Canadian developmental model is Gray’s Mentor – Protégé Relationship model (Gray & Gray, 1985). Gray and Gray focused their research on mentor teachers and their protégés, the beginning teacher. This model describes a series of five sequential levels of involvement within the mentoring relationship (Figure 1). These stages are predictable and may be repeated many times throughout the overall life of the relationship. The repetitiveness of the stages depends on the number of new issues or new activities initiated.

Smink (1999, p. 37) describes the levels of involvement in the Gray model as follows:

- At Level 1 (M), the mentor possesses information or expertise that the protégé does not. Recognition and introductions of different roles occur. The mentor is the principal lead person at this level and initiates nearly all of the actions or discussions.

- At Level 2 (Mp), the mentor shares discussion ideas with the protégé from a position of leadership. Mutual trust is built and the protégé begins to acquire information and skills to put into practice. However, the protégé still relies on the mentor for guidance.
- At Level 3 (MP), the mentor and protégé gain more equal footing and respect. The protégé is assimilating behaviors or skills and using them, as well as making more decisions without consulting the mentor.
- At Level 4 (mP), the protégé becomes less dependent on the mentor and utilizes new information and skills, turning less to the mentor for assistance.
- At Level 5 (P), the protégé has acquired desired expertise and can stand alone. The relationship between the pair may be redefined to permit a different stage of friendship. However, it can also be characterized by dissolution or separation of the relationship.

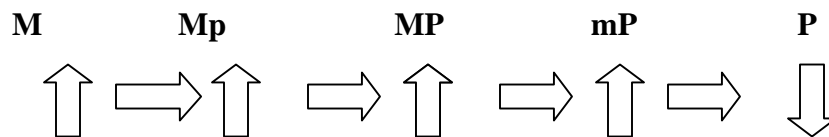


Figure 1. Gray's Mentor-Protégé Relationship Model (Gray & Gray, 1985, p. 41)

Darwin (2000) suggests that developmental models have lost their potency as many organizations have reengineered and downsized in the name of efficiency. She notes, "People are being forced to reframe their notion of work. The organization will not provide a job for life. Mentoring models may be useful when times are stable, but reproduction of the status quo may not be what organizations need when faced with rapid changes" (p. 201). Darwin challenges the reader to consider mentoring from a critical or radical humanist perspective rather than the more common functionalist models of mentoring. The radical humanist perspective goes beyond the

notions of efficiency to “dig below the surface and examine power relations and ontological commitments nested in mentoring” (Darwin, 2000, p. 206). Within this perspective, mentoring becomes a

collaborative, dynamic, and creative partnership of co-equals, founded on openness, vulnerability, and the ability of both parties to take risks with one another beyond their professional roles. Relationships become opportunities for dialogue, and expert and learner become arbitrary delineations... the relationship becomes adult-like and interdependent. The concept of co-learning suggests that individuals transcend roles (or create different roles) and interact as colleagues (Darwin, 2000, p. 206).

The Radical Humanist perspective is founded on a learning model that uses tacit knowledge. Examples of mentoring relationships within this perspective include peer mentoring that acknowledges individuals as co-equals and supports mutualism, and mentoring circles in which diversity can be optimized.

Clinton and Clinton (1991) studied the development of leaders; their model is conceptually based on comparative analysis of 600 case studies of leaders over eight years. They suggest yet another conceptual model, identifying nine types of mentoring categorized along a continuum of involvement (Figure 2). The various types depend on the kind of empowerment, deliberateness, depth, and awareness of the effort. Clinton and Clinton developed this model as a practical framework to support the complex role of mentoring. Through their research they found that "most leaders had been helped along the way in timely situations by other persons...their [the protégés] development was significantly enhanced by a relationship to another person, most case studies listed between 3 and 10 significant people who had helped shape these leaders" (Clinton & Clinton, 1991, p. 1-1).

In the Clinton and Clinton model, the protégé identifies a need, which requires a specific mentoring type and then finds a person who can meet that particular need. As the needs change, the protégé will look for different mentoring types depending on the current need, this eliminates the difficult task of finding the ideal mentor who can do it all and meet all needs of the protégé.

Controversy continues, does this continuum truly reflect mentoring, or is mentoring only found in the active and occasional categories? Is mentoring a relationship, or is it a relational process?

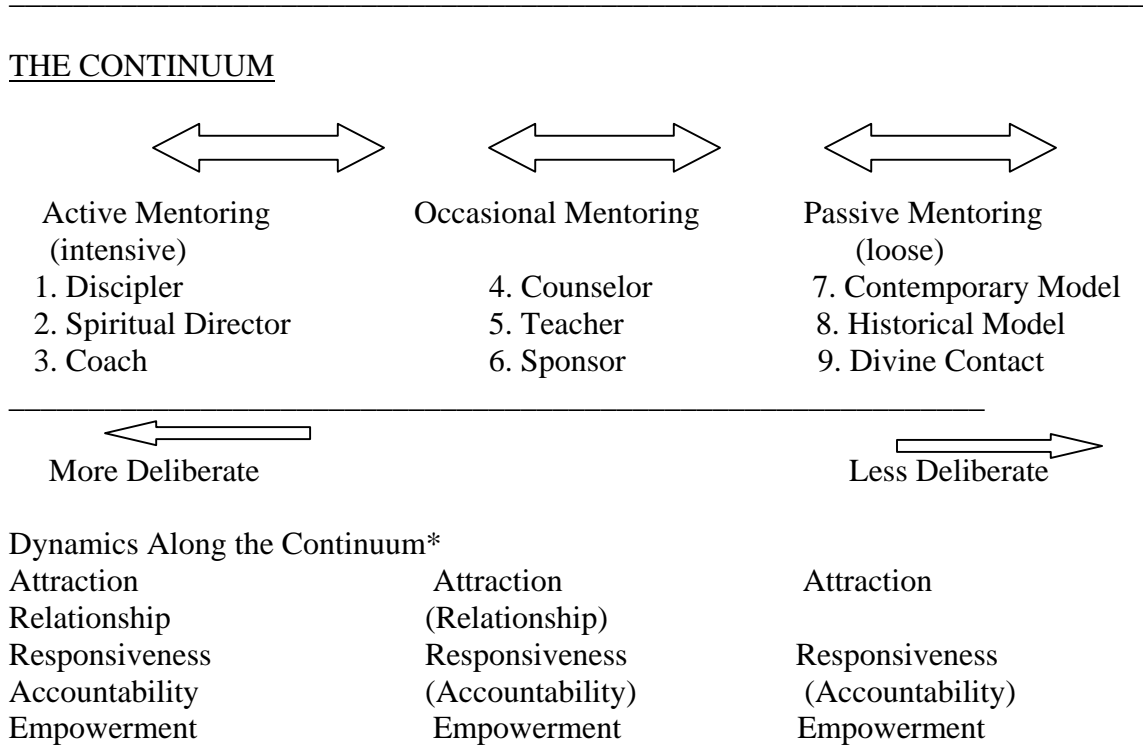


Figure 2. Mentoring Along the Continuum – Varying Dynamics (Clinton & Clinton, 1991)

Parenteses around a dynamic factor means that the factor is not there naturally and will either be absent or must be supplied on the protégé’s part in some pseudo fashion. Notice that relationship is missing altogether for passive mentoring.

These models describe how mentoring occurs (Gray & Gray, 1985; Clinton & Clinton, 1991; Darwin, 2000), but not why individuals take on the role of mentor. Gibb (1999) raises the question, “Why are mentors prepared to sacrifice their time and energy to support/assist others for

no tangible rewards?” (p. 1059). He theorizes about “virtuousness” in relation to mentoring by connecting the development of formal mentoring with salient theories of “social exchange” and “communitarianism”. He used four case studies of British business organizations, which implemented a formal mentoring program, to explore the two theories. Gibb concluded that neither social exchange nor communitarian theory alone could explain the elements of success and failure within the mentoring relationship. Gibb (1999) suggests that the motivational force for mentoring may involve both a communitarian element (the need to re-invigorate a spirit of community), and a social exchange element (“tit-for-tat” strategies within the mentoring relationship) and goes on to suggest the approach supported or balance of approaches supported may vary with the climate and culture of the organization.

The Role of a Mentor

The role of a mentor is challenging and complex, Alleman (1982) notes that the *Dictionary of Titles* ranks mentoring as the highest and most complex level of functioning in the person-related hierarchy of skills. Gibb (1999) states that “while mentoring can be difficult to pin down precisely as a “role,” its essence, in a phenomenological sense, is virtuousness; it is, apparently, pro-social helping behavior par excellence on the part of mentors” (p.1058).

Schein (1978) and a group of students from the Massachusetts Institute of Technology found mentoring to fulfill many roles. These included teacher, coach, and positive role model, as well as developer of talent, opener of doors, protector, sponsor and successful leader. Clawson (1985), Kay and Gerhke (1984), and Levinson (1978) validated Schein’s work. Zey (1984) concurs, adding counselor and provider of psychological support to the list. Merriam (1983) extends the list further, including guide and cultivator of talents.

Jay Smink is the Executive Director of the National Dropout Prevention Center at Clemson University, where he also is professor of education in the College of Health, Education, and Human Development. In 1999, he published a *Training Guide for Mentors*. Smink (1999) states that “the mentor role is more than a pal and offers much more continuous support for the protégé” (p. 32). He lists many of the same roles as those previously listed, and adds more, stating that a mentor fulfills many “roles such as friend, coach, motivator, companion, counselor, sponsor, supporter, advisor, tutor, teacher, advocate and career model” (1999, p. 32).

Lee (2000) highlights the fact that a mentor “ must have a firm belief in the novice’s capacity to succeed” (p. 24). According to other researchers, the role of mentoring may involve advising, affirming, counseling, encouraging, facilitating, guiding, listening, seeking input, helping with career directions, role modeling, and helping the novice develop to an expert (Galbraith & Cohen, 1995; Kaye & Jacobson, 1996; Haney, 1997; Shaffer, Tallarica & Walsh, 2000).

Mentor Behaviors/Attributes

Alleman (1982) asserts that the difference between mentors and non-mentors is found in what they do, not who they are (as cited in Papalewis, 1991, p. 4). According to Papalewis (1991), mentors should do certain functions, as well as have certain characteristics. The functions and behaviours that are critical to a successful mentor are listed below. A mentor:

- Is an effective communicator;
- Is willing and able to share insights on performance skills;
- Is able to laugh at oneself;
- Is open and willing to share ideas;
- Is willing to share time;
- Is willing to introduce the protégé to the inside workings;

- Is able to provide a calming, supportive influence;
- Is willing and able to spend a lot of time allowing the protégé to apply what he/she is learning;
- Is willing to let the protégé take on responsibilities that he/she feels capable and confident enough to handle;
- Is willing and able to provide relaxed time for brainstorming, discussing, laughing, crying and growing;
- Is willing to help the protégé to understand that much of what is felt is not abnormal for change.

Shaffer, Tallarica, and Walsh (2000) also suggest that it is important for a mentor to lead by example and reflect a strong moral and ethical fiber. According to Smink (1999), a mentor should demonstrate a personal commitment to the protégé, be consistent, accessible, flexible, open, and have a sense of humor. A mentor must also be persistent, respectful, willing to listen, kind, patient, and have the ability to accept different points of view. Clinton and Clinton (1991) observed the following characteristics in mentors:

- discernment to see potential in a person, tolerance for putting up with mistakes, brashness, abrasiveness, and other undesirable character traits frequently seen in raw leadership potential;
- flexibility to allow young leaders room to try, fail, and do things differently;
- patience, i.e., seeing the big picture and willing to wait while processes mellow and bring the younger leader to a point of openness to learn;
- vision to see down the road and predict or suggest next steps appropriate for the younger leader; and

- giftedness, which includes natural abilities, acquired skills, and gift-mix for relating to individuals so as to encourage and motivate.

Rogers (1982) is an Associate Professor of Occupational Therapy, who studied mentoring among occupational therapists. She emphasizes the need for competence that embodies skill and commitment. She also highlights motivational power, which emanates from the mentor's concern and caring.

Smink (1999) notes, "mentoring requires individuals with a high level of caring for others and a keen interest in having others succeed" (p. 32). According to Rogers (1982), the critical attributes for a mentor include authenticity, openness, sensitivity, responsiveness, availability, and generativity.

Protégé Behaviours/Attributes

Rogers (1982) suggests protégés should be willing to learn, exhibit career directness, exhibit trust in the mentor, and be appreciative. Shaffer, Tallarica, and Walsh (2000) go as far as to say that protégés who don't exhibit positive qualities won't find mentors. They highlight the need for a protégé to be hardworking and anxious to succeed. Other beneficial qualities are a desire to grow, respect for the mentor, openness to feedback and advice, willingness to be held accountable, and effort.

Protégé Needs

Smink (1999) notes that protégés cite numerous reasons for seeking a mentor including passing a course, getting a job, learning new ideas or skills, and helping them to escape from their current situation (p. 47). In Texas, the needs of beginning teachers were highlighted in relation to concerns about teacher quality and teacher shortage problems. The subsequent mentoring program links a mentor with a beginning teacher during their two-year induction period. This

program assists protégés in developing professional expertise and provides psychosocial support, both of which results in an increase in teacher retention (Pan & Mutchler, 2000). Rogers (1982) suggests that individuals who are not new to their profession, but rather who are experiencing professional role strain may also seek and benefit from a mentoring relationship.

The Need for Mentoring in the Occupational Therapy Profession

Occupational therapy is a diverse profession; therapists work in urban and rural settings, and in a variety of program settings such as hospitals, continuing care centers, schools, community clinics, and homecare. Professionals in rural practice operate in very different working environments compared with their urban counterparts. Research studies in Australia and Canada reflect similar challenges in regard to remote area practice. Some of the challenges are “professional isolation, large caseloads with a limited number of service providers, reduced access to resources, equipment and professional development” (Bent, 1999, p. 203).

Rogers (1982) discusses professional role strain within the field of Occupational Therapy and suggests a number of potential reasons including high caseloads, little administrative support, rarely receive recognition, working alone, and not feeling apart of a team. Bohannon (1985) states, “many therapists may be unfamiliar with the concept and the implications of mentorship”(p. 920). Despite barriers to the mentor-protégé relationship, both the mentor and the protégé may experience benefits.

In Canada, after graduating with a baccalaureate in Occupational Therapy, all Occupational Therapy graduates must pass a national exam prior to working as an Occupational Therapist. In the interim, a restricted permit can be issued. The General Regulations of the Occupational Therapy Profession Act, 5(2)(b) specify, that the holder of a Restricted Permit must practice under the supervision of an occupational therapist. To support the implementation of this

regulation, the Alberta Association of Registered Occupational Therapists has developed guidelines for the employer, the supervising occupational therapist, and the restricted practitioner. The guidelines for the supervising occupational therapist states, “We, (AAROT), expect the supervising Occupational Therapist to be a mentor...” (Alberta Association of Occupational Therapists, 1998, p. 3). The guidelines go on to give basic information such as assisting in orientation, promoting networking, graduating supervision, and facilitating communication and feedback. Further clarification and support of this mentoring relationship is needed to enable effective social interaction, to reduce potential confusion and uncertainty, and to enhance the understanding of the role of mentor and protégé for those involved.

Bohannon (1985) challenges the reader by suggesting the responsibility for fostering mentorship for rehabilitation therapists lies with “those who would be mentors, those who would be protégés, and those who would have the position to encourage the two to come together”(p. 923). This challenge really emphasized the notion that all therapists, whether new or old to the profession, have a responsibility to support mentoring relationships.

Supporting Mentoring with Distance Education Technology

Distance education has tremendous potential for contributing to the development of human knowledge, skills, and competencies. Numerous studies have shown the effectiveness of distance education technology in facilitating learning and collaboration despite barriers of time, distance and diversity in setting. However, few studies specifically link mentorship with distance education principles and delivery.

Bates (1997) argues, that there are three generations of distance education. The first generation is characterized by lack of direct student-teacher interaction and predominant use of a single technology. The second generation is characterized with the multi-media approach and

two-way communication by a third person. The third generation is characterized by direct interaction between the student and teacher utilizing two-way communications media. This generation highlights “learner control, opportunities for dialogue and emphasis on thinking skills rather than mere comprehension” (Bates, 1997, p. 23).

Can third generation distance education support mentoring relationships? Owens, Herrick, and Kelley (1998) suggest it is possible to mentor nursing students successfully despite “barriers of time, distance, and apparent mismatch in interests” (p. 78). Similarly Shaffer et al (2000) note that internet relationships “enable protégés to gain a mentor in an uncommon field, talk to a mentor outside his own facility, and maintain a long-term relationship during scarce time” (p. 33).

Internet mentoring is possible through communication technology such as e-mail, bulletin boards, and chat rooms. “The Lower Kuskokwim School District Mentor Teacher Program in Bethel, Alaska utilized minimal classroom visitation and observation. Most of the mentor support occurred through e-mail and telephone. Mentor training takes advantage of audio-seminars and satellite distance delivery” (Dagenais, 2001, p. 2).

Mihkelson (1997) presents a mentoring model, which provides opportunities for learning through reflection, interpersonal relationships, and the application of technology to enhance reflection and communication. She proposes that the mentor’s role of a ‘guide’ can be supported effectively through e-mail, and further notes that “e-mail provides a record of considered thought development; the history of the evolution of ideas can be surprising and satisfying in retrospect” (p. 10).

The business world has extensive experiences with maximizing results by using technology to connect mentors and protégés around the world via electronic mail or videoconferencing (Jossi, 1997). Boyd (2000) notes, “enterprises struggling to retain high-tech

talent are increasingly offering flexible work schedules and other benefits, in part to appeal to female workers...almost three quarters of those companies offer flex time, more than half offer telecommuting” (p. 90). Occupational therapy is a predominantly female profession. Many therapists juggle family responsibilities with professional responsibilities. Technology may offer valuable options for maintaining a mentoring relationship despite these challenges.

Mikhelson (1997) reviewed the application of a mentoring model with junior academic staff and senior staff at the University of Tasmania. The teaching staff involved was professions such as nursing, education, the creative arts, and business. She suggested that technology could be very useful in supporting mentoring relationships once mentor-protégé relationships were established. The use of technology did not completely replace face-to-face meetings, but supported dialogue between visits. This approach reduced time and travel costs and streamlined face-to-face contact for special purposes.

Rodriguez & Brown (2000) describe an online mentoring service to support students taking a nutrition course. The mentoring program provided the opportunity for students to develop a network of professional contacts and to enhance their e-mail skills.

Murray (1999) describes a mentoring program offered to junior and senior engineering students at Queensland University of Technology in Australia. The following outcomes were observed: increased collaboration and teamwork, high student satisfaction, opportunities for development of leadership and organizational skills, and dramatically improved academic results.

In a qualitative study, Boreen and Niday (2000) found that pre-service teachers could effectively correspond with practitioners through an e-mail mentoring relationship. They suggest e-mail mentoring correspondence should be optional, as all practitioners may not have a need or

desire to be apart of a long distance mentoring program. They challenge readers to consider how to move toward mentoring in an in-depth, caring manner to meet the needs of students.

Michelson (1997) notes that "the use of e-mail, videoconference and teleconference were essential in maintaining communication, providing feedback and gentle pressure" (p. 14). She proposes that e-mail is beneficial for the mentoring relationship as it can support initiating and maintaining dialogue, widening networks, written expression and reflection, critiquing draft material, informing a wider group, sign-posting and negotiating. Other technology, such as videoconferencing and teleconferencing may support individual and group involvement. These conferences can be a regular, planned event in which a mentor may meet with more than one protégé.

Barriers to Mentoring

Despite the success of mentoring relationships, there are barriers to initiating, maintaining, and sometimes terminating these relationships. Pan and Mutchler (2000) suggest a number of barriers which primarily relate to initiating mentorship, such as lack of staff time, lack of training for the mentor/protégé, lack of funds for stipends and for substitute wages, lack of a coordinated formal program, unwillingness to serve as a mentor, and distance between mentor and protégé. Smink (1999) suggests there may be difficulties in maintaining a mentoring relationship if there are problems such as poor communication, a bad match, unrealistic expectations by mentor or protégé, and problems in taking the initiative. According to Owens, Herrick and Kelley (1998), a mentoring relationship may become toxic or exploitive if one takes advantage of the other, if expectations are in conflict, or if the mentor/protégé have entirely different perspectives. Problems may arise in the termination phase if the mentor or protégé have different expectations or if they differ in redefinition of the relationship.

Darwin (2000) refers to potential problems within a power-dependent, hierarchical mentoring relationship. She states

there are problems in perspectives that assume one right way to advance a career...individualistic and competitive notions of social stratification embedded in functionalist perspectives imply that those who succeed have done so solely through their own efforts. Such views ignore inequalities of race, gender, and class (Darwin, 2000, p. 203).

She further adds, “women and racial minorities have mainly been excluded from organizational norms and, as such, have been granted limited access to this cycle of power”(p. 203).

Bohannon (1985) reviews the concept and implication of mentorship within the physical therapy field. He also discusses obstacles to mentorship as well as methods to foster mentoring relationships. Bohannon suggests that obstacles may be related with the potential mentor, potential protégé, and the profession itself. Potential mentors may build obstacles to the mentoring relationship if they fear that the protégé will leave the organization after a great deal of time and energy has been invested. The mentor may feel threatened by the talent and ambition of the protégé or, on the opposite side, the mentor may not want to be held responsible for the performance of the protégé. Protégés may present obstacles to a successful mentoring relationship if they strive to get ahead without regard for the mentor, or if they are unwilling to accept direction/feedback. Obstacles that may arise from the profession are related to gender, age, and potential movement among jobs. Bohannon concludes that in general, mentors are more predominant in male-oriented professions. To explain why mentoring is difficult in the physical therapy profession, he notes that physiotherapists tend to be young female therapists who may leave the profession; there are limited numbers of therapists in the field with sufficient age, experience, and expertise to be mentors. Bohannon (1985) cites that 60% of the practicing

therapists registered in The American Physical Therapy Association, are less than 35 years of age and have fewer than 10 years of experience. As well there is a high rate of turnover, with therapists moving through multiple jobs in their career.

Many, if not all, of the obstacles Bohannon cites within the physical therapy profession may also relate with the occupational therapy profession. Like physical therapy, occupational therapy has a high percentage of young female therapists, who experience multiple jobs within their career.

The use of technology may support mentoring relationships; however, barriers may impact the use technology such as lack of knowledge and comfort with technology, restricted access, lack of typing skills, lack of technical support, and preference for face-to-face communication (Hughes, J. & Pakieser, R., 1999).

Outcomes of Mentoring

Despite numerous barriers to mentoring, research to date provides accumulating support for the value of mentorship. However, as Cunningham (1999) cautions, studies are primarily anecdotal reports rather than empirical studies, and the majority of these studies focus on corporations and businesses.

In business circles, mentoring is often seen as a process by which senior executives groom young protégés for rapid promotion. Peter Elwood, the former president of Lipton in Canada stated, “mentoring works well in marketing because the process of advancement is rapid... mentoring involves good professionals who want to use their skills to advise, teach and lead high-potential people”(Smith, 2000, p. 42).

In education, mentoring programs have also shown successful results, particularly in induction programs for new teachers. These programs have adopted constructivist approaches in

which the teachers are expected to practice reflective and collaborative action. Protégés benefit by having the mentor help them learn the philosophy, cultural values, and behaviors associated with teaching (Little, 1990). The educational organization also receives benefits such as enhanced quality of teaching and increased retention (Weiss & Weiss, 1999).

In healthcare organizations, mentors gain expertise in leadership and teaching, and protégés learn diverse skills that are not part of their orientation. Mentoring also fosters better management-staff relations and can be an excellent tool for retention in the health field, as people who feel valued and empowered are more likely to stay. Moreover, mentoring is a relatively inexpensive process to develop untapped resources within staff. The mentoring relationship can boost pride and self-confidence of both the mentor and protégé. Numerous reviews of literature (Murray, 1999; Trossman, 1998; Vance et al., 1997) conclude that research confirms that an active, involved mentor can make a great difference in the protégé's career development, job satisfaction, and leadership skills (as cited in Shaffer, Tallarica, & Walsh, 2000).

According to Galbraith and Cohen (1995), benefits of mentoring are not only work-related; mentoring can provide individuals with opportunities to enhance cultural awareness, aesthetic appreciation, and the potential to lead meaningful lives (as cited in Kerka, 1998).

Summary

Mentoring has been defined in the literature many ways over the years. Some researchers speak of mentoring in the broad sense, as a more skilled or more experienced individual serving in many roles to benefit a less skilled or less experienced individual (e.g., Kram, 1983, Gray & Gray, 1985). Others speak of mentoring in the narrow sense, where an individual may serve in only one or two roles to benefit another individual (e.g., Clinton & Clinton, 1991, Darwin, 2000). This diversity reflects the complexity of the relationship.

The make-up of the relationship varies from a dyadic relationship (senior/junior (i.e., hierarchical) relationship or peer relationship) one of multiple mentoring to group mentoring. Debate surrounds issues such as, is it the mentor's chronological age and experience, or career age that benefits the mentoring relationship? How does the duration of the relationship, formality of the relationship, and the degree of commitment within the relationship impact the success of the mentoring relationship?

Over the years, many theorists have extended the mentoring concept to include other forms of relationships, such as advisor, coach, preceptor, and peer relationships. By doing so, the definition of a mentoring relationship has become even more ambiguous. Some researchers (e.g., Gray & Gray, 1985; Kram, 1983) identify unique distinguishing features between the mentor/protégé relationship and other helping relationships, whereas other researchers (e.g., Clinton & Clinton, 1991; Darwin, 2000) rationalize reasons for blurring the definitions.

To further complicate the task of clarifying the nature of mentoring, there is no widely agreed upon explanation or theory of mentoring. A number of theorists (e.g., Gray & Gray, 1985) agree that mentoring has an evolutionary nature and proceed to define specific stages within the mentoring relationship. Others suggest that these developmental models are no longer

meaningful due to the ever-changing workforce (e.g., Darwin, 2000). This viewpoint suggests that a hierarchical mentoring relationship is only beneficial in a stable environment. In an unstable, changing environment, it is necessary to consider a variety of forms of mentoring that may include both homogeneous and heterogeneous relationships.

Another conceptual model (Clinton & Clinton, 1991) identifies mentoring types along a continuum of involvement. The key feature within this model is empowerment. The types of mentoring along the continuum include active, occasional, and passive mentoring, based on the presence or absence of the identified dynamics of attraction, relationship, responsiveness, accountability, and empowerment.

The literature reflects the complexity of the role of a mentor. Most authors suggest mentoring is not one particular role, but a number of roles requiring many behaviors and attributes. Common roles fulfilled by a mentor are friend, coach, counselor, sponsor, advisor, role model, teacher, and advocate. The behaviors and attributes of a protégé are also important to optimize the mentoring relationship. Beneficial qualities for a protégé to exhibit are willingness to learn, openness to feedback, and desire to grow.

A review of the literature suggests numerous reasons for a potential protégé to seek a mentor. The most common reasons are related to psychosocial support and help in developing professional expertise. There are very few studies which link mentoring practice specifically with the profession of occupational therapy. Occupational therapists may benefit from a mentoring relationship at various points within their career. Research focuses primarily on the need for mentoring therapists new to the profession, therapists in remote area practice, and therapists experiencing professional role strain.

Numerous distance education studies have shown effectiveness in facilitating learning and collaboration despite barriers of time, distance and diversity in setting. Telementoring is an approach utilized to foster mentoring relationships despite time and distance barriers. Contact between the mentor and protégé is supported through telecommunication media such as e-mail and list serves. A number of studies have described online mentoring services, which facilitate instrumental and psychosocial functions.

Despite the success of mentoring relationships, there are barriers to initiating, maintaining, and terminating these relationships. If these barriers are overcome, protégés, mentors, and organizations may all benefit.

CHAPTER III

METHODOLOGY

Research Design

This study utilized a combined, qualitative and quantitative research design undertaken in two phases. In this design, the two paradigms were clearly separate, yet associated developmentally. The combined approach enabled a developmental process in which “the first method is used sequentially to help inform the second method” (Creswell, 1994, p.175).

In Phase One, a qualitative approach was used to address the research questions and identify key themes and critical questions. Four focus groups were conducted with a non-probability sample of occupational therapists who had supervised restricted practitioners. In this supervisory role, occupational therapists agreed to be a mentor to a restricted practitioner. Two focus groups were conducted in rural health authorities and the other two in urban health authorities.

In Phase Two, a quantitative approach was used to address the research questions and construct knowledge around the themes identified in Phase One. A survey provided information from a stratified random sample of occupational therapists regarding their perceptions of mentoring relationships, mentor roles and behaviors, protégé roles and behaviours, reasons for seeking a mentoring relationships, and barriers to mentoring.

The Sample

The population of this study comprised the total number of registered occupational therapists in Alberta. As of December 21, 2001, there were 1020 occupational therapists registered with the Alberta Association of Registered Occupational Therapists (AAROT) (J. Voyer, Executive Director, AAROT, personal communication, November 23, 2001).

Phase One Sample

In Phase One the sample was purposefully selected in an attempt to choose “informants that would best answer the research question. No attempt was made to randomly select informants” (Creswell, 1994, p.148). Focus groups were conducted with this non-probability sample of occupational therapists who had supervised restricted practitioners in the previous year. In this supervisory role, occupational therapists agreed to mentor the restricted practitioner. Guidelines for this role included orientation to the professional workplace, promotion of networking, graduating supervision and facilitating communication and feedback (AAROT, 1998).

The target sample was obtained through the Alberta Association of Registered Occupational Therapists, as this organization is required to link all restricted practitioners with a supervising occupational therapist. All therapists who had supervised restricted practitioners within the previous year were sent an introductory letter and information sheet (Appendices A and C), and invited to participate in a focus group. Originally 19 therapists agreed to participate in the focus groups; however three therapists were later unable to attend, so the number of therapists participating was 16. These therapists were from urban and rural regions, thereby enabling the focus groups to represent two urban and two rural regional health authorities.

Groups A and B, representing the rural health authorities, contained six participants and five participants respectively. Group A met in Smoky Lake the second week in January 2002; Group B met the following week in Red Deer.

Groups C and D, representing the urban health authorities, contained three participants and two participants respectively. Group C met in Edmonton and Group D met in Calgary in the last week in January 2002.

Phase Two Sample

Guidelines for choosing a sample often suggest 1% to 10% of the population (Dobbs, 2000). In this study, 25% of the population was sampled in order to strengthen the power of the study. A sample of 256 therapists was obtained.

Stratified random sampling occurred. First, therapists working in urban regions (772 therapists) were separated from therapists working in rural regions (258 therapists). The researcher determined that the sample should have an equal number of participants from rural and urban settings, i.e., 128 in each group. Second, the sample was further stratified to reflect the distribution of therapists working in each of the 17 Regional Health Authorities in Alberta. (Column 1 of Table 2 contains the number of therapists working in each Regional Health Authority. Columns 2 and 3 reflect the percentages and number of participants to be included from each region. Columns 4 and 5 reflect the actual percentages and number of survey respondents.) The specified number of participants to be sampled from each region was obtained by randomly selecting participants from a list using a random number table.

Selected subjects received a mailed questionnaire package. From the sample of 256 therapists, 106 therapists responded giving a response rate of 41 %. After follow-up phone calls and e-mails to regional representatives asking them to remind occupational therapists in their region to return the questionnaire, the response rate increased to 58.5 % (150 respondents). An additional nine questionnaires arrived after data analysis was completed, so they were not included in the results.

Instrumentation

Phase One

In each of the focus groups, the key questions listed below were provided to facilitate discussion.

1. What are the characteristics of successful mentor/protégé relationships?
2. What are the precipitating reasons for an occupational therapist to seek a mentoring relationship?
3. What are the barriers to initiating and maintaining mentoring relationships among occupational therapists in Alberta?
4. How can a mentoring relationship be supported through distance education technology?
5. Is it feasible to use technology to support mentoring relationship among occupational therapists in Alberta?

The following probes were used to expand upon the discussion of the key questions.

- What factors have an impact on the success of a mentoring relationship?
i.e. senior- junior therapist mentoring versus peer mentoring, dyadic mentoring relationship versus group mentoring relationship, one mentor at a time versus multiple mentors?
- Is it necessary for the mentor and protégé: (a) to work in the same region, (b) to work in the same organization (c) to work in the same practice area?
- Is it necessary to have a mentor in the same field or could a mentor be from another discipline?

- Researchers suggest a number of functions/behaviours for both the mentor and protégé. What do you believe are the essential behaviours of a mentor? What do you believe are the essential behaviours of a protégé?
- Researchers focus mentoring studies on therapists that are new to the profession, therapists that practice in an isolated area and therapists that are experiencing role strain. To what extent do these factors influence a therapist to seek a mentor?
- What other factors may influence a therapist to seek a mentoring?
- What work factors may create barriers to a mentoring relationship?
- What personal factors may create barriers to a mentoring relationship?
- To what extent does awareness and knowledge about mentoring influence the development and maintenance of mentoring relationships among therapists?
- Does the geographical location of a mentor and a protégé present a potential barrier? If so, what alternatives to face-to-face meetings could be considered to support the relationship?
- Research studies describe how mentoring may be supported through technology such as the telephone, email, electronic bulletin boards and audio/video conferencing. What forms of technology do you think would be most helpful in supporting mentoring relationships among therapists?
- What types of technologies do you have available at work? What types of technologies do you have available at home?

Phase Two

A cross-sectional survey was utilized in Phase Two of the study. A questionnaire was developed, consisting of forced-choice, likert scaled, and open-ended questions (Appendix F).

The questionnaire was developed based on the information received in Phase One as well as from instruments used in other research studies. The survey instrument developed by Cunningham (1995) to analyze workplace-mentoring relationships among faculty members provided a framework for the questionnaire. Cunningham's survey instrument was a revision of that developed by Sands et al. (1991). Permission was granted through e-mail communication for the use and modification of these survey instruments. Pilot testing was conducted with five therapists to establish face validity of the instrument and to improve questions, scales and overall format.

Data Collection Strategy

Phase One

The data collection procedure in Phase One involved four focus groups. Therapists were informed of the purpose, background, and procedures of the study in an introductory letter (Appendix A) and information sheet (See Appendix C) sent to participants. They indicated their willingness to participate in a focus group by contacting the researcher by telephone or e-mail. The researcher then contacted each participant to inform them of the time and place of the focus group. A consent form was attached to the introductory letter (See Appendix D). The participants were asked to sign the consent form and bring it with them to the focus group.

A protocol for the focus groups included the following: (a) an introduction to the study, (b) instructions to the participants, (c) key research questions, (d) probes to follow key questions, and (e) conclusion.

The interviews were taped and transcribed to ensure an accurate report of the individual responses. This procedure reduced selective filtering of data through recall and summation, thereby increasing the reliability of data (Holloway, 1991). Focus group participants were

identified by a code number on transcripts. The respondent's name and identifying information were removed when the typist transcribed the interviews.

The codebook and consent forms are stored in a locked file cabinet separate from other data. Consent forms will be kept for three years. The tapes, transcripts and research notes are stored in a locked file cabinet and will be kept for a maximum of three years.

Phase Two

In Phase Two of the study, the participants were informed of the purpose and procedures of the study in an introductory letter (Appendix B). The introductory letter, information sheet, instructions, and the survey questionnaire were mailed to the 256 registered occupational therapists in the sample. A reminder notice was sent via the regional representatives, four weeks later to increase the response rate. Adhering to these procedures resulted in the return of 150 questionnaires, representing a return rate of 58.5%.

Data Analysis

Ethnographer v 5.0 software was utilized in the analysis of the qualitative data obtained in Phase One. The transcripts were coded and sorted into categories reflecting the common themes identified. Data was reviewed and analyzed several times using the constant comparison method. Subcategories were developed; these categories became the major and minor headings in the narrative presented in Chapter IV. In this chapter, the researcher's interpretations are intertwined with the quotations of the focus group participants.

Descriptive and comparative analyses were used to examine the survey data obtained in Phase Two in response to the relevant research questions. The descriptive statistics were augmented by inferential statistics to enable comparison between subgroups and generalization to the population from the sample. Where significant differences were found, correlational and factor analyses were conducted. SPSS software was used for all statistical analyses.

CHAPTER IV

RESULTS

Phase One

In Phase One, a qualitative approach was used to identify key themes associated with the following research questions:

1. What are the characteristics of successful mentor/protégé relationships?
2. What are the precipitating reasons for an occupational therapist to seek a mentoring relationship?
3. What are the barriers to initiating and maintaining mentoring relationships among occupational therapists in Alberta?
4. How can a mentoring relationship be supported through distance education technology?
5. Is it feasible to use technology to support mentoring relationships among occupational therapists in Alberta?

Four focus groups were conducted with occupational therapists who had supervised restricted practitioners. Two focus groups were conducted in rural regional health authorities (Group A and Group B) and two focus groups were conducted in urban health authorities (Group C and Group D).

Question 1: What are the Characteristics of Successful Mentor/Protégé Relationships ?

The first research question sought to identify characteristics of successful mentor/protégé relationships. This question elicited a great deal of discussion, and numerous themes emerged. These themes were as follows:

- essential elements within a mentoring relationship,
- peer mentoring versus hierarchical mentoring, dyadic relationships versus group relationships, and one mentor at a time versus multiple mentors,
- mentoring across regional boundaries,
- mentoring between different facilities and different practice areas, and
- mentoring across different health professions.

Essential Elements

Open communication, trust, and respect were voiced in every focus group as critical attributes of a successful relationship. One therapist stated, "there needs to be open communication, open minds, and mutual respect within a mentoring relationship" (Group D, # 19-20). Another commented, "it takes open communication on both the mentor and the protégé" (Group A, #52-54). Listening was identified as a key component of communication, "I found that listening was a really big credit. To really find out what they wanted to know or how I could help them. They [protégés] had a lot of ideas that I found that I learned from them as much as they learned from me and vice versa" (Group C, #42-47). Another therapist elaborated on the need to communicate in order to develop a good, clear understanding of the mentors' experiences and the protégés needs (Group B, #16-24).

Trust and respect were also essential elements identified within a mentoring relationship. "You have to have trust that you can share- 'I don't know what I'm doing or whatever'. I think that's an important starting point" (Group B, #11 – 14). Another therapist commented, " I think you need mutual respect between the two parties" (Group A, #56-58). Yet another emphasized the fact that trust together with a sense of equality is needed between the mentor and protégé. "Trust, you have to trust and there has to be reciprocity and a perception of equalness rather than sort of a supervisee/supervisor kind of relationship. There has to be a sense that there's equality and reciprocity" (Group C, #14-20).

Other characteristics of the mentoring relationship were highlighted such as facilitating and motivating, supporting, partnering, understanding, shared problem solving, validating, appreciating, consistency and comforting. One therapist described a mentoring relationship as "hopefully a motivating, facilitating kind of thing. Much, much more than this is what you do; rather than spelling it all out and spoon-feeding it all the time. You are trying to create hunger or something" (Group D, #22-29).

Another therapist said "it's also a partnership, building on the trust, on the understanding, on being supporting in different ways" (Group B, #51-54). Another agreed with the idea of partnership and equality characteristics, " I look at mentorship as being with your peers, as being a partnership irregardless of whether it is a junior-senior therapist or a peer" (Group B, # 98-101). Understanding and supporting was mentioned by a number of therapists such as, "being able to understand the service that they're in, and what the issues are, and what the service is all about, and how can we learn from each other and support each other" (Group B, #107-112). Another therapist described the

relationship as two people who "can pull together and support each other, and that also address issues, projects, and working situations together at that moment in time" (Group B, #191 – 194).

Yet another stated that a mentoring relationship "facilitates problem solving, and that sometimes that's what it is, just having another person to bounce it [ideas] off" (Group B, #235-238). "A mentoring relationship offers the opportunity to discuss it [issues], throw it around, and [determine] what are the possible problem solving things [options/solutions]" (Group B, #521-523). Mentoring relationships should also include "validation and thank-you" (Group B, #526).

In addition, mentoring relationships ought to facilitate "educational support or emotional support" (Group B, #538-539). Consistency of rapport was also mentioned, "when you look for someone you want to know that whenever you call that person they are kind of in, that you kind of know what to expect. You know that person isn't somebody who for lack of a better description is hot or cold. You know that even though they are really busy they are going to say, "I'm really busy right now; can I call you back" (Group B, #734-744). "There also has to be a very non-threatening sort of environment so there can be some constructive criticism that is provided or direction or guidance that is given. So there is potential for growth" (Group C, #22-27).

Frequency was also cited as an important characteristic. A mentoring relationship should include "frequent opportunities to hook up and observe each others skills" (Group A, #254-256).

Peer Mentoring versus Hierarchical Mentoring

Therapists were asked to consider their preferences between a peer mentoring relationship and hierarchical (senior-to- junior) mentoring relationships. There was no distinct preference within the groups. Opinions seemed to vary with the environment and individuals involved. One therapist stated, "I think it really depends on the situation, the environment" (Group D, #96-97). Another therapist stated, "I'm not sure if one or another would be better. It really depends on the relationship"(Group C, #62-64).

When the discussion focused on peer relationships, some therapists felt that it may be easier to create a level of comfort for protégés when peers mentored them. "Peer mentoring is really good. If someone you went to school with asks you a question, you can say 'oh I forgot that, where did I get that' and you don't have to feel that you should know it, if it's your peer it's more of a easier kind of thing to ask the question" (Group A, #79-86). Another therapist noted the changes in the health system and the organizational flattening. "Basically, I think one of the things we have in our work place now is an absence of the delegation between senior and junior. So truly it ends up that everybody is on the same level maybe at a different pay scale but it's got nothing to do with what you are really bringing to your work site. So I think it tends to be more peer mentoring" (Group C, # 75-83).

In addition, one therapist in the support of peer mentoring raised cautions, "I think that as a peer you can facilitate somebody getting knowledge from a more senior person so you don't have to pair them with a more senior person. I think people do struggle sometimes as peers to be able to give feedback in a constructive way so they have to

maybe develop that skill before entering into it [a mentoring relationship]" (Group C, #64-72). One therapist felt that effectiveness of peer mentoring might depend somewhat on the resourcefulness of the individuals involved. "I do think a peer relationship would probably be just as effective [as senior-junior relationship]. I think it depends on how resourceful they are. If they are both new grads and they are willing to go to other resources" the relationship might be very successful (Group C, #101-106).

It appeared that therapists experience different mentoring relationships at different points in their career. "I think sometimes it starts off for example for brand new grads they start off as a senior-junior relationship and then it evolves more into a peer mentoring relationship" (Group A, #95-99).

A therapist supporting senior-junior mentoring relationships stated, "Certainly when I think back to when I was a new grad and who I learned my trade from or however way you want to put it, I was very lucky I had a very strong mentoring relationship with the senior occupational therapist on service at that time" (Group D, #63-69). Further elaboration of the senior-junior relationships was, "these relationships are more top down in nature and that's very clearly what they [junior occupational therapists] told me they wanted" (Group D, #122-124).

Dyadic Mentoring versus Group Mentoring

Next the pros and cons of dyadic and group mentoring relationships were discussed. When considering a dyadic relationship, therapists felt this kind of relationship facilitated more accountability and higher emotional intensity than group mentoring. "I think in the one to one [relationship] you have a little more direct and obvious accountability" (Group

D, #150-152). Another therapist said "having just one [mentor] helped to get her feet under her" (Group C, #141-142). Yet another said, "I think initially starting out its helpful if you only have one [mentor]" (Group D #273-275). "If someone is uncomfortable asking questions, it's nice if they have somebody specific that's assigned to them and then they know it's that person's job to do this" (Group D, #281-285).

Points of comparison were raised between group and dyadic mentoring. "I think group mentoring is fine but as with many other things in a group you tend to lose focus and you forget who is steering the ship and who isn't. Everybody thinks somebody else is taking responsibility and it gets a bit lost. The advantages are to get many opinions and different ideas about the same problem perhaps" (Group C, #121-129). Many agreed with the benefit of diversity in ideas when participating in group mentoring, "potentially in a group they [protégés] would get certainly a diversity of ideas, but there may not be as much of a closeness with the relationship" (Group C, #158-162).

Some occupational therapists participated in special interest groups (i.e., geriatrics, pediatrics) and felt this was a good example of group mentoring. "A group of people comes together to support each other and learn from each other" (Group B, #128-131). Another therapist stated, "We will have a continuing care group of therapists that are urban and rural based so we can take an opportunity to get together let's say once every three to four months. I would find it's a very successful moment in time where you can pull together and support each other and also address issues, projects, working situations together at that moment in time" (Group B, #185-194).

Single Mentor versus Multiple Mentors

Therapists were also asked about having one mentor versus multiple mentors at a time. Again there were mixed opinions with participants citing benefits and limitations to having one mentor or having multiple mentors. Therapists felt that having one mentor could facilitate consistent, structured support, which was particularly helpful for a new graduate or a therapist new to a practice area. "I think initially starting out it's helpful if you only have one [mentor]" (Group D, #274-275). Another therapist stated that multiple mentors "would basically fragment things too much for them... they need to anchor with one" (Group C, #218-220). Yet another therapist commented, "I think the consistency [of one mentor] is important...for a new grad I think sometimes to help build confidence and develop your skills is that consistency, once they're a little bit more established and they're thinking a little bit more critically about things, they're maybe looking for different things from different people and so I guess as a protégé it depends on what you're after" (Group A, #172-185). Multiple mentoring brings richness in diversity, but "sometimes it's confusing; it's harder for them to know where to go" (Group D, #278-281).

Despite the limitations, there were also many benefits cited for having multiple mentors. These benefits include diversity of ideas, approaches, and expertise. It was also noted that multiple mentors could also be helpful in sharing resources of time and person. "I was mentoring an individual with another individual. There were two of us mentoring one person. I think the individual felt that they got a lot of information and two different perspectives, although I was mentoring on this aspect of the job and the other individual was mentoring from that aspect of the job. She just got two different perspectives, two different approaches. She found that very valuable" (Group A, #190-201). Multiple mentors may be

especially beneficial for rural therapists. "I work in the rural areas, so one day I may need to do this assessment and then the next day I need to do another type. So you may have different mentors that you contact depending on what types of issues you're coming up with that time" (Group B, #146-153). Another therapist stated, "I think multiple mentors can sometimes be more practical because I was supposed to be mentoring a new grad in a facility that I have never been in, a private facility, with different standards. I wasn't familiar with these standards, so I could hardly mentor her on those things. So a therapist that was in place [private facility] one day a week helped put those organizational things in place and I was more just a general mentor for some problems, and then she also worked at a different facility and had an informal mentor there" (Group A, #203-217).

Yet another therapist commented, " I was involved with a new grad, where we had three of us sharing the responsibility of mentoring. She was an outstanding therapist, very independent and showed great initiative and so on. So for her, she grew dramatically having access to basically three people. So there was never a situation of her feeling boxed in to only one way to handle something" (Group C, #143-153).

Mentoring Relationships across Regional Boundaries

Therapists were asked to consider the possibility of maintaining a mentoring relationship across different regions, different facilities, or different practice areas. There was a consensus throughout the focus groups that, if a therapist was mentoring a restricted practitioner where liability was a potential concern, the closer in proximity the mentor worked to the protégé the (i.e., same facility, same practice area), the better. Although close proximity was the preference, therapists also realized this may be impossible in

some of the rural health authorities. If the mentoring relationship involved two therapists, or where liability was not an issue, geographical proximity was not such a concern.

Therapists felt face-to-face observation of skills was a definite advantage, but not necessarily a necessity. All therapists agreed that ideally the relationship should involve initially face-to-face contact, and then could potentially evolve through distance education technology. One therapist stated, "in terms of liability issues what I've learned in the year, I'd be very, very reluctant not to have that person work in the same facility as me, never mind in the same region" (Group A, #297-302). Another stated, "the other thing I think you need to consider is if you're acting as a mentor in specific regards to a restricted practitioner, you need to sign off on all their charts. It's your license that's on the line yet I think you need to be close so you know exactly what's going on " (Group A, #269-276).

Other deterrents to crossing regional boundaries may be travel and organizational constraints. One therapist stated, " I think when you're looking outside the region; you're looking at the travel end of things. If you need that face-to-face [contact], then I think that travel can be a really huge deterrent for people; having to set up time, to block that time to travel" (Group B, #293-299). A different therapist stated "sometimes there are also institutional barriers, where the region or whoever the person you're working for doesn't want you talking about certain things to somebody out of house or out of region. There are some pretty touchy subjects that you can't go into because you're not allowed to" (Group A, #687-695).

Other therapists support mentoring across regional boundaries. "If you're a more senior experienced therapist and you're looking for other clinical avenues, I don't think it

matters [to go outside of your region], I think we do that all the time, we call people in Edmonton" (Group A, #237-242). Another therapist stated, "I think it's advantageous as a mentor to connect with other people whether they're in province or out of province. Other regions that have similar services as yourself that you can pull from each other, assist each other and go from there" (Group B, #248-254). Yet another said, "I don't think it's necessary [for mentor and protégé to work in the same region], but I think it would be tough to do it. I think again if you are looking at a specialty area and there are only one or two people in the province, then obviously that would almost be irrelevant which region you work in. Again, community [service] is tougher because some of the services you deliver are very regionally oriented and how you deliver them might be really locally based" (Group C, #262-274).

Another therapist spoke of mentoring across regions through distance education technology, "Through our telehealth sessions, there's one therapist from up north that hooks up with us and she is the only occupational therapist from that region. She does that with the entire group and she brings forward things she wants more information on and that works fine. If she wants more, she follows up with a phone call. Again it comes back to what is the goal and type of mentorship you're looking for" (Group A, #339-349).

Mentoring Relationships Between Different Facilities/ Different Practice Areas

Therapists were also asked if a mentoring relationship could occur between two therapists who work in different facilities or even in different practice areas. Responses from therapists supported the belief that similarity in practice area and similarity in organizational policy simplified and eased the mentoring relationship. Working in the

same department allowed for incidental mentoring to occur as well as more hands-on demonstration of skills. "It's [mentoring relationship] got both a formal and informal aspect to it. It's deliberate and incidental... you can't always pick how you are going to help them or what they are going to learn from you. Often it's the incidental stuff; it's the stuff you never actually talked about even just in the course of being around each other and working together" (Group D, #30-46). If you didn't work in the same department, "you lose the incidental stuff. What they pick up on just by overhearing you discuss things with a patient or a family member or just seeing how you work" (Group D, #307-311).

Another therapist stated, "being a very concrete person, I know the mentoring experience that I've been involved in. I've felt much more effective if it's been something I can relate to. I have mentored someone in a very different work situation and I have quite a bit of difficulty. Mind you, you could always be there for moral [support] - 'you're doing O.K.'. I guess my answer is, it may depend on the mentor's personality" (Group B, #280-291).

"In some areas there are some skills where it is easier to teach them hands-on. You can take the person you are trying to teach the skill to and say now here 'give me your arm or your hand or your fingers and see what this is?' That helps them" (Group D, #341-347).

A number of therapists also felt that geographical distance or different practice areas between mentor and protégé were not significant factors in mentoring relationships and that it depended on the circumstances and the individuals involved. "It depends on the situation you've created for the relationship. So if you want your mentor just to ask you

some questions and make you think about the issues yourself rather than to depart knowledge, then of course it works over distance and time or space or whatever. So it's sort of what you determined as the basis of your mentoring relationship" (Group C, #421-431). Another therapist stated, "I guess part of what I see as a mentoring role is actually helping another individual develop as a professional. So in that respect, an occupational therapist is a professional, whether they work with community rehabilitation, home care, long-term care, or acute care. There are very common elements. There may be very specific skill sets that are different, but looking at different approaches fitting in within the broader application of occupational therapy, I think there is certainly something that can be gained" (Group C, #374-387).

Yet another stated, "I think especially when you're dealing with different individuals, when you're talking about difficult patients or difficult outside connections... [for example] with the LSHIP [student health initiative program] they're having difficulty with the teachers and the school staff following through, whereas traditionally an occupational therapist would maybe have difficulty with nurses following through. They could get together and talk about trying this approach or using this tone. They could talk about professional skills, they could definitely do it that way" (Group A, #366-381). Yet another emphasized, "I guess I think that's really crucial, especially in rural practice because you come across a lot more things in your practice that you may not know. There may be areas where you don't deal with a lot, but there are other therapists [in different facilities] in that [practice] area that may be able to answer your questions. There are all kinds of issues" (Group A, #383-391).

Health care organizations are constantly changing. One change seems to be that of heightened awareness of financial costs and the value of service. Although this awareness generates many positive cost-saving activities, one detriment might be less collaboration among organizations or service areas, particularly in urban centers. Therapists alluded to this problem in various comments: "I wonder if people in private practice have a greater idea of how much they're worth. So they are not going to share their skills. It sounds funny when you think about private practice, but would that occur with [public] facilities? If you were looking at going from one facility to another, [for example] is home care management going to make it O.K. for me to mentor somebody who works at a hospital, because I'm going to enhance the hospital service. Am I putting my energies outside of what the parameters of my job are?" (Group C, #470-484). Another therapist responded, "In speaking as a manager, you think about things like that. You think about how long this person is going to be here? What is their goal, and do they really want to be in another area? Would I mentor them in that direction so they can leave? There are some questions around that and your use of resources, it is time" (Group C, #486-494).

Survival of a service within an environment of cost containment and cutbacks breeds competition between service programs. One therapist stated, "I also think that when I look at especially some of the sense of competition that happens between programs and sometimes within facilities from one clinic to another or if you have a specialty clinic in one hospital and the same kind of thing is being developed in another. It's very hard to get nice, safe transferred information back and forth. So I could see that as being potentially quite a threatening situation even though it may seem logical. So if the therapist from a clinic at one hospital will be involved with the same clinic at another hospital, they could

easily mentor each other. Somehow being that I'm the person that does all the referring right now and I listen to them haggle back and forth, I'm not sure it would work that well" (Group C, #387-407).

Mentoring Relationships Across Different Health Professions

Therapists were asked about their experiences in a mentoring relationship with someone in a different health profession and to discuss the strengths and challenges of this relationship. Most therapists felt that mentoring relationships among different health professions could be very beneficial. Many felt it was necessary for an occupational therapist to have a mentor in the same profession when they were a new graduate, but otherwise would benefit from mentoring from other professions. One therapist commented, "I think going beyond looking at restricted practitioners, certainly we're looking into professional peer mentoring. I think there is certainly a lot to learn from other rehabilitation disciplines and nursing, certainly there are common issues we share" (Group A, #526-533). Another therapist stated, "certainly not initially as a new grad, but my second job was sole charge and so I only had nursing [staff] around... but yes, it certainly helped. I mean they can give you the basics of how the system works, then you have to find your place in it" (Group C, #717-729).

Therapists gave numerous examples of experiencing mentoring from different professionals. Often occupational therapists work sole charge, so it is important to develop linkages with other disciplines. "I worked basically sole charge, so there was no other occupational therapist. So I had at my disposal basically, another physiotherapist, a social worker, a nurse, and a physician within the clinic. I was responsible for the

occupational therapy piece, so that kind of research piece was definitely up to me and I did seek out clinical information from other people. But all of the others that were working side by side me were in fact more in a mentoring kind of role because they were guiding my overall development. So, yes, I think that given certain situations you can get that support" (Group C, #686-704). Another therapist stated, "when I started working here, there was no other occupational therapist working near me, I learned most of what I needed from the physiotherapist" (Group A, #824-828). Yet another added " yes, I agree, you may still want an occupational therapist to be your formal mentor, but other disciplines may be helpful in the day to day functioning (Group A, #831-834). In addition, another therapist said, "when I think about who I learned rehab from, it was a social worker and a speech pathologist... there was kind of a chemistry and we shared a passion for a population. That was what made that work and made that possible. That's not always going to be there and that's one of the great challenges with this relationship. How do you make sure this happens, to the extent that it has to happen?" (Group D, #73-87).

Characteristics of a Successful Mentor

Therapists suggested many behaviours and attributes when they were asked to describe an effective mentor. These behaviours and attributes included the following: effective communicator, particularly listener, "motivator", "role model", "guide", "supporter", "encourager", "counselor", "teacher", "facilitator", "ambassador", and provider of resources. They also indicated that a mentor should be credible, approachable, available, flexible, respectful, and humble.

One therapist stated, " I see four or five critical roles. I think the first is to assist the protégé in developing a philosophy and a sort of excitement about occupational therapy and values and sort of getting that solid core of 'what is it that you're doing and how do you want to practice' and that comes in those first couple of years when it's critically developing. The second role, I think is to assist in the process of developing a reflective practice... then they do that by coaching or guiding, listening skills, by facilitating opportunities for them. Modeling, I think it's really key that they have a sense that they are modeling behaviour and activity, helping the protégé develop a research based or evidence based practice as well" (Group C, #613-638). Another therapist stated, "I see communication and listening as one of the key ones [behaviours]. Because I think to really hear the persons' concerns that we do a lot of listening, but don't always hear" (Group B, #495-499).

Further a therapist stated, " You have to tell them [the protégé] that they know the stuff, you know what I mean, you have to encourage them. It's more than giving them the answer. I didn't want to give them the answer, I wanted them to figure it out for themselves or try it or whatever or you like, you have the knowledge, use it, encourage" (Group A, #452-461). Yet another said, "as the mentor you can't be afraid to be critical sometimes, especially if that's one of the things the protégé is looking for" (Group A, #479-482). "It's important to be supportive and that we're not taking 'the air out of their balloons' so to speak, by giving them opportunities to learn in a safe environment" (Group A, #45-49). Another therapist commented, " one of the things I think is important is that the feedback be constructive and that it is presented in a way that is open and not condescending" (Group A, #37-41).

In addition, a therapist commented that a mentor has to have the ability to "guide and allow for the growth and the process basically of them [protégés] learning to spread their

wings and feel comfortable" (Group C, #606-611). Yet another therapist emphasized that "a mentor should have some good problem-solving skills and also be able to recognize the basic competency that each person has to be able to empower that person to take them beyond" (Group B, #488-493).

One therapist stated, "I feel that a mentor and the characteristics that they require should be as a counselor and have some knowledge of how to support and how to counsel them within not just education, but socially. To have a good understanding of what is happening and what their needs are, identifying their needs" (Group B, #43-51). Another therapist emphasized moral support, "you could always be there for moral [support] – 'you're doing O.K.'" (Group B, #288-289). Yet another reinforced the need for support, "It's got to be a pivotal person [mentor] in that person's [protégé's] learning process. I don't know the correct words, but you don't want to be judgmental. You don't want to say 'No, you did that wrong'. You want to be totally supportive and that the person does feel comfortable with you so that if you have to say that there's another way to do something, that you're not breaking their spirit or breaking their heart or something" (Group B, #469-480).

Provider of resources was also highlighted as an important role of a mentor. A therapist commented that she provided resources, "I've actually taken her [protégé] examples of our assessments and stuff, so that she has things to look at, to make some decisions on, if she wants to adapt what she personally has or doesn't have or whatever. Just giving suggestions" (Group C, #572-583).

Another therapist commented that new grads "tend to show up with skills-focused thinking. So it's the big picture you wind up doing most of your mentoring about. These are bright people, it's hard to get into occupational therapy and it's hard to get through it. They

can learn all the bits and pieces of what they need to learn about a condition and how to treat a condition. It's more seeing the big picture, who is the human being I'm sitting across from and what does that mean? All that stuff and feeling free to take risks and think on your feet and how to let go if they need to be right in your interaction with them, all of that stuff. 90% of the mentoring I do here is all about stuff like that – not about skills" (Group D, #606-625).

Characteristics of a Successful Protégé

The two key characteristics of a protégé identified by all four focus groups were openness and insight. Other characteristics cited were willingness to learn, honesty, willingness to fail, openness, willingness to accept feedback, self-assessment abilities, insight, good judgment and an interest in occupational therapy.

One therapist described the most important characteristics of a protégé as follows, "I think openness. You know, both directions, being willing to tell us where their concerns are and where they are having problems. As well as hearing about different ideas. And I guess some judgment in being able to choose what would be most effective in a situation. I think self-insight, as they need to figure out what the issues are and recognize that themselves, without somebody else pointing that out to them also, an interest in occupational therapy and the desire to learn" (Group C, #647-659). Another therapist stated, "I think it's openness, being open to some of the criticism and also being willing to listen when the mentor is recommending, and is willing to give it a try" (Group A, #497-501). In addition, a therapist alluded that honesty needed to go hand in hand with openness, "I think when you're mentoring, the protégé has to be fairly open and honest. If you're asking them how they're doing, and they say 'I'm doing fine, there are no problems', and you're not there to see, and

then you hear from somebody else that they are struggling, then you know they're not honest with you" (Group A, #506-514).

Yet another stated, "I think they also have to have some self assessment skills to be able to identify when they're struggling" (Group A, #516-518). One therapist responded, "I think their [protégé's] skills should be pretty much identical to what the mentor has as well, and also the willingness to learn and to move on and move forward with the information, the sharing time, the understanding they have together" (Group B, #506-512).

Therapists commented specifically about restricted practitioners, "some think that they know it all. They really know as much as they need to know. For them to get feedback, it's very threatening" (Group D, #503-536). Another stated, "They have to come with a sense that they are not the finished product yet. That is sometimes hard in the first couple of years to acknowledge, that you are not going to do a perfect job. That sense, I think is where sometimes people run into trouble in the mentoring relationships, if there isn't that openness... that's probably openness and insight and a willingness to fail and to talk about what's not working and to hear that back. It takes a fairly mature person sometimes" (Group C, #663-680).

Question 2: What are the Precipitating Reasons for an Occupational Therapist to Seek a Mentoring Relationship?

Therapists identified a number of reasons for seeking a mentoring relationship. The most frequently mentioned reasons were role strain, support (emotional and educational) and professional growth. Other reasons mentioned were being new to the profession, shared problem-solving, validation, isolation, being a generalist, being new to a practice area, and to assist in lifelong learning.

One therapist commented, "role strain in a workplace is one of the most critical ones [precipitating factors] because it's the most sensitive" (Group C, #767-770). In addition, "I think it [role strain] is so critical and because a lot of times really you are faced with having to provide a lot of service but not given a lot of time or resources. It's a real challenge and I think sometimes in some situations, you need a mentor who is in that situation or has been because it's so complex" (Group B, #607-616).

Another therapist stated, " peer support, we are looking for it in many ways, whether it be educational support or emotional support. It is one of the precipitating factors" (Group B, #537-541). Another therapist commented, "even just continued professional development and making sure that you are marketable. We work in a field where job security is, well it really doesn't exist, and do you have the skills to be able to export out? What is the job you want to do? Or maybe you want to do something different, you know you could utilize mentorship to develop some other skills" (Group A, #603-612).

In regard to being new to the profession, one therapist commented, "the new therapist knows there has to be someone out there that's been there, done that, to help me out through this. And if the relationship is set up such that the communication can occur it continues" (Group B, #568-574). Another therapist jokingly said that a new therapist seeks a mentor because of "professional requirements, you have to if you want to practice" (Group A, #569-570).

Isolation was also discussed. One therapist stated, "I think distance still [is a precipitating factor]. If you can't see a face, it's difficult to seek out. I think that is the one we hear about in this region a little bit. It's hard to connect" (Group B, #575-579). Another therapist commented, "I think not so much when you're working in isolation, but being a generalist

that you may only do something every two years and that's when I'd call someone" (Group A, #614-618).

Another therapist stated she sought a mentoring relationship " when I am having difficulty, I would like just to discuss it, throw it around, and see what are the possible problem solving things. The second reason would be, I have already decided what to do and I want somebody to say that 'ya that's a good idea'. So there are two things – validation, thank you, that sort of thing" (Group B, #520-526).

In addition, a therapist commented, " I guess in the ideal world you would always be involved in some kind of mentoring relationship. That would just be a lifelong thing and I think you would use them for yearly reviews or goal setting, establishing a learning plan" (Group C, # 786-792).

A therapist also mentioned the need for mentors to be recharged, " I see mentoring as so beneficial, and yet there has to be a way in which we recharge people. I don't know if that makes sense. You give and give and give, but you need. It's so critical that the mentor recharges... mentors need their own mentors too" (Group B, #1029-1037).

Question 3: What are the Barriers to Initiating and Maintaining Mentoring Relationships among Occupational Therapists in Alberta?

Therapists identified a number of barriers to initiating and maintaining mentoring relationships, such as lack of structure to support mentoring, lack of awareness of the need for mentoring, high workloads, time limitations, personality differences, staff turnover, difficulty coordinating schedules, geographical distances, lack of available, experienced occupational therapists to mentor, complacency, poor access /comfort with technology, discomfort in sharing a need for mentoring, liability concerns with restricted practitioners, and lack of guidance.

One therapist stated a barrier "is that there haven't been a lot of tools in the occupational therapy literature and probably not a lot in school about how to develop and foster mentoring relationships. So you don't see a lot about it, but it's starting to become a bit more prevalent, so there needs to be better research and available tool base" (Group C, #970-979). Another therapist stated, "I'm not aware of anything out there right now for training people on that sort of thing [mentoring]" (Group A, #748-751).

A number of therapists discussed the frustration in the lack of awareness and support from management regarding the need for mentoring. One therapist said "I was just thinking about considering the personality of some of our supervisory staff and some of the limitations that are imposed. You know where I've offered to mentor, say for a different office in a different part of the city, and they went 'Oh my goodness, it will take too much time.' And then bang, that's the end of it. Not even being open to the concept that we could meet for lunch and have a brief discussion and then do it over the phone or do joint visits. It's that whole program management concept again because the individual in question [supervisor] isn't an occupational therapist. So her sense of what kind of support for the discipline is needed is perhaps different from what mine would be" (Group C, #1108-1127). Another stated, "I agree, I think there is still a pressure from that medical model, well you can get certification on this or if you need specific training in this area that's fine, but if it's more general mentoring there isn't the same level of acceptance and time" (Group C, #1129-1135). In addition, another therapist stated, "one of the things thrown at me at times is 'Well we gave you an in-service on that two years ago, isn't that enough? Why do you need this [mentoring]?' We need to be allowed to say, professionally, I need some support in this area to grow, and give some sense of credibility as a professional making that statement and

support in it" (Group C, #1137-1146). One therapist commented, "We never really had formal mentoring relationships. We've had so many staff changes in the last number of years, what would be the point? Mentoring could not be possible" (Group D, #169-173). Another stated, "We need understanding which is communicated through administrative action rather than mission statements" (Group D, #757-759). It was noted that the nursing profession often holds management positions within the health system, and often allied health professionals are not acknowledged for these same positions. One therapist stated, "I think some nurses sense is well you learn and then you can do it and you're competent and that's all you need" (Group D, #261-264).

Support for mentoring seemed to be one area where there was a difference between rural groups and urban groups. Urban groups appeared to have less support for mentoring from management than the rural groups.

One therapist said, "We're starting to see institutionally more structure coming in this region, very recently with regards to mentorship, and establishing guidelines for new employees, not new grads, but new employees that you would have someone tagged up with you to be a mentor (Group A, #708-715). Yet another therapist added, "just thinking in this region, where even five years ago it was a completely different picture, where there was not a lot of support for mentoring; whereas now I just view the scene so different... mentoring is supported from the top down"(Group B, #661-671).

Geographical barriers were also discussed. One therapist stated, "it can be a real challenge, especially when you come out here where you are relatively isolated and have no contact with a lot of people, and you don't know where possibly to go for help" (Group A, #682-687). Another stated, "I've found that geography is actually quite a big issue, just in

terms of time required for me to mentor someone. If I need to drive an hour each way, then the feasibility of me seeing patients with them was much more difficult" (Group A, #757-763). In addition, another therapist commented, "I think having some of the distance issues, it certainly increases the importance of having something formal set up. Thinking back to my own experience as a new grad, I was in a very rural, isolated position. And if you're in a large facility, you do a lot more of that informal mentoring, it just sort of happens. When you're isolated, there needs to be a lot more structure to the mentoring process to make sure it happens " (Group A, #788-800). Geographical barriers were not limited to rural regions. One therapist spoke of her mentoring relationship in a city, "it's really hard. She's [the protégé] across town. So to make time to do that [mentoring visit], and to have it be seen as a priority, to be in both places and dealing not with just one facility, but both" (Group D, #715-720). Another therapist spoke about "micro-geography "and how that could influence relationships, stating, " being on a different floor can negatively affect cross disciplinary learning and the strength of relationships" (Group D, #690-695).

Discussions also included time and heavy workloads as constraints. "I feel that there are times when maybe we are not necessarily given the time to mentor because we're dealing with caseloads ourselves too. The opportunity may not be given because of time restraints" (Group B, #653-658). Another said "cutbacks, the stress, the workload has really taken a toll on the team where we work... there is less conferencing between disciplines, less incidental talking during the week, less mentoring as well. When you are running around putting out fires, like chickens with their heads cut off, that's [mentoring] the first thing that stops" (Group D, #214-227). Yet another stated that difficulty may arise "if you work part-time

versus full-time, there's time limitations" (Group C, #1070-1072). In addition, "sometimes it can be difficult coordinating schedules" (Group A, #636-637).

Personality differences and mentoring mismatches were also brought forward as potential barriers. "Maybe the person that has been selected is actually, well hasn't kept up with the times or maybe isn't a good match" (Group C, #1087-1090). Yet another stated, "just that some personalities are interested [in mentoring] and some aren't. Some people are better at it than others" (Group C, #1097-1099).

Another concern raised was that "sometimes, identifying a mentor who has a lot of good experience in an area is difficult" (Group A, #677-679).

Yet another barrier was noted as follows: "sometimes just complacency with your own skills, like you're happy just fumbling along" (Group C, #673-675).

Liability issues were mentioned as barriers a number of times, particularly in relation to the willingness of some therapists to mentor restricted practitioners at a distance.

Question 4: How can Mentoring Relationships be Supported through Distance Education Technology?

When asked if therapists felt mentoring relationships could be supported through distance education technology, there were mixed responses. A number of therapists felt face-to-face interaction was necessary; as one therapist commented, "you have technology, but that's not quite the same to me, as being right there within that person's [protégé's] environment" (Group B, #708-712). In addition, "it's always nice to look at the person. I think you get a better feel, the other person gets a better feel" (Group B, #321-214).

Some therapists felt technology could support a mentoring relationship if there was initially face-to-face time to build rapport between the mentor and protégé. One therapist elaborated, "I think you need to set up initially a fair block of time on a face-to-face [basis] and I think then you can get to know one another and have that bit of trust. Then I think when that's sort of set up, then those can gradually be decreased – the amount of time you spent face-to-face, and other options can come in. Yes, there is email, there's telephone, there's regular mail. I think the whole telehealth or videoconferencing is available, but that's limited" (Group B, #897-911). "There are options for us to use. I think it is a personal preference sometimes. What can I access easier? Personally I use the phone more than email because of the accessibility to the computer at certain times" (Group B, #928-934).

Email was suggested in every focus group. A therapist stated, "we've got email which is really good" (Group A, #808). Agreeing with, a therapist replied, "yes, I would have to second that, when you get a question on your email you can answer it right back. You know other technology, faxes are great, and if you have an article you can fax it to them. Also the Internet. If you come across something on a website, you can email them that. It opens up opportunities for transmission of information much easier than just telephones" (Group A, #810-820). Another therapist stated, "I love email, absolutely excellent" (Group C, #991-992). Yet another commented, "I have access to much more than what I know how to use. I have email and I use it. It's interesting for me because I'm not somebody who really likes technology. I really like the face-to-face interaction, but certainly I've done some conversations with people about particular issues over email" (Group D, #789-797).

Therapists also discussed videoconferencing. One therapist stated, "Yes, I do think Telehealth is helpful, it certainly has limitations, but it has benefits in terms of being able to show and have the protégé observe" (Group A, #851-855). In addition, a therapist commented, "you can judge their [the protégé's] level of understanding that much more. When you're talking above their level you can observe their body language, expressions – whoa- big eyes- 'what are you talking about?' You can't really see that when talking on the phone. I prefer it [videoconferencing]" (Group A, #940-947). Yet another stated, "the TeleMed stuff is interesting, tempting, certainly helpful to the mentor because then you have the option to actually see the client and the therapist together, and you have a lot more context from watching the interactions... you're just losing then that hands on actual – 'here feel this, this is what it should be like', that's all you're really losing" (Group D, #770-783). Another therapist stated, "what we actually did with our occupational therapists in long term care is when we can, we coordinate with Two Hills [another region], with their videoconferencing out there... that is how we got together with them" (Group C, # 1043-1049).

Therapists also referred to computer-mediated discussion groups and online courses. One therapist referred to the value of distance education technology for mentoring, noting "email and some of the web-based courses and certainly interest groups online, just access to resources online, evidence- based practice groups, and those kinds of things. We don't use videoconferencing" (Group C, #1161-1167). Another replied, " I think there is a perception that [videoconferencing] wouldn't be needed [among city sites]... I think if looking at the SHIP program with pediatrics, we were out at the school, if you could in fact do a videotape of your client and then put it out, you would get information and

support in getting guidance, opposed to having to physically move somebody from one site in the city to the other" (Group C, #1176-1187). Another therapist stated "there are these gurus who are getting on towards retirement and have been very active in the [United] States as mentors over email, and now a couple of them are setting up websites where people can access information and post questions" (Group D, #819-824).

Question 5: Is it Feasible to use Distance Education Technology to Support Mentoring Relationships among Occupational Therapists in Alberta?

When therapists were asked if they felt it is feasible to use distance education technology to support mentoring relationships, there was agreement in varying degrees. It appeared that three key factors influenced the feasibility of technology use: therapist preference, accessibility to technology, and knowledge in using technology.

Most therapists felt that some face-to-face contact was required initially in the mentoring relationship and at least periodically throughout the relationship. One therapist stated, "now if I did something where I actually met with them [the protégé] and they spent a couple of days with me and then they went out, I would then have a greater feeling of confidence. I think that I know who this person is a little more, and it would be a little easier for me to say I can guide you a bit more by telephone and via email, videoconferencing, whatever" (Group C, #326-335).

Some therapists felt that face-to-face mentoring was highly preferred; however, if this were impossible, only then would they consider the use of technology. A therapist who strongly supported face-to-face mentoring stated, "I think you do lose something when you are doing it [mentoring] on the phone or on the computer or pencil and paper sort of

things. I know there's other ways around it, but I think face-to-face you need" (Group B, #299-304).

Still others were very receptive to using technology to support their mentoring relationships. A therapist supportive of technology use in mentoring relationships stated, "Yes, I think it's quite feasible [to support mentoring with technology]. All occupational therapists in this region have access to computers and access to telehealth" (Group A, #841-843).

The second factor discussed was accessibility to technology. Here responses varied from region to region. One region had ready access to technology; however, this was not consistent across all regions. One therapist commented in a frustrated tone, " we have the telephone, but we don't even have cell phones, we don't have voice mail, and we don't have access to a computer" Group C, #1007-1012). Another therapist stated, "in this department we have two computers that are linked up to the Internet... 20 or 30 [therapists] could be sharing those [computers]" (Group B, #950-954). Yet another commented, "it's limited [access], yet its way better than it was, way better" (Group B, #962-963). A further therapist commented, " I think most people have access or could find access to it [technology] if they wanted it. I don't have one [a computer] at home, but if I need one, I go to the office or to my friends house; it's just my choice not to have one. I suspect there would be very few therapists who wouldn't have access if they needed it" (Group D, #897-904).

The third factor relates to knowledge of technology. The feasibility of using technology to support mentoring relationships is influenced by the therapist's knowledge

of technology and its' use. A therapist stated, "the individual who's using the technology has to know how to use it" (Group A, #860-862). Another therapist stated, "I have access to much more than what I know how to use" (Group D, #789-790). In addition, another therapist commented, "I think whenever you're using new technology there is a learning curve associated with it. When you first start off you use it one way, and then you learn better ways" (Group A, #864 – 868).

Phase Two Results

The second phase of this study followed a quantitative research paradigm. A survey was conducted to investigate characteristics of successful mentor/protégé relationships, precipitating reasons for seeking a mentoring relationship, barriers to initiating and maintaining a mentoring relationship and the feasibility of using distance education technology to support mentoring relationships.

There were 1020 registered occupational therapists in Alberta at the time of this survey. Following the selection of a random stratified sample as outlined in Chapter III, 256 occupational therapists were mailed the survey. The initial response rate was 41%; after phone calls and emails to regional representatives asking them to remind occupational therapists in their region to return the questionnaire, the response rate increased to 58.5%. An additional nine questionnaires arrived after data analysis was completed, so they were not included in the results.

Characteristics of the Respondents

The survey instrument included questions related to various demographic characteristics of the respondents. The discussion and tables in this section will summarize these characteristics.

Gender

Of the 150 respondents, 133 (88.6 %) were female, 14 (9.3 %) were male, and 3 did not identify their gender. This gender representation parallels the characteristics of the larger population of registered occupational therapists in Alberta.

Age

Nearly half of the respondents (45.2%) were between 25 – 34 years of age. The distribution of ages represented by the respondents is shown in Table 1.

Table.1 Age of Survey Respondents

Age of Respondents	<u>n</u>	%
Under 25 years	11	7.5
25 to 34 years	66	45.2
35 to 44 years	43	29.5
Over 45 years	4	2.7
Total	124	84.9
Unreported age	26	15.1

Work Status

Of the 150 respondents, 97 indicated they worked full-time, 50 worked part-time, two did not work, and one respondent did not identify work status.

Regional Health Authority

As indicated in Table 2, there was representation from every Regional Health Authority in the survey. Overall, there was higher representation from the rural health authorities in comparison to the urban health authorities (i.e. Capital and Calgary). This under-representation was largely due to the poor response rate from the Calgary region.

Table.2 Respondents from Regional Health Authorities Surveyed and Responding to Questionnaire

Rural Regional Health Authority	# of Therapists working in Region	% of Total Rural Therapists	# to be Sampled	Actual %	Actual # in sample
Chinook	37	14.3	18	8.6	11
Palliser	22	8.5	11	4.7	6
Headwaters	17	6.5	8	3.1	4
Region 5	5	1.9	2	.8	1
David Thompson	57	22.0	28	16.4	21
East Central	22	8.5	11	8.6	11
Westview	10	3.8	5	1.6	2
Crossroads	7	2.7	4	2.3	3
Aspen	21	8.0	10	3.9	5
Lakeland	24	9.3	12	4.7	6
Mistahia	23	8.9	11	6.3	8
Peace	3	1.2	2	.8	1
Keeweenok	3	1.2	2	.8	1
Northern Lights	6	2.3	3	2.3	3
Northwestern	1	.4	1	.8	1
Total	258	100	128	65.7	84
Urban Regional Health Authority	# of Therapists working in Region	% of Total Urban Therapists	# to be Sampled	Actual %	Actual # in Sample
Capital	458	60	77	34.4	44
Calgary	304	40	51	14.0	18
Total	762	100	128	48.4	62
Region Unspecified				2.6	4

Work Setting

Occupational therapists work in many different settings. The largest number of respondents (n=47; 31.8%) worked in multiple sites (i.e., Acute Care/Continuing Care, Community Rehab/ Student Health Initiative). The next most common setting was Acute Care (n=30; 20.3%). Table 3 shows the distribution of work settings.

Table.3 Work Setting of Respondent

Work Setting	<u>n</u>	%
Multi-Site	47	31.8
Acute Care	30	20.3
Continuing Care	15	10.1
Specialized Program	14	9.5
Home Care	12	8.1
Community Rehabilitation	12	8.1
Student Health Initiative	12	8.1
Private Practice	4	2.7
University	2	1.3
Total	150	100.0

Length of Service

Length of service has been cited as a potential barrier to the initiation of mentoring relationships within the field of rehabilitation medicine (i.e., occupational therapy, physical therapy), as there may be a lack of experienced therapists to fulfill the mentor

role (Bohannon, 1985). In this survey, the length of service ranged from less than one year to 30 years. The majority of respondents (n=87; 59.2 %) had worked 10 years or less in the field of occupational therapy; 41(27.3 %) had worked 15 years or more in occupational therapy.

Prevalence of Mentoring

Occupational therapists were asked on the questionnaire if they had ever experienced a mentoring relationship. To assist with their responses, a definition of mentoring, mentor, and protégé were provided: "Mentoring is a relational process, in which someone who knows something, the mentor transfers that something (the power resources such as wisdom, advice, information, emotional support, protection, linking to resources, career guidance, status, etc to someone else, the protégé, at a sensitive time so that it impacts development" (Stanley & Clinton, 1992, p.48).

Of the 150 respondents, 92 % (138 respondents) replied that they currently had or have had a mentor. Only 12 respondents had never had a mentor within the field of occupational therapy.

Reasons for not having a mentoring relationship related primarily to reduced access to other therapists and lack of support; the following comments were received:

- "None available and I did not realize the importance of this relationship."
- "Lack of management, supervision roles for occupational therapists in program based management structure."
- "Official mentorship programs not considered important or promoted at the time, everyone is so busy with their own caseload."
- "None available, unwillingness to offer support."

Theories of Mentoring

Respondents were asked to indicate their preferences within a mentoring relationship, according to the following three choices: (a) peer mentoring versus senior to junior therapist mentoring, (b) group mentoring versus dyadic mentoring, and (c) multiple mentors at a given time versus one mentor at a given time. The results revealed the following preferences:

- 45.8 % of the respondents preferred peer mentoring, whereas 54.2 % preferred senior- to- junior mentoring;
- 80.5% preferred a dyadic mentoring relationship whereas 19.5 % preferred a group mentoring relationship; and
- 50.4 % preferred one mentor at a given time whereas 49.6% preferred multiple mentors at a given time.

Precipitating Factors for Seeking a Mentor

Numerous reasons are cited in the literature for seeking a mentor. In the questionnaire, therapists were asked to rate the importance of 12 precipitating factors for seeking a mentor, from 1.0 "not at all important" to 5.0 "extremely important." Table 4 lists the factors in descending order from the most to the least important. The three reasons with the highest mean scores (i.e., over 4.0) related to being new to the profession and/or new to a practice area.

Table.4 Precipitating Factors for Seeking a Mentoring Relationship

Precipitating Factors	Mean Score	SD
New to profession	4.28	.90
Restricted practitioner	4.18	1.16
New to a practice area	4.15	.76
Professional isolation	3.88	.84
Role strain – working alone	3.78	1.03
Reduced access to professional development	3.76	.93
Reduced access to resources	3.72	.97
Role strain – not feeling apart of the team	3.69	1.10
Practice in rural setting	3.61	1.16
Role strain – high caseloads	3.52	1.01
Role strain – little admin support	3.36	1.06
Practice in urban setting	3.02	.99

A correlation matrix was examined to determine if adequate correlation existed between the precipitating reasons in Q-2 to indicate that common factors were shared and that factor analysis would be an appropriate statistical procedure. This correlation matrix identified over 55 correlations that were significant at an alpha level of .000.

A Rotated Factor Analysis was performed on the 12 precipitating factors for seeking a mentor. Three factors were identified with an eigenvalue over 2.

Factor I had an eigenvalue of 3.18, explaining 26.49 % of the variance in precipitating factors. This factor identified "isolation and restricted access" including (a) practice in rural settings, (b) reduced access to resources, (c) professional isolation, (d) practice in urban setting, and (e) role strain from working alone. The precipitating reasons in Factor I had loadings of .836, .737, .717, .715, and .561 respectively.

Factor II had an eigenvalue of 2.56, explaining 21.31 % of the variance. This factor identified "role strain" including (a) role strain from little administrative support, (b) role strain from high caseloads, and (c) role strain from not feeling apart of the team. The precipitating reasons in Factor II had loadings of .845, .821, and .694 respectively.

Factor III had an eigenvalue of 2.20 explaining 18.32% of the variance. This factor identified "being new" including (a) being new to profession, (b) restricted practitioner, (c) new to a practice area. The precipitating reasons in Factor III had loadings of .850, .798, and .630 respectively. Together, these three factors explained 66% of the variance.

Initiation of a Mentoring Relationship

Protégés were asked to consider their most significant mentoring relationship and identify how this relationship was initiated. As shown in Table 5, 42.1 % of the mentoring relationships were mutually initiated, 20.6 % were assigned roles, and 19.0 % were protégé initiated. Only 7.1 % of the mentoring relationships were mentor-initiated, and 11 % were initiated through other means primarily evolving over time. Comments describing the latter kinds of relationships included the following. "It was informal, not initiated but came about because of being a new grad and sole charge therapist in a rural area." "We were stuck

together to drive to and from facility in a rural area." "It was a part of my role as a supervisor." "It just grew."

Table.5 Initiation of Most Significant Mentoring Relationship: Protégé's Perspective

How the most significant mentoring relationship began	<u>n</u>	%
Protégé initiated	24	19.0
Mentor initiated	9	7.1
Mutually initiated	53	42.1
Assigned role	26	20.6
Other	14	11.2
Total	12	100.0

Table.6 Initiation of Most Significant Mentoring Relationship: Mentor's Perspective

How most significant mentoring relationship began	<u>n</u>	%
Protégé initiated	12	13.3
Mentor initiated	18	20.0
Mutually initiated	30	33.3
Assigned role	28	31.1
Other	2	2.3
Total	90	100.0

From the mentor's perspective, one-third of the respondents felt their mentoring relationships were mutually initiated (Table 6). In addition,

- 31.1 % stated that mentoring was a role assignment,
- 20.0 % felt they, as a mentor initiated the relationship,
- 13.3 % felt the protégé initiated the relationship, and
- 2.3 % stated through other means.

Comments included the following: "If there is something to offer and where there is a need...give." "Gradually involved by asking questions and being open to learning, not a formal assignment/agreement." "Our facility has a formal mentoring program for all new staff. The mentors volunteer and are assigned to a similar professional who is new to our program."

Although the questionnaire was not sent to "matched" mentoring pairs, the agreement between mentor and protégé is noteworthy. Both the mentor and the protégé respondents agreed that mentoring relationships were often mutually initiated or assigned relationships.

In the open comments, many therapists expressed the opinion that mentoring relationships should occur on a voluntary basis; the following examples illustrate this belief:

- "Not sure it needs to be adopted as policy, but rather informally adopted, encouraged, and understood at each level, except for restricted practitioners, this should be in policy or standards of practice."

- "Mentoring should be a luxury, it is an option for both parties, it shouldn't be mandatory. People have to want the mentoring relationship; whatever their reason, it shouldn't be forced."
- "Better if it occurs naturally, mentorship really works when combined with respect, affection, and genuineness."
- "This relationship should be suggested, fostered but never imposed. Both the mentor and protégé need to be comfortable with each other's practice style and approach and they must want the relationship. Some personality combinations work, others don't. Some people make very poor mentors."

As illustrated by the following comments, other therapists felt that some structure was required to support the initiation of mentoring relationships.

- "I think that [mentoring activities] should be made explicit in job expectations/descriptions and adopted as a philosophy at work sites."
- "Although I would hope this would just occur, my experience has been there is rarely time unless the mentoring relationship is made a priority and more formal."

Functions/Behaviours of a Successful Protégé

The functions and behaviours of a protégé are important to a successful mentoring relationship. Therapists were asked to rate the importance of 11 behaviours for a protégé from most to least important. The responses are shown in Table 7 in descending order of

importance. The most important functions/behaviours identified were the following: open to feedback and advice, willing to learn, desire to grow, and respect for the mentor.

Table.7 Functions/Behaviours of a Successful Protégé

Functions/Behaviours of a Protégé	Mean Score	SD
Open to feedback & advice	4.59	.60
Willing to learn	4.55	.65
Desire to grow	4.44	.66
Respect for the mentor	4.42	.68
Willing to devote effort	4.29	.72
Willing to be held accountable	4.26	.81
Appreciative of the mentor	4.11	.79
Hardworking	3.92	.89
Anxious to succeed	3.60	.97
Exhibit career directness	3.22	.93

Nature of Mentoring Relationships: Protégé's Perspective

The nature of mentoring relationships among occupational therapists was first explored from the perspective of the protégé. When responding to the questions in this section of the questionnaire, protégés were asked to think about their "most significant mentoring relationship."

When asked to state the position they held when experiencing this mentoring relationship, protégés responded as follows: 21.2 % were restricted practitioners, 59.3 % were occupational therapists I, 16.9 % were occupational therapists II, and 2.6 % were supervisors (Table 8). Protégés were also asked what position their mentor held and they responded as follows: 22.4 % were occupational therapists I, 36.0 % were occupational therapists II, 27.2

% were supervisors, 1.6 % were practice leaders, 2.4 % were researchers/educators and 10.4 % were peers from another discipline (Table 9).

Table.8 Position held by protégé

Position held by protégé	<u>n</u>	%
Restricted Practitioner	25	21.2
O.T. I	70	59.3
O.T.II	20	16.9
Supervisor	3	2.6
Total	118	100.0

Table.9 Position held by mentor

Position held by mentor	<u>n</u>	%
O.T. I	28	22.4
O.T. II	45	36.0
Supervisor	34	27.2
Practice Leader	2	1.6
Researcher/Educator	3	2.4
Peer from another Discipline	13	10.4
Total	125	100.0

A number of commonalities in the mentoring relationships were explored such as gender, cultural background, regional health authority, workplace, and practice area. The following commonalities were identified: 87.2 % of their mentors were of the same gender, 73.8 % were of the same cultural background, 92.8 % worked in the same regional health authority, 83.3 % worked in the same facility, and 78.4 % worked in the same practice area.

As a number of therapists in the focus groups had multiple mentors at one time, a question related to this relationship was added to the questionnaire. Protégés were asked if they had multiple mentors and if so how many. Of the respondents, 71.9% indicated they had multiple mentors at one time, with an average of 2.67 mentors per protégé.

Functions/Behaviours of a Successful Mentor

The functions and behaviours of a mentor are essential to the success of a mentoring relationship. Q-18a of the questionnaire listed 31 potential functions and behaviours of a mentor, and asked respondents to indicate their importance from most (5) to least (1) important. These are listed in Table 10 in descending order from most to least important. The top four behaviours and functions are as follows: constructive criticism and honest feedback, role model, willingness to share time, and belief in capabilities.

Factor Analysis was performed on 31 mentor functions. Three factors were identified with an eigenvalue over 2.

Factor I had an eigenvalue of 6.87, explaining 22.2 % of the variance in mentor functions. This factor identified a function of "caring communicator" which included (a) keen interest in having the protégé succeed, with a loading of .679, (b) facilitates active learning, with a loading of .635, (c) belief in capabilities, with a loading of .608, (d) caring, committed relationship, with a loading of .587, (e) encouragement and coaching, with a loading .586, (f) promotion of an equal and collaborative relationship, with a loading of .577, (g) willingness to share time, with a loading of .570, and (h) emotional support, with a loading of .543.

Factor II had an eigenvalue of 8.68, explaining 8.7% of the variance. This factor identified a function of "practice advisor" including (a) constructive criticism and honest feedback, with a loading of .484, (b) advice about resources, vendors, etc, with a loading of .461, (c) review of documentation, reports, with a loading of .427, (d) help with therapy practice, with a loading of .373, and (e) help with integrating theoretical principles with practice, with a loading of .331.

Factor III had an eigenvalue of 2.26, explaining 7.3 % of the variance. This factor identified a function of "career guide" including (a) introductions to professional network, with a loading of .448, (b) information source re: organizational policies/procedures, with a loading of .428, (c) nomination for important awards, with a loading of .409, (d) introductions to persons who could further career, with a loading of .382, and (e) career guidance, with a loading of .347. Together these factors explained 38% of the total variance in mentor functions.

Using the same 31 mentoring functions, all therapists who had been mentored were asked to identify which functions they had actually experienced in their most significant mentoring relationship. Table 10 shows the frequency and percentage of functions, which actually occurred. When comparing the ideal mentor functions with the actual mentor functions, it is very encouraging to see that the top four functions of the ideal mentor parallel the top four functions of the actual mentor. The top four functions are constructive criticism and honest feedback, role model, willingness to share time, and belief in capabilities.

Table.10 Functions/behaviours of a mentor

Functions/Behaviours of a Mentor	Mean Score of Ideal Functions/ Behaviours	SD	% of Actual Functions/ Behaviours
Constructive criticism and honest feedback	4.40	.68	87.1
Role model	4.36	.89	82.8
Willingness to share time	4.29	.75	81.7
Belief in capabilities	4.18	.79	79.3
Facilitates active learning	4.08	.87	63.8
Encouragement and coaching	4.06	.86	76.7
Flexibility, to allow protégé to do things differently	4.04	.75	76.7
Keen interest in having the protégé succeed	4.00	.91	67.2
Help making difficult professional decisions	3.96	.92	67.2
Help with skill development	3.91	.91	69.0
Help with integrating theoretical principles with practice	3.82	.99	62.9
Help with therapy practice	3.79	.99	59.5
Provide inspiration	3.79	1.06	60.3
Promotion of an equal and collaborative relationship	3.76	.87	69.8
Advice about resources, vendors, etc.	3.70	1.01	67.2
Emotional support	3.65	1.07	71.6
Information source: organizational policies/procedures	3.63	1.03	70.7
Caring, committed relationship	3.59	.990	58.6
Introductions to professional network	3.39	1.06	46.1
Review of documentation, reports	3.37	1.02	57.8
Informed advice about people	3.28	1.00	56.9
Career guidance	3.08	.97	42.2
Fostering of professional visibility	2.81	1.12	36.2
Friendship	2.72	.93	69.0
Informal advice about committee work	2.52	.96	29.3
Introductions to persons who could further career	2.50	1.02	28.4
Defense from criticism by others	2.37	1.01	26.7
Help with personal problems	1.85	.93	17.2
Social activities (i.e. meals, recreation)	1.76	.85	34.5
Nomination for important awards	1.50	.82	8.5

Nature of a Mentoring Relationship: Mentor's Perspective

The nature of mentoring relationships among occupational therapists was also explored from the mentor's perspective. Of the respondents, 62 % indicated they had served as a mentor. When asked to indicate the gender, cultural background, and position of their protégés, the mentors responded as follows:

- 95.6% stated they had mentored women,
- 37.4 % had mentored men,
- 40.7 % had mentored a therapist of another cultural background,
- 46.2 % had mentored restricted practitioners,
- 82.4 % had mentored occupational therapists,
- 51.6 % had mentored occupational therapy assistants; and
- 25.3 % had mentored another health professional.

As time spent mentoring a protégé is an important element of the mentoring relationship, mentors were also asked to estimate the average time per month that they spend, or have spent, mentoring a protégé. The mentors were given the following categories to choose from: less than one hour, two to five hours, five to 10 hours, and more than 10 hours. The highest number of mentors (n=40; 44 %) spent two to five hours per month in mentoring activities (Table 11).

Table.11 Time spent mentoring

Time spent mentoring	<u>n</u>	%
Less than 1 hour	5	5.5
2 to 5 hours	40	44.0
5 to 10 hours	26	28.6
More than 10 hours	20	22.0

Mentors were given a list of 14 possible reasons for becoming a mentor and asked to determine the importance of these reasons using a Likert scale, with 1 representing "not at all important" to 5 being "extremely important". Table 12 lists these reasons from most to least important. In this table, mentoring functions are grouped into two categories, instrumental functions and psychosocial functions. As discussed in the literature, often mentoring functions reflect these two broad categories (Pan & Mutchler, 2000). The highest mean score was "to maintain professional standards", which is an instrumental function; and the next two highest mean scores were "to experience satisfaction" and "to invigorate a spirit of community", which are psychosocial functions. Discussion of the open comments accompanying the responses appears below.

- Many of the open comments reinforced the theme of profession passion; for example: "To ensure continuity of professional excellence." "To facilitate professional growth, 'pass the torch' of professional passion." "To enhance the professional growth of O.T. and maintain a high standing professional image of O.T."
- A number of comments focused on a sense of professional responsibility, for example: "Because it is not a choice to mentor or not to mentor. It is a professional responsibility. "If we are to enjoy the benefits of professional status and self-regulation then there must be a mechanism to perpetuate this, we are not the slaves of collective agreements and the myths of more information will meet every need." "Professional responsibility, professional development (mentor also learns from protégé), team and network building, promote O.T."

- Other comments focused on a desire to help the protégé, "I believe the majority of new therapists are a bit insecure at first and just need a helping hand to reassure them, help develop their clinical skills, and ensure their self-confidence in themselves." "Sympathy, remembering what it felt like to be new and bewildered prompts me." "To support and encourage another, to assist to succeed." "To help others- I remember being a new grad and many people not giving me the time."
- Others spoke of facilitating lifelong learning, "To inspire others towards being better O.T.'s, to learn new approaches, get a different perspective, foster an atmosphere of learning."

Table.12 Reasons for becoming a mentor

Reasons for becoming a mentor	Mean Score	SD
<i>Instrumental Functions</i>		
To maintain professional standards	3.91	1.06
To pass on my ideas to others	3.25	.93
To fulfill job responsibilities	3.24	1.23
To recruit people to region	2.66	1.26
To enhance my professional status	2.19	1.12
To achieve success vicariously	1.83	1.12
<i>Psychosocial Functions</i>		
To experience satisfaction	3.67	.98
To invigorate a spirit of community	3.35	1.14
To pass on the mentoring tradition	3.18	1.34
To repay past mentors	2.34	1.28
To make friends	1.53	.81
To make future favors more likely i.e. social exchange	1.38	.74

Development of Mentoring Relationships

This section pertains to functions that encourage mentoring relationships. The first question asked therapists if the 'suggestion' that senior therapists have a 'responsibility' to mentor junior therapists, and therapists (junior and senior) have a 'responsibility' to mentor restricted practitioners was a necessary or unnecessary suggestion. More than half indicated (n=83; 56.1 %) that their responsibility was very necessary and nearly one-third (n=48; 32.4%) indicated it was somewhat necessary. When asked if it was necessary for occupational therapists (senior, junior) to mentor other occupational therapists (junior, restricted practitioners), 88.5 % felt it was somewhat or very necessary and 11.5 % thought it was not at all necessary.

As evidenced by the following comments, many therapists voiced strong support for senior therapists mentoring junior therapists, and therapists (junior and senior) mentoring restricted practitioners:

- "Not all occupational therapists need to be reminded of their responsibility to the profession; however, some do and that would make the suggestion necessary."
- "It's important for occupational therapy as a profession that all therapists feel supported in their roles. Team cohesion develops from these types of relationships as it highlights communication and facilitates personal growth for all parties."
- "Part of being a professional is a willingness to share knowledge and skills with others to enhance the quality of service (O.T.) our clients receive. Under the legislation (O.T. Professions Act) there is a legislated requirement for mentors for restricted practitioners or they cannot work in Alberta; thus rendering them unemployable plus adding to the acute shortage of occupational therapists providing

service to Alberta. It's incredibly important during times of health care and service delivery change to have new occupational therapists develop a professional network for ongoing support and learning."

- "There is much value in experience – maybe especially in occupational therapy where primarily theory is taught at school and application is developed through work experience."
- "As new grads, we have a lot to learn in order to be successful occupational therapists, without mentors our likelihood of succeeding is significantly less."

A number of therapists supported the suggestion that senior therapists mentor junior therapists, and therapists (junior and senior) mentor restricted practitioners, but did not want to limit the mentoring relationship to only senior- to- junior relationships. For example, respondents commented as follows:

- "A mentor provides many important functions, besides providing knowledge in an area of practice, which either a senior or junior therapist can provide."
- "One would think the senior therapist has more experience and knowledge in that clinical area that the junior therapist can draw upon. On the other hand, the junior therapist may be more knowledgeable with newer treatments, etc."
- "Mentorship is possible in an equal relationship, not necessarily senior- to- junior therapist or restricted practitioner."

A few therapists were opposed to the suggestion of having senior therapists mentoring junior therapists, and therapists (junior and senior) mentoring restricted practitioners,

possibly because they disagreed with the definition of mentoring. Their comments appear below.

- "In the true definition of mentorship this is contraindicated as the relationship should be non-hierarchical. In some situations this informally occurs which is congruent with mentorship."
- "Not all therapists will be able to build the relationship required to act in a mentoring role – if mentoring becomes a "must" or a "requirement" for continuing practice the true qualities of mentoring may be lost or jeopardized."
- "I wouldn't say they have a responsibility to mentor. They have a responsibility to pass on work related knowledge and give resources, etc. but mentoring means more than that and not everybody can be a mentor."

Therapists were also asked if they felt mentoring was a "realistic expectation." The largest number (n=77; 51.3%) selected a response of very realistic; the next largest number (n=60; 40%) selected the response of somewhat realistic. In total, 91.3% of the respondents felt it is a somewhat to very realistic expectation for therapists to participate in mentoring activity. Only 13 respondents (8.7%) thought mentoring activity was not a realistic expectation for occupational therapists.

There was very strong support for mentoring being a realistic expectation, as evidenced by comments such as the following:

- " Time is always a factor but the value taken out for facilitating these types of processes far outweighs this."

- "This is one of the most important roles as occupational therapists – is to transcend profession- role modeling skills and compassion to others."
- "There are times when a junior therapist is a sole charge therapist. Here long distance mentoring would be very helpful."
- "We all started by learning from others... we need the circle to continue."
- "I think it may take time, but the benefits to the profession, the public, and the individual make it worthwhile."

Although there was strong support for mentoring, the open comments contained many concerns related to administrative support, scheduling time, and heavy caseloads; for example:

- "Supervisors (non-O.T.) may not believe in the ideal."
- "Could be interpreted by some to be just one more thing that I don't have time for, this could leave the protégé feeling like a burden if the mentor is not willing of his/her own volition."
- "Not always possible given small regions, remote areas, expanding scope of practice, emerging O.T. roles, etc."
- "Unfortunately we are not supported or recognized for "non-patient" activities by management."

- "It seems natural that a staff member that has experience with a facility would become a mentor to new staff, but it isn't always the case."

There were also a small number of therapists who felt the expectation for mentoring activity was not realistic, as evidenced by the following comments:

- "No time, I don't even know everybody in the department, don't think you can say, will you mentor me. It develops when two people really relate well and the mentor has the inclination and time to foster it."
- "It would be nice and would be appreciated, but has proven both impractical and not feasible."

Therapists were asked to consider the following scenario: a therapist comes into your office and asks you about entering into a mentoring relationship. They were asked to consider what factors were important in guiding them in the decision of whether they should develop a mentoring relationship. Eleven factors were provided with space to write additional considerations (see Appendix, Page 10, Q25a & b). Respondents were asked to indicate the importance of each of these factors using a Likert scale with 1 representing "not at all important" to 5 being "extremely important". Responses are listed in Table 13 in descending order from most important to least important.

The top consideration, "an open, teachable attitude toward learning," is related to the instrumental function of mentoring, and the second and third considerations, "value peer relationships" and "personal compatibility" reflect psychosocial functions of mentoring. The open comments added considerations related to common expectations and mutually agreed

upon mentoring goals, clear expectations regarding time, and protégé characteristics such as initiative, enthusiasm, and a dedicated work ethic. The following comments were included:

- "Mutual respect and similar thinking."
- "Both parties must be open and honest about expectations from this relationship and agree upon objectives."
- "Common expectations of time." "Agreement to time constraints, i.e. work out reasonable system for touching base, feedback, etc."
- "Logistically possible i.e. either working in close proximity or have access to reliable method of communication."
- "Time availability and support from upper management."
- "Having some time for this relationship and being acknowledged that this relationship exists by management."
- "Enthusiasm towards profession and dedicated work ethic."

Table.13 Guiding criteria for developing a mentoring relationship

Guiding criteria for developing a mentoring relationship	Mean Score	SD
Have an open, teachable attitude toward learning	4.49	.68
Value peer relationships	3.51	.99
Personal compatibility	3.51	1.04
Mutual emotional commitment	3.42	1.03
Shared professional goals	3.37	1.07
Same clientele served	2.99	1.09
Work in the same region	2.97	1.24
Work in the same organization	2.55	1.24
Same gender	1.27	.62
Around the same age	1.25	.62
Same race or cultural background	1.05	.28

Barriers to Initiating/Maintaining a Mentoring Relationship

Many researchers indicate that certain aspects of mentoring might be uncomfortable within a mentoring relationship. Therapists were asked to identify which of the following factors they saw as potentially uncomfortable within a mentoring relationship. The factors presented were power/dependency issues, fears about self-disclosure, cultural differences, and sexual tension. The following results were obtained:

94.8 % felt power/dependency issues could be uncomfortable,

75.4 % felt there might be fears about self-disclosure,

52.1 % felt sexual tension might be uncomfortable, and

27 % felt cultural differences may be uncomfortable.

When therapists were asked to identify other aspects of mentoring that might be uncomfortable, their comments included the following:

- "Fears about appearing inadequate." "Things are not as they seem i.e. insecurity."
- "Protégé does not agree with or feel comfortable with suggested course of action by mentor."
- "Competency of the young therapist when observing a mentor who is quite good as an O.T.; the feeling of I'll never be that good."
- "It can be uncomfortable to receive constructive criticism." "Mentor's inability to give constructive criticism and suggestions."
- "Fear that you may disappoint your mentor."
- "Communication skills and learning styles."

A number of therapists within the focus groups discussed heightened awareness of financial costs and the value of service, which has resulted in the reduction of collaboration among organizations. Distance education technology may reduce the barriers of time and distance; however, competition among facilities within a region as well as between regional health authorities may limit the effectiveness of technology supporting long distance relationships.

Liability concerns arose from discussions in the focus groups. Therapists felt these concerns would cause barriers to supporting mentoring relationships through distance education technology. One therapist stated, "in terms of liability issues what I've learned this year, I'd be very, very reluctant not to have that person work in the same facility as me, never mind in the same region" (Group A, #297-302). Another stated, "the other thing I think you need to consider is if you're acting as a mentor in specific regards to a restricted

practitioner, you need to sign off on all charts. It's your license that's on the line yet I think you need to be close so you know exactly what's going on" (Group A, #269-276).

Career pressures may impact the mentoring relationship. Therapists were given a list of 34 conditions (see Appendix F, page 13, Q30a) and asked to indicate to what extent these conditions might affect the development and maintenance of mentoring relationships among therapists. They rated the importance of these conditions using a Likert scale from 1 "not at all important" to 5 "extremely important." Table 14 lists the mean scores and standard deviations in descending order. The top two career pressures are related to workload, i.e., "heavy workload" and "large client caseload". The next two career pressures, "poor communication" and "unwillingness to serve as a mentor," are related to psychosocial skills and perceptions.

A Factor analysis was also used to further analyze career pressures for occupational therapists in Alberta. Six factors were identified with an eigenvalue over 1.3, together these factors explain 60.5 % of the variance in career pressures.

Factor I had an eigenvalue of 9.85, explaining 28.99 % of the variance. This factor identified "psychosocial issues" which included (a) unrealistic expectations, with a loading of .801, (b) unwillingness to serve as mentor, with a loading of .791, (c) poor communication skills, with a loading of .745, (d) potential of a bad match, with a loading of .705, (e) personal problems, with a loading of .619, and (e) problems in taking initiative, with a loading of .600.

Factor II had an eigenvalue of 3.35, explaining 9.84 % of the variance. This factor identified "lack of structure for mentoring activity" which included (a) no formal development or training for mentoring, with a loading of .834, (b) unsure of how to mentor,

with a loading of .776, (c) lack of an organized, formal mentoring program in place, with a loading of .763, (d) lack of knowledge about the mentoring process, with a loading of .758, (e) no prior experience in a mentoring relationship, with a loading of .689, (f) lack of awareness about mentoring process, with a loading of .523, and (g) no institutional value placed on mentoring, with a loading of .503.

Factor III had an eigenvalue of 2.38, explaining 7.01% of the variance. This factor identified "insecurities" which included (a) emphasis on being experts, with a loading of .705, (b) fear of opening up to another person in an honest way, with a loading of .644, (c) humility and freedom to admit need, with a loading of .608, and (d) individualistic/competitive mindset, with a loading of .594.

Factor IV had an eigenvalue of 2.03, explaining 5.96 % of the variance. This factor identified "personal life demands" including (a) demands from the local community, with a loading of .756, (b) responsibilities for my family or personal network, with a loading of .712, and (c) demands from my supplemental work involvement, with a loading of .663.

Factor V had an eigenvalue of 1.60, explaining 4.71 % of the variance. This factor identified "fears" including (a) fear that the protégé may leave the organization after a great deal of time/effort, with a loading of .733, (b) mentor may feel threatened by talent and ambition of protégé, with a loading of .684, and (c) mentor may not want to be held responsible for the performance of the protégé, with a loading of .671.

Factor VI had an eigenvalue of 1.35, explaining 3.98 % of the variance. This factor identified "heavy workload" including (a) large client caseload, with a loading of .917, (b) large client caseload, with a loading of .907, (c) committee work, with a loading of .292, and (d) high rate of turnover, with a loading of .255.

Table.14 Career pressures that affect mentoring relationships

Career pressures	Mean Score	SD
Heavy workload	4.31	.78
Large client caseload	4.20	.83
Poor communication skills	4.08	1.10
Unwillingness to serve as a mentor	4.03	1.19
Demands from work-outside of work hours	3.78	1.08
Unrealistic expectations	3.76	1.09
No institutional value placed on mentoring	3.62	1.22
High rate of turnover	3.61	1.17
Problems in taking initiative	3.60	1.05
Potential of a bad match	3.55	1.12
Limited number of therapists with significant age, experience, expertise to be mentors	3.54	1.14
Individualistic/competitive mindset	3.54	1.22
Humility and freedom to admit need	3.49	1.05
Lack of skills in negotiating workload, time off, etc.	3.46	1.11
Travel distance	3.37	1.08
High task performance expectations leave little time for developing personal relationships	3.36	1.05
Emphasis on being experts	3.35	1.23
Responsibility for my family or personal network	3.34	1.23
Lack of awareness about mentoring process	3.32	1.02
Personal problems	3.29	1.24
Fear of opening up to another person in an honest way	3.24	1.13
Committee work	3.23	1.12
Lack of knowledge about mentoring process	3.16	1.04
Social isolation	3.11	1.19
Mentor may not want to be held responsible for the performance of the protégé	3.09	1.13
Demands from my supplemental work involvement	3.03	1.07
Unsure of how to mentor	3.01	1.14
No prior experience in a mentoring relationship	2.98	1.13
Lack of an organized, formal mentoring program in place	2.98	1.26
No formal development or training for mentoring	2.87	1.20
Demands from the local community	2.80	1.08
Fear that the protégé may leave the organization after a great deal of time and effort	2.68	1.22
Mentor may feel threatened by talent and ambition of the protégé	2.64	1.12
Lack of funds for stipends and/or substitute wages	2.43	1.15

Supporting Mentoring Relationship Using Distance Education Technology

In Alberta, the distance between therapists may be vast, particularly in rural regional health authorities. Therapists were asked if they felt a mentoring relationship could be supported through technology such as the telephone, teleconference, email, electronic bulletin board, and online audio/video conferencing. They were also asked to evaluate how realistic it was to use various media to support mentoring relationships, using a Likert scale ranging from 1 "not at all realistic" to 5 "extremely realistic." As shown in Table 15, email was considered the most realistic medium for supporting mentoring relationships (n=146; mean 3.64).

Table.15 Realistic media for supporting mentoring relationships

Realistic Media	Mean Score	SD
Email	3.64	1.02
Telephone	3.49	1.02
Online audio/video conferencing	2.87	1.14
Chat - synchronous	2.78	1.00
Teleconference	2.77	1.08
Electronic bulletin board - asynchronous	2.46	1.01

Feasibility of Supporting Mentoring Relationships through Distance Education Technology

Access to and comfort with technology are two important factors when considering the feasibility of supporting mentoring relationships with distance education technology. The majority of respondents (93.7%) had a computer at home; 87.4 % had a Windows-based personal computer, and 6.2 % had a MacIntosh computer. As technology is ever

changing, it may be challenging for computer users to keep pace and to upgrade their computers every few years to enable access to the latest programs. Of the 150 respondents, 42 % have computers that were manufactured in the last two years.

Internet access is necessary for participation in email communication, asynchronous bulletin boards, chat groups, and participation in online courses. Of the respondents, 74.3 % had a home Internet connection. As most therapists would prefer to maintain their mentoring relationship during work hours it is optimal to also have an Internet connection at work. Of the respondents, 85.8 % indicated they had a work Internet connection.

Comfort with technology is an important element when considering use of technology to support distance relationships. Therapists were asked how frequently they used computers using a Likert scale with 1 representing "not at all " to 5 being "extremely frequent". From 150 respondents, the mean score was 4.47 with a standard deviation of .903. Therapists were then asked how comfortable they felt using computers, with 1 representing "not at all comfortable" to 5 being "extremely comfortable. The mean score of comfort was 3.97 with a standard deviation of 1.068.

To gain a better understanding of the therapists comfort level with computer uses, the researcher asked therapists to quantify their level of comfort with various media, Table 16 presents the mean scores and standard deviations in descending order. The respondents identified that they are most comfortable with email.

Table.16 Comfort level in various computer activities

Computer use for:	<u>Mean Score</u>	<u>SD</u>
Email	4.24	.96
Internet search	3.35	1.10
Electronic bulletin board	1.58	.97
Online audio/video conferencing	1.56	.97
Chat	1.39	.87

Correlational analysis was conducted to examine the relationship between the following variables: having a mentor; gender; age; work status; region of work, work facility; years in the field; position of work; computer access; computer manufactured in the last two years; home internet connection; and work internet connection. A significant correlation was found between "currently or have had a mentor" and "having a work Internet connection"(Pearson's R= .198, $p < .05$) and (Pearson's Chi-square = 12.72, $p < .05$).

A t-test was conducted to examine the difference between urban respondents and rural respondents in relation to "frequency of computer use" and "comfort in computer use". A significant difference was found between the urban therapists and the rural therapists in "frequency of computer use" ($t = 2.43$, $df = 135$, $p < .05$). A significant difference was also found between the urban therapists and the rural therapists in "comfort in computer use" ($t = 3.25$, $df = 135$, $p < .001$).

CHAPTER V

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to explore the nature of mentoring and the reasons why individuals seek mentoring relationships, and to examine how mentoring may be supported through distance education technology. In Phase One, a qualitative study was conducted to identify key themes and questions. In Phase Two, the quantitative approach was used to answer the research questions and construct knowledge surrounding the themes identified in Phase One. This chapter provides a review of the results of this study. It is divided into three parts, discussion of findings, implications, and recommendations for further research.

Discussion of Findings

Demographic data were collected to gain an understanding of the respondents. Of those who indicated their region of work, 42.5% were from urban regions, and 57.5% were from rural regions. This representation is close to the proposed sample of 50% representation from urban regions and 50% representation from rural regions. Eighty-seven percent of the sample was female, which parallels the larger population of registered occupational therapists in Alberta. Forty-five percent of the sample was from the age group 25 – 34 years, and 30% was from the age group 35-44 years, together representing 75 % of the respondents. Sixty-seven percent of the sample currently worked full-time. Fifty-nine percent had worked in the field for ten years or less. These demographic characteristics closely resemble the demographics from Bohannon's study (1985) where he cited that 60% of physical therapists had worked less than ten years, resulting in reduced access to available, experienced therapists to mentor in a traditional mentoring relationship.

Characteristics of a Successful Mentoring Relationship

Five research questions focused this study. The first question was a global question asking, "What are the characteristics of a successful mentoring relationship?" The first step to exploring this question was to ascertain the familiarity of occupational therapists with the concept of mentoring, and then to explore the models and meaning of mentoring relationships. Mentoring is clearly a familiar concept to occupational therapists as 92% of the respondents indicated they had or have had a mentor.

Three key characteristics of a mentoring relationship arose from the focus group participants. Mentoring relationships involve open communication, trust, and respect between the mentor and protégé. Other characteristics identified of a mentoring relationship are facilitating, motivating, supporting, partnering, understanding, shared problem solving, validating, appreciating, and comforting. Throughout the focus groups, it was evident that many of the descriptors reflect a psychosocial function. Instrumental functions were discussed, but not as frequently.

As the focus groups progressed, it became apparent that there is no one definition of a mentoring relationship, which is agreed upon by all occupational therapists. Lack of clarity in the definition of mentoring is not restricted to the field of occupational therapy. As Gibb (1999) notes, "the nature and number of activities linked to the concept and practice of mentoring seems to be growing everyday" (p.1055).

Types of Mentoring Relationships

A number of researchers have designed developmental models where the mentoring relationship goes through various stages from initiation to termination (Kram, 1983; Gray & Gray, 1985; Egan, 1990). These models tend to represent a traditional relationship in which

a senior, more experienced individual mentors a junior, less experienced individual in a dyadic relationship. The intensity of the relationship usually limits the mentor and protégé to involvement in only one mentoring relationship at a time (Nolinske, 1995).

Differences in theories raise potential controversies, as Darwin (2000) suggests developmental models lose their potency in unstable, changing times. Clinton & Clinton (1991) suggest one person is not able to meet all of an individual's need. They propose a mentoring continuum, which reflects multiple mentors. These differences raise important questions. Is a mentoring relationship between a senior and junior, or may it be between peers? Is a mentoring relationship a dyadic relationship or a group relationship? Can protégés have only one mentor at a time or may there be multiple mentors? As focus group participants discussed these questions, it became apparent that many felt that the definition of a mentoring relationship depended on the individuals involved, the circumstances, and the environment. Some felt that therapists may have different mentoring relationships at different points in their lives for example, a new graduate may choose only one mentor, a senior therapist, who is willing to be involved in a dyadic mentoring relationship. With experience, the once new graduate may have a number of peer mentoring relationships later in her career when looking for diversity of ideas, approaches, and expertise.

Results of the survey indicate no substantial preference between peer mentoring (45.8%) and junior-to senior mentoring (54.2%). Benefits cited for peer mentoring include an increase in comfort level for the protégé and increased opportunities for finding eligible mentors. Benefits cited for junior- to- senior mentoring include enhanced ease and/or ability to provide constrictive criticism, and greater experience and resources for the senior mentor to share. These findings suggest that a substantial number of occupational therapists seek junior-to-

senior mentoring relationships, despite the tumultuous times in healthcare. These findings vary somewhat from Darwin's study (2000), which suggested that individuals seek multiple peer mentoring relationships during times of change. Further support for the hierarchical relationship is reflected in the relative low importance of "a collaborative relationship," which respondents identified when presented a list of ideal mentor functions. .

Similarly, the results suggest no substantial preference between one mentor at a time (50.4%) versus multiple mentors (49.6 %). Benefits cited for one mentor at a time include consistency and reduced fragmentation; benefits for having multiple mentors include a diversity of ideas, approaches, and expertise, as well as the opportunity of sharing resources.

However, a substantial preference was evident for dyadic relationships (80.5%) over group relationships (19.5%). The need for personalized psychosocial support was also very evident throughout the focus groups. Identified benefits of dyadic mentoring include increased accountability and intensity within the relationship, increased comfort level in asking questions, and enhanced structure. The benefits of group mentoring were related to diversity of ideas and opinions.

Further exploration is needed to determine if occupational therapists experience a continuum of mentoring relationships. For example, a restricted practitioner joins the workforce and at the same time benefits from a single, mentoring relationship with an older, more experience therapist. This dyadic relationship will provide a consistent base of support and will provide clarity and structure for the development of instrumental skills. The mentor is willing to provide adequate time and energy to build a strong relationship, to which she is accountable. As the protégé gains experience she will have more to offer the relationship, and would like to try options that the mentor may not consider, and will also offer knowledge

and experience which the mentor will benefit from, this relationship is evolving into a peer, dyadic, yet still one mentor at a time relationship. As the therapist continues to grow personally and professionally, she may seek ideas from different therapists, evolving to a peer mentoring relationship, which involves multiple mentors, yet these relationships still occur one at a time. The therapist thrives on diversity and would like to be involved in brainstorming and problem solving as a group, she also would like the support of therapists potentially in a common practice area, so she participates in group mentoring. Group mentoring may occur anytime; however, is supplementary, rather than exclusionary to a one to one mentoring relationship.

Commonalities with Mentoring Relationships

Commonalities within a mentoring relationship were also analyzed. In general therapists felt that mentoring another therapist in the same region, facility and practice area were ideal. These preferences are reflected in current practice, where 93% of the mentoring relationships are in the same region, 83% are in the same facility, and 78% are in the same practice area. Discussion occurred regarding the practicality of these commonalities and the potential limitation to mentoring activity if these preferences are precedent setting, particularly in rural regions.

As the occupational therapy profession is predominantly female, it is not uncommon to work in a department of only women. Not surprising, 87% of the respondents reported mentoring relationships among the same gender. However, therapists did not feel that gender affected mentoring relationships. Similarly, 74% of the respondents indicated they had mentoring relationships with individuals of the same cultural background. Although therapists did not consider differences in cultural background to be a negative factor affecting

mentoring relationships, they did think that it was important to be aware of the potential influences on a relationship. These influences discussed were related to language, communication styles, customs, and social class. Cross-cultural mentoring may be optimized if both parties are familiar with the partner's cultural needs and preferences. Despite the majority of mentoring relationships currently reflecting homogeneity, occupational therapists felt heterogeneous relationships are also successful and desirable. Generally, therapists do not want to limit mentoring relationships to only homogeneous relations.

Characteristics of a Successful Mentor/Protégé

To understand the mentoring relationship, it is important to define the role of a mentor and protégé. As the mentoring relationship is complex, so too is the role of a mentor.

Critical behaviours identified in the focus groups fit within the two dimensions of psychosocial and instrumental functions. Psychosocial functions included effective communicator, encourager, and supporter. Instrumental or career functions included role model, guide, teacher/facilitator, and ambassador.

Triangulation was employed by reviewing the functions identified in the focus groups together with an analysis of the means and factor analysis of the survey data, thereby developing a pattern of mentor functions and behaviours. The three factors identified in the factor analysis can be divided into the psychosocial function of "caring communicator," and the instrumental functions of "practice advisor" and "career guide."

- The practice advisor involves "constructive criticism and honest feedback," which had the highest mean score. The focus group participants emphasized the importance of being a "role model", which had the second highest mean score.

- The caring communicator involves "willingness to share time", which had the third highest mean score and "belief in capabilities", the fourth highest mean score.
- The third factor "career guide" includes similar characteristics described in the focus group such as career guidance and ambassador (introduction to professional network, nomination for important awards, and introductions to persons who could further career).

As the role of a mentor is a complex, multi-dimensional role, therapists may benefit from having a training guide discussing the desirable functions/behaviours of a mentor. The top 22 functions identified in a comparison of means fits uniformly into psychosocial functions and instrumental functions (Table 17). These functions were also identified in the focus groups, and the majority is incorporated in the three key factors. It may be helpful to emphasize psychosocial functions when training occupational therapists as mentors; currently the guidelines for mentoring restricted practitioners focus primarily on instrumental functions.

Table.17 Ideal Mentor Functions/Behaviours (psychosocial/instrumental)

Psychosocial Functions	Instrumental Functions
<i>Encouraging Communicator</i>	<i>Practice Advisor</i>
Willingness to share time	Constructive criticism and honest feedback
Belief in capabilities	Role model
Facilitates active learning	Help making difficult professional decisions
Encouragement & coaching	Help with skill development
Flexibility, allow protégé to do things differently	Help with integrating theoretical principles with practice
Keen interest in having the protege succeed	Help with therapy practice
Inspiration	Advice about resources, vendors, etc.
Promotion of an equal and collaborative relationship	Information re: organizational policies and procedures
Caring, committed relationship	<i>Career Guide</i>
Informed advice about people	Introductions to professional network
	Career guidance

The role and function of the protégé is also very important for the success of a mentoring relationship. Based on feedback from the focus groups and analysis of survey findings, the following behaviours reflect a successful protégé: openness to feedback and advice, willingness to learn, desire to grow, self-assessment skills, and respect for the mentor.

Precipitating Reasons for Seeking a Mentoring Relationship

The second research question asked, "What are the precipitating reasons for an occupational therapist to seek a mentoring relationship?" Focus group participants identified many reasons, such as role strain in relation to limited resources (i.e., time, people), need for support, professional growth, being new to the profession, shared problem solving, need for validation, isolation, being a generalist, being new to a practice area, to fulfill lifelong

learning, and to be recharged. Factor analysis identified three key factors as precipitating reasons for seeking a mentoring role. Isolation and restricted access to resources accounted for 45% of the variance, being new to the profession or new to a practice area accounted for 12% of the variance, and role strain related to little administrative support and high caseloads accounted for 8% of the variance. In total these three factors accounted for 65% of the precipitating reasons for seeking a mentor. The top four predisposing reasons as identified by comparison of means were being new to the profession, being a restricted practitioner, being new to a practice area, and isolation. All 12 precipitating reasons had a mean score over 3 (indicating fairly important to extremely important), therefore, all factors may be considered as reasons for occupational therapists to seek a mentoring relationship.

Initiating and Maintaining Mentoring Relationships

The third research question asked, "What are the barriers to initiating and maintaining mentoring relationships among occupational therapists in Alberta?" To further explore this question, the researcher first looked at how mentoring relationships are initiated and what motivates therapists to enter such relationships. The initiation of mentoring relationships seems to vary with the individual and circumstance. The most common form of initiation, from both a mentor's and a protégé's perspective, is through "mutual initiation." The second most common method is as an "assigned role"; this choice may be related to the requirement to mentor restricted practitioners as stated in the Occupational Therapy Act. The Alberta Association of Occupational Therapy together with the potential employer facilitates the initiation of mentoring relationships for restricted practitioners. Considerably fewer relationships were initiated either by the mentor or the protégé. A number of therapists also spoke of informal mentoring relationships, which seem to evolve without a specific

identification of being a "mentoring relationship." Many therapists emphasized that mentoring activity should be on a voluntary basis. Yet, a number of therapists had concerns that, if mentoring activity was not structured in some way, it may not happen. Further exploration is required to examine the following questions: Is there a need for an infrastructure to support mentoring activity at an institutional level, regional level, and provincial level? If a formal infrastructure is not required, how might an environment look which fosters natural, informal mentoring relationships? Is this environment possible in today's health care system?

Mentors were asked what reasons they held for taking on a complex, multi-dimensional role such as mentoring. Survey results indicated that the top three reasons were to maintain professional standards, experience satisfaction, and invigorate a spirit of community. Again these reasons can be categorized into psychosocial and instrumental functions. Maintaining professional standards is an instrumental function. Experiencing satisfaction and invigorating a spirit of community are psychosocial functions.

Gibb (1999) theorized about "virtuousness" in relation to mentoring. He compared "social exchange" and "communitarism," concluded neither theory in itself could explain success or failure within a relationship and suggested the need to consider duality of both elements. In the survey, occupational therapists gave communitarism (i.e., to invigorate a spirit of community) a mean score of 3.35, and social exchange (i.e., to make future favors more likely) a mean score of 1.38. This difference reflects that therapists seem to place more emphasis on mentoring to invigorate a spirit of community among therapists, rather than to increase the likelihood of future favors for oneself, at least on a superficial level.

When asked to consider the guiding criteria they use when deciding to enter into a mentoring relationship, the top five criteria were as follows: (a) having an open, teachable attitude, (b) value peer relationships, (c) personal compatibility, (d) mutual emotional commitment, and (e) shared professional goals.

Barriers to Initiating and Maintaining a Mentoring Relationship

When asked if therapists had a responsibility to mentor, 88.5% responded yes, and 91.3% responded that it was a realistic expectation. However, only 62% of the respondents stated they currently are or have acted in a mentoring role. What creates this difference in opinion and practice?

Focus group participants spoke of potential barriers to the initiation and maintenance of mentoring relationships. They identified barriers such as lack of awareness and support for mentoring from management, lack of structure, high workloads, time limitations, personality differences, staff turnover, scheduling difficulties, geographic distances, lack of available, experienced occupational therapists, complacency, poor access to and comfort with technology, liability concerns, facility/regional competition, and discomfort in sharing a need for mentoring. Survey respondents identified potential uncomfortable situations as follows: 94.8% power/dependency, 75.4% self-disclosure, 52.1% sexual tension, and 27% cultural differences. Other areas of discomfort were identified as feelings of inadequacy, insecurity, and disagreement between protégé and mentor.

A list of 34 career pressures was also analyzed. The top four pressures were heavy workload, large client caseload, poor communication skills, and unwillingness to serve as a mentor. Factor analysis identified the following six factors: (a) psychosocial issues, (b) lack

of structure for mentoring activity, (c) insecurities, (d) personal life demands, (e) fears, and (f) heavy workload. In total, these factors account for 60% of the variance.

Supporting Mentoring Relationships through Distance Education Technology

The fourth research question asked, "How can a mentoring relationship be supported through distance education technology?" Just as therapists held various opinions about what a mentoring relationship consisted of, they also held different opinions on how a mentoring relationship could be supported. A number of focus group participants felt that face-to-face mentoring needed to be the primary medium; while others felt face-to-face time was only needed to develop the relationship after which the relationship could be supported primarily through distance education technology. Still others felt mentoring relationships could be supported entirely through distance education technology, depending on the purpose of the relationship.

Focus group participants established that email and the telephone were the most popular media for mentoring. Other media currently used for mentoring included videoconferencing through Telehealth, and less frequently, chat and electronic bulletin boards. An analysis of the survey data identified email as the first choice, the telephone as second choice, and videoconferencing as third choice for media to support mentoring among occupational therapists.

Feasibility of using Distance Education

The fifth question asked, "Is it feasible to use technology to support mentoring relationships among occupational therapists in Alberta?" Through analysis of the focus group dialogue, it became apparent that at least three factors were important when considering the feasibility of using distance education technology to support mentoring

relationships among occupational therapy. These three factors were therapist preference, access to technology, and comfort with technology.

Many occupational therapists prefer face-to-face visits to support a mentoring relationship; however, a number of therapists are already supplementing these visits with email, telephone calls, and, in some regions, Telehealth conferences. Several therapists expressed a willingness and desire to enhance their mentoring relationships through the use of distance education technology.

Most therapists have access to a computer and have an Internet connection either at home or work. Of the respondents, 93.7 % had a computer in their home, 42 % had a computer that was manufactured in the last two years, 74% had an Internet connection at home, and 86% had an Internet connection at work. Most therapists report using computers frequently or very frequently (generally daily).

Correlational analysis was conducted to examine the relationship between being a mentor and computer use characteristics. The only significant factor was having an at-work Internet connection. Based on the analysis of these data, further exploration is required to assess the degree of mentoring presently occurring through distance education.

A t-test was conducted to examine the difference in frequency of computer use and comfort in computer use between urban and rural respondents. There was a significant difference in both frequency and comfort in computer use. The rural respondents used their computers more frequently, and were also more comfortable with computer use.

Videoconferencing through Telehealth was discussed during the focus groups. Fifteen of the seventeen regional health authorities in Alberta have Telehealth; however, the majority of therapists have not accessed this technology. Some therapists in the Northern health regions

and other therapists in specialized programs in the urban regions are the forerunners in using this technology for networking. It seems that videoconferencing is an area with potential for the support of mentoring relationships, particularly when requiring visual representations to teach instrumental skills.

Comfort level is also important in determining the effectiveness of distance education technology. Survey respondents were generally comfortable with technology (mean score 3.97, SD=1.068; a score of 3.0 being somewhat comfortable and a score of 4.0 being comfortable). To gain a better understanding of the level of comfort, therapists were asked to rate how frequently they used a computer for various activities such as Internet search, email, electronic bulletin board, chat, and online audio/video conferencing. Email had a mean score of 4.24 (very frequently used) and Internet searches had a mean score of 3.35 (fairly frequently used). The other suggested uses all had mean scores below 2.0 (somewhat used to not at all); these activities included bulletin boards, audio/video conferencing, and chat.

The high comfort level and frequent use of email supports the potential use of this distance education technology among occupational therapists in the initiation and maintenance of mentoring relationships. This view is supported by Michkelson (1997), who proposes that e-mail is beneficial for the mentoring relationship as it can support initiating and maintaining dialogue, widening networks, written expression and reflection, critiquing draft material, informing a wider group, sign-posting and negotiating. If asynchronous or synchronous audio/videoconferencing were to be used, training will be required to enhance the knowledge and comfort level among occupational therapists.

Implications

Develop infrastructure

Many therapists voiced a concern for lack of awareness and support of mentoring activity. Although they do not want mentoring activity to be compulsory, they would like support from employers in developing informal mentoring relationships, by acknowledging the need for mentoring and the provision of time and potential technology to nurture these relationships.

Chance encounters and unplanned learning may be very effective, but often not very efficient, particularly when there is an imperative to learn skills and become proficient in a specific area. The display of institutional support for mentoring could potentially increase efficiency in the development and ongoing maintenance of lifelong learning.

Dagenais (2001) suggests when planning the development of successful mentoring programs, the following five dimensions are important to consider: program scope, mentoring incentives, mentor training, mentor selection and matching, and assessment and evaluation of the mentoring experience. Considerations of these dimensions would be helpful regardless of the scope of the mentoring program, whether a small, institutional program or a large, provincial program.

When considering the development of a mentoring program, the program scope should be clearly identified, including program expectations, program size and support required. The identification of incentives to move people to mentor should be further explored. Many people feel a responsibility to mentor, but need organizational support i.e., scheduled time. Other meaningful incentives should also be investigated. The mentor-training dimension ought to be explored, as a range of training approaches may be required to meet the diverse needs among occupational therapists. Respondents stated they did not want mentoring to be compulsory with formally assigned mentoring relationships; however, others stated some structure was needed to

facilitate mentoring, particularly in remote areas. An infrastructure to support voluntary mentor selection and matching may be very beneficial for the initiation of mentoring relationships. As with any program, it is important to evaluate the effectiveness of the mentoring program. Assessment strategies should be considered, as well as methods to collect, analyze and evaluate the data.

Consider mentoring preferences

A substantial preference was evident for dyadic mentoring relationships (80.5%) over group mentoring relationships (19.5%). The need for personalized psychosocial support was also evident throughout the focus groups. This preference should be considered when developing an infrastructure for mentoring. Distance education technology, which supports dyadic communication such as email, may be more meaningful than group communication such as chat groups. No substantial preference was shown between one mentor at a time (50.4%) and multiple mentors (49.6%). When considering distance education technology, multiple mentors differ from group mentoring, in regards to the 'timing' of communication. Multiple mentors could be facilitated through asynchronous communication (i.e., email, bulletin board discussion) whereas group mentors could be facilitated through synchronous communication (i.e., chat).

The medium chosen to support mentoring relationships will have benefits and challenges. It is important to consider the trade-offs. Face-to-face relationships facilitate familiar communication styles (i.e., verbal and nonverbal communication) and a hands-on approach. Distance education technology facilitates the opportunity for frequent communication despite barriers of time and distance. Technology such as email enables learning through reflection and interpersonal relationships. The review of email discussions provides a history of the thought development and consideration between mentor and protégé. Videoconferencing enables face-to-

face discussion and demonstrations, but does not enable a hands-on experience. The use of distance education technology varies with the purpose of the activity. Currently there seems to be a lack of understanding in how distance education technology could support mentoring among occupational therapists. Further study is needed to clarify how distance education technology could be used in supporting mentoring relationships.

Facilitate education

Although many occupational therapists have experience in mentoring activity, it appears to be very informal, often incidental mentoring. The definition and description of a mentoring relationship is variable from one therapist to another, and one facility to another facility. Many therapists expressed a desire for more structure and support for mentoring activity. Few others voiced concerns regarding mentoring activity and reasons why they would not mentor.

Therapists need more information regarding the functions of a mentor and protégé, the types of mentoring relationships, the potential benefits, and the limitations of mentoring activity. Training needs to consider how adults learn as well as practice in mentoring.

The potential mentor would benefit from learning about required functions such as establishing rapport and developing trust, facilitating active learning, providing constructive feedback, negotiating plans, and using techniques to gradually reduce assistance while the protégé constructs new knowledge.

The potential protégé would benefit from learning about functions such as how to reflect, how to formulate questions, and how to seek advice and follow through.

Joint training of the mentor and protégé may be beneficial to review needs assessments, goals of program, roles, joint planning, and strategies to prevent and/or resolve potential barriers.

Overall the benefit of mentor and protégé training needs to be explored by individual therapists, organizations, regional health authorities, and by the provincial association.

Reduce career pressures

The top two career related pressures, which negatively impact mentoring relationships, are heavy workload and large client caseload. Organizations need to consider the quality of life for their employees and the impact of fragmentation and unrealistic workloads on best practice initiatives. Occupational therapy is a diverse profession, struggling to gain recognition for valuable service provision within the health field. A greater understanding of the profession and realistic performance expectations will be helpful in creating an environment, which fosters professional growth and learning.

Optimize use of existing technology

Therapists are aware of the availability of computers at work; however a number are unaware of the availability of other media such as videoconferencing sites through Telehealth. Exploring existing technology options throughout their region would be advantageous for optimizing the use of technology in supporting mentoring relationships.

A number of therapists stated they had access to technology that they didn't know how to use. Time and support is needed for training in available technology to optimize its use in supporting mentoring relationships.

Many therapists prefer to maintain mentoring relationships through face-to-face visits with the protégé. As access and comfort levels increase over the next five to ten years, this preference may change, further exploration in how technology might best support the development of mentoring relationships would be beneficial.

Technology may be more effective in supporting certain mentoring functions more than others. A number of therapists gave examples of providing psychosocial support by means of technology such as email. It seemed that therapists were more uncomfortable providing support for instrumental functions i.e., teaching a particular skill, through technology.

Increase access to technology

If organizations are serious about supporting mentoring relationships across distances, they need to review and enhance the availability of technology and the knowledge level of technology use among employees. Of respondents, 85 % stated they had access to the Internet at work; however further exploration showed that some sites expect 20 to 30 therapists to share one computer. A ratio of this level does not support the active use of technology.

Updegrave (1991) cited six factors, which affected access within the education system. The factors are as follows: lack of desktop access to a computer, lack of typing skills, failure of total work group to be connected and committed, overly complex systems, inappropriate email use, and the perception that fax and voice mail were easier to use and offered the same advantages (as cited in Hughes & Pakieser, 1999). Further exploration is needed regarding additional factors, which impact access to technology.

Recommendations for Future Research

1. Restricted practitioners are formally assigned a mentor, if employed before successfully passing the national occupational therapy or if participating in a refresher program. The national exam is only held one time per year, so if a graduate chooses to work immediately after graduating, they require a mentor for a period of three to four months as legislated in the Occupational Therapy Act. Further exploration is

- required to determine the satisfaction and ideal duration of these assigned mentoring relationships.
2. This study initiated an exploration of occupational therapists' preferences within a mentoring relationship; a continuum of potential mentoring relationships is suggested in this study. Further exploration is required to determine if such a continuum exists throughout the career of occupational therapists.
 3. Ideal mentor functions and ideal protégé functions were identified within this study. A replication of this study is needed with other occupational therapists to determine if these preferences are indeed a reflection of ideal occupational therapy mentor/protégé functions.
 4. Incidental mentoring is closely aligned with professional socialization. Numerous therapists participate in this form of mentoring; however assume incidental mentoring cannot occur at a distance. Further study is needed to determine the potential of incidental mentoring through distance education technology.
 5. Further research is required to identify occupational therapists who are maintaining mentoring relationships through distance education technology. Some therapists suggested nonverbal communication, hands-on experiences, and incidental mentoring would be missing from mentoring relationships supported through distance education technology. Is this perception accurate? Are psychosocial functions more effectively supported through technology than instrumental functions? Further study should examine types of mentoring relationships supported through distance education technology and the mentor functions that are employed when mentoring primarily through distance education technology.

6. The need and value of an infrastructure to support mentoring among occupational therapists requires more intentional examination. If such an infrastructure is beneficial, what might it look like and who should be responsible for the development of the infrastructure?
7. Further exploration is required to determine the impact on liability issues related to mentoring a restricted practitioner through distance education technology. What strategies may be implemented to provide the needed supervision and still meet the requirements of the health information act?

References

- Alberta Association of Registered Occupational Therapists. (1998). *Restricted Practitioner Manual*. Edmonton.
- Alleman, E. (1982) . *Mentoring Relationships in Organizations: Behaviours, Personality Characteristics, and Interpersonal Perceptions*. (Doctoral Dissertation, University of Akron). Dissertation Abstracts International, 43 (1A) , 75A.
- Bates, A.W. (1997) . *Technology, Open Learning and Distance Education*. New York, NY: Routledge.
- Bauer, T.N. (1999) . Perceived mentoring fairness: relationships with gender, mentoring type, mentoring experience, and mentoring needs. *Sex Roles: A Journal of Research*. 40 (3-4) , 211.
- Bent, A. (1999) . Allied health in Central Australia: challenges and rewards in remote area practice. *Australian Journal of Physiotherapy*. 45 (6) , 203-212.
- Bohannon, R. (1985) . Mentorship: a relationship important to professional development. *Physical Therapy*. 65 (6) , 920 – 923.
- Boreen, J., & Niday, D. (2000) . Breaking through the isolation: mentoring beginning teachers. *Journal of Adolescent & Adult Literacy*. 44 (12) , 152.
- Boyd, J. (2000, November) . Firms work to keep women- flex time, mentoring programs intensify retention efforts in IT. *Internet Week*. p. 90.
- Bulstode, C., & Hune, V. (2000) . What is mentoring? *The Lancet*. 356 (9244) , 1788.
- Carden, A. (1990) . Mentoring and adult career development: the evolution of a theory. *The Counseling Psychologist*. 18 , 275-299.

- Cartwright, J. (2000) . Lessons learned: using asynchronous computer-mediated conferencing to facilitate group discussion. *Journal of Nursing Education*, 39 (2) , 87-90.
- Chapman, L. (2000) . Distance learning for post-registered nursing: the facts. *Nursing Standard*. 14 (18) , 33-36.
- Chandler, G. E. , & Hanrahan, P. (2000) . Teaching using interactive video: creating connections. *Journal of Nursing Education*, 39 (2) , 73-79 .
- Clawson, J. (1985) . Is mentoring necessary? *Training and Development Journal*, 39 , 36-39.
- Clinton, J.R. , & Clinton, R.W. (1991) . *The Mentor Handbook*. Altadena, Ca: Barnabas Publishers.
- Creswell, J.W. (1994) . *Research Design – Qualitative and Quantitative Approaches*. Thousand Oaks, Ca: Sage Publications, Inc.
- Cunningham, S. (1995). *The Nature of Workplace Mentoring Relationship Among Faculty Members in Christian Higher Education*. (Doctoral Dissertation, Biola University). UMI Dissertation Services.
- Cunningham, S. (1999) . The nature of workplace mentoring relationship among faculty members in christian higher education. *Journal of Higher Education*, 70 (4) , 441(2).
- Dagenais, R. J. (2001) . *Some Tentative Mentoring Program Standards*. The Mentoring Leadership & Resource Network.
- Darling, L.A. (1985) . "Mentors" and "mentoring". *Journal of Nursing Administration*. 15 (3) , 42-43.

- Darwin, A. (2000) . Critical reflections on mentoring in work settings. *Adult Education Quarterly*, 50 (3) , 197-211.
- Davidhizar, R.E. (1988) . Mentoring in doctoral education. *Journal of Advanced Nursing*, 13 (6) , 775-781.
- Dobbs, B. (2000) . *Conducting Rehabilitation Research*. Edmonton, AB: University of Alberta, Alberta Rehabilitation Continuous Learning Network.
- Duff, C. (2000) . Online mentoring. *Educational Leadership*. 58 (2) , 49-52.
- Egan, G. (1990) . *The Skilled Helper*. 5th ed. London: Constable.
- Galbraith, M.W. , & Cohen, N.K. (1995, summer) . Mentoring: new strategies and challenges. *New Directions for Adult and Continuing Education*. 66.
- Ganser, T. (1996) . Mentor roles: views of participants in a state-mandated program. *Mid-Western Educational Researcher*. 9 (2) , 15-20.
- Ganser, T. , & Koskela, R. (1997) . A comparison of six Wisconsin mentoring programs for beginning teachers. *NASSP Bulletin*. 81 (591) , 71-80.
- Gray, W. A. , & Gray, M.M. (1985, November) . Synthesis of research on mentoring beginning teachers. *Educational Leadership*. 37 – 43.
- Gibb, S. (1999) . The usefulness of theory: a case study in evaluating formal mentoring schemes. *Human Relations*. 52 (8) , 1055 (2).
- Haney, A. (1997) . *The Role of Mentorship in the Workplace, In Workplace Education*. Toronto, Ont.: Culture Concepts. (Eric Document Reproduction Service No. ED 404 573).
- Hayes, E. (2000) . Mentoring and nurse practitioner self-efficacy. *Western Journal Nursing Residence*. 20 (5) , 521-535.

- Holloway (1991) . Qualitative research in nursing. *Journal of Advance in Health & Nursing Care*. 1 (2) , 39-58.
- Horgan, D. (1992) . Multiple mentoring: All of the gain; none of the pain. *Performance and Instruction*, 31 (6) , 20-22.
- Hughes, J. & Pakieser, R. (1999) . Factors that impact nurses' use of electronic mail (e-mail). *Computers in Nursing*, 17 (6) , 251-258.
- Hunt, D.M. , & Michael, C. (1983) . Mentorship: A career training and development tool. *Academy of Management Review*, 8 (3) , 475-485.
- Jones, B.J. , & Schiff, S.J. (1989). *Education & School District Partnership*. (Eric Document Reproduction Service No. ED 329 508).
- Jonson, K. (1998) . Learning the ropes through mentoring. *The Canadian Nurse*, Feb. 27-30.
- Jossi, F. (1997) . Mentoring in changing times. *Training*. 15 , 50-55.
- Kay, R. , & Gehrke, N. (1984) . *Mentoring in the Training and Socialization of Teachers*. Seattle: University of Washington.
- Kaye, B. , & Jacobson, B. (1996) . Reframing mentoring. *Training & Development*. 50 (8) , 44-47.
- Kerka, S. (1998) . *New Perspectives on Mentoring*. U.S.: Ohio. (Eric Document Reproduction Service No. ED 418 249).
- Kielhofner, G. (1995) . *A Model of Human Occupation Theory and Application*. 2nd ed., Baltimore, Maryland: Williams & Wilkins.
- Kling, R.E. , & Brookhart, D. A. (1991) . *Mentoring: A review of Related Literature*. (Eric Document Reproduction Service No. ED 346 095).

- Kram, K.E. (1983) . Phases of the mentoring relationship. *Academy of Management Journal*. 26 , 608-625.
- Kram, K.E. (1985) . Improving the mentoring process. *Training and Development Journal*. 39 , 16-23.
- Kram, K.E. , & Hall, D.T. (1995) . Mentoring in a context of diversity and turbulence. In S. Lobel & D. Kosseck (Eds.). *Managing Diversity*. London: Blackwell.
- Krupp, J.A. (1983) . Mentoring: A means by which teachers become staff developers. *Journal of Staff Development*. 8 (1) , 12-15.
- Krupp, J.A. (1985) . Mentoring: A means of sparking school personnel. *Journal of Counseling and Development*. 64 , 154-155.
- Levinson, D.J. , & Darrow, C. , & Klein, E. , & Levinson, M. , & McKee, B. (1978) . *The seasons of a man's life*. NY: Alfred A. Knopf.
- Lee, L. A. (2000) . Buzzwords with a basis. *Nursing Management*. 31 (10) , 24.
- Le Moal, D. (2000) . Corporate mentoring offers mutual benefits. *First Perspective*. 19 (7) , 19.
- Lindenberger, J. , & Zachary, L. (1999) . Play '20 questions' to develop a successful mentoring program. *Training and Development*. 53 (20) , 12-17.
- Little, J.W. (1990) . The mentor phenomenon and the social organization of teaching. In C.B. Courtney (Ed.) *Review of Research in Education*. (pp. 297-235). Washington, DC: American Educational Research Association.
- Loeb, M. (1995, November) . The new mentoring. *Fortune*. pp. 213.
- Mauch, J. , & Birch, J. (1998) . *Guide to the Successful Thesis and Dissertation*. New York, New York: Marcel Dekker, Inc.

- Merriam, S. (1983) . Mentors and protégés: a critical review of the literature. *Adult Education Quarterly*. 33 (3) , 161-172.
- Mihkelson, A. (1997) . *A Model of Research Mentoring for Higher Education- An Overview*. (Eric Document Reproduction No. ED 418 661).
- Morales-Mann, E.T., & Higuchi, K.A. (1995) . Transcultural mentoring: An experience in perspective transformation. *Journal of Nursing Education*. 34 (6) , 272-277.
- Murray, M. (1991) . *Beyond the Myths and Magic of Mentoring: How to Facilitate an Effective Mentoring Program*. San Fransisco: Jossey-Bass.
- Nolinske, K. (1995) . Multiple mentoring relationships facilitate learning during fieldwork. *American Journal of Occupational Therapists*, 49 .
- Oswald, P. (1996) . *Distance Learning in Psychology: Organizing, Managing and Mentoring*. (Eric Document Reproduction No.: ED 405 024).
- Owens, B.H. , & Herrick, C. A. , & Kelley, J. A. (1998) . A prearranged mentorship program: can it work long distance? *Journal of Professional Nursing*. 14 (2) ,78-84.
- Pan, D.T. , & Mutcher, S.E. (2000) . Mentoring beginning teachers: lessons from the experience in texas. *Policy Research Report*. Southwest Educational Development Laboratory.
- Papalewis, R. (1991) . *Preparing School Administrators for the Culturally & Linguistically Diverse. A Formal Mentor Training Program in Progress*. (Eric Document Reproduction Service No. ED 333 094).
- Robbins, P. (1991) . *How to Plan and Implement a Peer Coaching Program*. Alexandria, V.A.: Association for Supervision & Curriculum Development. (ERIC Document Reproduction Service No. ED 337 881).

- Robbins, P. (1999) . Peer coaching and mentoring. *LOTE CED Lowdown*. 31 , 1.
- Robertson, S. (1992) . *Find a Mentor or Be One*. American Occupational Therapy Association.
- Rodriguez, J. C. , & Brown, G. (2000) . Online mentoring in an undergraduate nutrition education. *Journal of Nutrition Education*. 32 (1) , 60b(2).
- Rogers, J. C. (1986) . Mentoring for career achievement and advancement. *The American Journal of Occupational Therapy*. 40 (2) , 79 – 82.
- Rogers, J. C. (1982) . Sponsorship: developing leadership for occupational therapy. *The American Journal of Occupational Therapy*. 36 (5) , 309 –313.
- Rowley, J.B. (1999, May) . The good mentor. *Educational Leadership*. pp. 20-22.
- Schein, E. (1978) . Socialization and learning to work. *Career Dynamics: Matching Individuals and Organizational Needs*. Mass: Addison-Wesley.
- Shaffer, B. , & Tallarica, B. , & Walsh, J. (2000) . Win-win mentoring. *Nursing Management*. 31 (1) , 32.
- SLA Chapters. (1999) . Mentoring: a key resource to develop professional and personal competencies. *Information Outlook*, 3 (2) , 12.
- Slater, S.C. (1993, May) . Mentoring – an enriching experience. *ASHA*. pp. 55.
- Smink, J. (1999) . *A Training Guide for Mentors*. Clemson, NC: National Dropout Prevention Centre.(Eric Document Reproduction Service No. ED 430 125).
- Smith, S. (2000) . Creating a mentoring culture: smart companies ensure there's someone to give new employees a guiding hand. *Marketing*. 105 (43) , 42-43.
- Stanley, P.D. , & Clinton, J.R. (1992) . *Connecing: The mentoring relationships you need to succeed in life*. Colorado Springs, CO: Navpress.

- Sumner, T. (1998) . *Design Considerations i Developing a Web-Based Mentor Network*. U.S.: New York. (Eric Document Reproduction Service No. ED 433 159).
- Swigger, K.M. , & Brazile, R. , & Byron, S. , & Livingston, A. , & Lopez, V. , & Reynes, J. (1999) . *Real-Time Collaboration over the Internet: What Actually Works?* (Eric Document Reproduction Service No. ED 432 311).
- Thoresen, C. (1997) . Early career support program: telecommunication mentoring for rural teachers. *Journal of Science Teacher Education*, 8 (4) , 283-293.
- Trossman, S. (1998) . Mentoring leads to meaningful relationships, professional growth. *American Nurse*. 30 (2) , 12.
- Valdez, A.M. , & Lund, C.A. (1993) . Mentorship: maslow and me. *The Journal of Continuing Education in Nursing*. 24 (6), 259 – 263.
- Vance, A. , & Davidhizar, R. , & Bechtel, GA. (1997) . The relationship of mentoring to role socialization among academic nurse administrators. *Journal of Nursing Science*. 2 (1-6) , 119-132.
- Weiss, Eileen , & Weiss, Stephen. (1999) . *Beginning Teacher Induction*. US: District of Columbia. (Eric Document Reproduction Service No. ED 436 487).
- Wighton, D.J. (1993). *Telementoring: An Examination of the Potential for an Educational Network*. B.C.: Research Coordinator Education Technology Centre.
- Zey, M. (1984) . *The mentor connection*. Burr Ridge, IL: Dow Jones-Irwin.

APPENDIX A – INTRODUCTORY LETTER TO FOCUS GROUP PARTICIPANTS

January 11, 2002

Dear Occupational Therapist,

I am a fellow occupational therapist who is currently enrolled in the Master of Distance Education Program at Athabasca University. I am currently working on the thesis component of my degree.

You are being invited to participate in a focus group as part of a research project. All occupational therapists in Alberta, who have supervised restricted practitioners in the last year, are invited to participate in one of four focus groups. Two focus groups will be held in urban health authorities and two focus groups will be held in rural health authorities.

My purpose for the research is to explore the nature of mentoring and why individuals seek mentoring relationships and to examine how mentoring may be supported through distance education technology. Please see the attached information sheet for more information on this research study.

Your participation is entirely voluntary. Furthermore, your responses will be kept strictly confidential.

I would very much appreciate your participation in my focus group. Please contact me within the next week by phone or email if you are willing to participate in a focus group. My phone number is 780-679-3019, Email is efinseth@telusplanet.net. The Edmonton focus group will be held on January 30 at 12:00 pm at the Capital Health office - #300, 10216 – 124 Street in the Central Meeting Room. Lunch will be provided. The focus group will be approximately one hour. There is parking across the street at Mountain Equipment Co-op.

Please see the attached Consent for Focus Group Participants. Please sign it and bring it with you.

The confidentiality of your participation is assured. Your name will never appear in any results. Only the researcher and the researcher's supervisor will see your responses. It is anticipated that the results of this research project will be available from Athabasca University's Library in 2002.

I look forward to your collaboration in this research study. Thank-you.

Elaine Finseth

Master of Distance Education,
Athabasca University

APPENDIX B – INTRODUCTORY LETTER TO SURVEY RESPONDENTS

January 21, 2002

Dear Occupational Therapist,

I am a fellow occupational therapist who is currently enrolled in the Master of Distance Education Program at Athabasca University. I am currently working on the thesis component of my degree.

You are being sent this questionnaire as part of a research project. You have been randomly selected from occupational therapists registered with the Alberta Association of Registered Occupational Therapists for the 2001/02 year.

My purpose for the research is to explore the nature of mentoring and why individuals seek mentoring relationships and to examine how mentoring may be supported through distance education technology. Please see the attached information sheet for more information on this research study.

Your participation is entirely voluntary. Furthermore, your responses will be kept strictly confidential.

I would very much appreciate your help in completing the enclosed questionnaire. It asks you to respond to a number of questions that reflect your personal views about mentoring among occupational therapists. The questionnaire consists primarily of yes/no responses, five-point scales, and short answer. This questionnaire will take approximately 20 to 30 minutes to complete.

The confidentiality of your participation is assured. Your name will never appear in any results. Only the researcher and the researcher's supervisor will see your responses. It is anticipated that the results of this research project will be available from Athabasca University's Library in 2002.

Thank you for your participation in this study.

Elaine Finseth

Master of Distance Education Program,
Athabasca University

APPENDIX C – INFORMATION SHEET FOR PARTICIPANTS

Information Sheet for Participants

Study Title: Fostering mentoring relationships using Distance Education Technology

Principal Investigator: Elaine Finseth, B.Sc.O.T.(c) , MDE student, Athabasca University

Advisor: Dr. Susan Moisey, Associate Professor, Centre of Distance Education

Study Purpose/Background

The purpose of this study is to explore the nature of mentoring and why individuals seek mentoring relationships, and to examine how mentoring may be supported through distance education technology.

Research to date provides accumulating support for the value of mentorship. In reviewing studies though, it is apparent that most studies are primarily anecdotal reports rather than empirical studies, and the majority of these studies focus on corporations and businesses. Articles reviewed focus on mentoring in the business world, education and healthcare, reflecting a variety of meanings from one setting to the next.

A number of research studies suggest it is possible to develop a mentoring relationship despite barriers of time and distance. The majority of studies refer to maximizing results by using technology to connect mentors and protégés within the business world and within the field of education. Very few studies reflect the use of distance education technology to support mentoring in the health field. This study will explore how mentoring may be supported through distance education technology in one area of the health field, notably occupational therapy.

Restricted practitioners and practicing clinicians have a need for reflective and collaborative action with peers. As the delivery of health and education services is ever changing with new information, increasing demands, and progressively complex issues, mentoring is an invaluable tool for support and guidance. Moreover, as occupational therapy is a diverse profession, therapists work not only in urban and rural settings, but also in a variety of program settings. Further clarification of the characteristics of mentoring relationships, the types of situations where such relationship may be beneficial, and people who may benefit from a mentoring relationship is needed to reduce potential confusion and uncertainty.

Benefits

By participating in this study, you are assisting the researcher in clarifying the meaning of mentoring relationships within the field of occupational therapy, identifying barriers to mentoring, and determining the feasibility of how mentoring may be supported through distance education technology. The findings of this study may assist organizations in the development of mentoring policies and practices to support successful mentoring relationships among occupational therapists.

Research Design

This study will utilize a combination, qualitative and quantitative research design and will occur in two phases.

In Phase One, the qualitative approach will be utilized to identify key themes and critical questions. Four focus groups will be conducted with a non-probability sample of occupational therapists who have supervised restricted practitioners. In this role, occupational therapists agree to be a mentor to the restricted practitioner. Two focus groups will be conducted in rural health authorities and the other two in urban health authorities.

In Phase Two, the quantitative approach will be used to answer the research questions and construct knowledge surrounding the themes identified in phase one. A survey will be administered to a stratified random sample of occupational therapists to elicit their perceptions of mentoring relationships, mentor and protégé roles and behaviors, reasons for seeking mentoring relationships, and barriers to mentoring.

Confidentiality

All quantitative and qualitative data will be stored in secured password-protected computer files. Only the primary researcher will have access to this information. The focus group participants will be identified by a code number on transcripts. The respondent's name and identifying information will be removed when the typist is transcribing the interviews. The identity of survey respondents will not be known as questionnaires will be returned in pre-addressed envelopes and there will be no identifying information on the questionnaires. Subjects will not be identifiable in the reporting of research results.

Potential Risks

There are no known risks to taking part in a focus group or completing a questionnaire.

Freedom to Withdraw

You do not have to take part in a Focus Group or answer the Survey, unless you want to. If you do decide to be in the study, you may drop out at any time by telling the Focus Group leader.

Right to Refuse a Question

You are not expected to answer any question that you do not want to answer.

Contacts

If you have any question about any part of this study, you may contact Elaine Finseth at Phone Number: (780) 679-3019, Fax: (780) 679-3001, E-Mail: efinseth@telusplanet.net or Dr. Susan D. Moisey at (800) 788-9041 ext. 6401, E-Mail: susanh@athabascau.ca

APPENDIX D - CONSENT FORM

Title of Project: Fostering Mentoring Relationships with the use of Distance Education

Researcher: Elaine Finseth, B.Sc.O.T.(c)
MDE student, Athabasca University
Phone: (780)-679-3019, Email: efinseth@telusplanet.net

- | | | |
|--|-----|----|
| Do you understand that you have been asked to participate in a focus group for a research project on mentoring relationships? | Yes | No |
| Have you received and read a copy of the attached information sheet? | Yes | No |
| Do you understand the benefits and risks involved in taking part in this focus group? | Yes | No |
| Have you had an opportunity to ask questions and discuss this study? | Yes | No |
| Do you understand that you are free to refuse to participate or withdraw from the focus group at any time? You do not have to give a reason. | Yes | No |
| Has the issue of confidentiality been explained to you? Do you understand who will have access to the information shared in the focus group? | Yes | No |
| Do you agree to respect the privacy and confidentiality of other group members and what will be discussed in the focus group sessions? | Yes | No |

This study was explained to me by: _____

I agree to take part in this study.

Signature of Participant

Date

Signature of Witness

Printed Name

Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Researcher

Date

APPENDIX E – FOLLOW-UP REMINDER

March 4, 2002

To All Occupational Therapists that received a Mentoring survey,

Hi, I forwarded a mentoring survey to 25 % of the occupational therapists in Alberta. If you received a survey on mentoring among O.T.'s and have not yet completed the survey and mailed it back to me, please take the time to do so within the next week (by March 08). If you already have, thank you for your response and please disregard this follow-up. Please feel free to contact me if you have any questions at (780) 679-3019.

Thank you for your assistance in this research.

Sincerely,

Elaine Finseth

APPENDIX F: SURVEY INSTRUMENT
Mentoring Questionnaire

Q-1 Think of the person who has helped you the most in your career. This could be:

- Someone who helped you find out what you wanted to do;
- Someone who helped you achieve the success you achieved;
- Someone who served as a model of what an effective individual at work looked-like;
- Someone who exemplified the characteristics you wanted to obtain in your own worklife.

Was, or is, there such a person in your own life? (check one)

1. Yes, at one time, but not now.
2. Yes, currently.
3. I'm not sure.
4. No, I've never had such a person.

IN THE QUESTIONS THAT FOLLOW, THE DEFINITION OF “MENTORING”,
 “MENTOR”, AND “PROTÉGÉ” WILL BE:

MENTORING is a relational process,

- in which someone who knows something, the MENTOR,
- transfers that something (the power resources such as wisdom, advice, information, emotional support, protection, linking to resources, career guidance, status, etc.)
- to someone else, the PROTÉGÉ, at a sensitive time so that it impacts development.

Part 1: Your Experience as a Protégé

Q-2 There are numerous reasons cited for seeking a mentor. How important are the following predisposing reasons for seeking a mentor ? (circle the appropriate number)

	1	2	3	4	5
	not at all important	somewhat important	fairly important	very important	extremely important
1. Working as a restricted practitioner	1	2	3	4	5
2. New to the profession, but not a restricted practitioner	1	2	3	4	5
3. New to a practice area	1	2	3	4	5
4. Professional isolation	1	2	3	4	5
5. Reduced access to resources	1	2	3	4	5

	1 not at all important	2 somewhat important	3 fairly important	4 very important	5 extremely important
6. Reduced access to professional development	1	2	3	4	5
7. Role Strain – high caseloads	1	2	3	4	5
8. Role Strain – little admin. support	1	2	3	4	5
9. Role Strain – working alone	1	2	3	4	5
10. Role Strain – not feeling apart of a team	1	2	3	4	5
11. Practice in rural setting	1	2	3	4	5
12. Practice in urban setting	1	2	3	4	5

Q-3 The functions/behaviours of a protégé are important to a successful mentoring relationship. Determine how important these functions/behaviours are /were for you as a protégé by circling the appropriate number.

1. Willing to learn	1	2	3	4	5
2. Exhibit career directness	1	2	3	4	5
3. Exhibit trust in the mentor	1	2	3	4	5
4. Appreciative of the mentor	1	2	3	4	5
5. Hardworking	1	2	3	4	5
6. Anxious to succeed	1	2	3	4	5
7. Desire to grow	1	2	3	4	5
8. Respect for the mentor	1	2	3	4	5
9. Open to feedback & advice	1	2	3	4	5
10. Willing to be held accountable	1	2	3	4	5
11. Willing to devote effort	1	2	3	4	5

Part 2: Your Experience with a Mentor

Q-4a Using the mentoring definition on page 1, have you ever had a mentor?

1. ___ Yes 2. ___ No

Q-4b If no, what were the reasons? Proceed to Q-7.

Q-5 If **YES**, what was your position at the time? (check all that apply)

- 1. ___ Undergraduate student
- 2. ___ Restricted practitioner
- 3. ___ Occupational Therapist I
- 4. ___ Occupational Therapist II
- 5. ___ Supervisor
- 6. ___ Practice Leader
- 7. ___ Researcher/Educator

Q-6a Have you had multiple mentors?

1. ___ Yes 2. ___ No

Q-6b If so, how many? _____

Q-7 There is no widely accepted explanation or theory of mentoring. The mentoring relationship supported seems to vary with the climate and culture of the organization. Indicate your preferences within a mentoring relationship?

- 1. ___ peer mentoring or 2. ___ senior to junior therapist mentoring
- 1. ___ dyadic mentoring relationship or 2. ___ group mentoring relationship
- 1. ___ one mentor at a given time or 2. ___ multiple mentors at a given time

PLEASE ANSWER QUESTIONS 8-17 ONLY IF YOU CURRENTLY HAVE,
OR HAD, A MENTOR while working as an occupational therapist.

Q-8 How did your **most significant** mentoring relationship begin (within your place of employment)?

- 1. ___ I initiated the relationship
- 2. ___ My mentor initiated the relationship
- 3. ___ It was mutually initiated
- 4. ___ Assigned role
- 5. ___ Other (explain: _____).

Q-9 What was your position at the time?

1. restricted practitioner
2. occupational therapist I
3. occupational therapist II
4. supervisor
5. practice leader
6. researcher/educator

Q-10 What was the position of your mentor?

1. occupational therapist I
2. occupational therapist II
3. supervisor, specify discipline: _____)
4. practice leader
5. researcher/educator
6. peer from another discipline, specify: _____)

Q-11 Was your mentor of the same gender as you?

1. Yes
2. No

Q-12 Was your mentor of the same ethnic/racial background as you?

1. Yes
2. No

Q-13 Did your mentor work in same regional health authority as you?

1. Yes
2. No

Q-14 Did your mentor work in same facility/agency as you?

1. Yes
2. No

Q-15 Did your mentor work in the same practice area as you?

1. Yes
2. No

Q-16 What did you find most meaningful to you in the mentoring experience or relationship?

Q-17 In the research, some authors indicated that certain aspects of mentoring may be uncomfortable. Which of the following items do you see as potentially uncomfortable? (check all that apply)

1. Power/dependency issues
2. Fears about self-disclosure
3. Cultural differences
4. Sexual tension
5. Other (explain: _____).

Part 3: Mentoring Functions

EVERYONE IS ASKED TO COMPLETE THIS SECTION IN WHOLE OR IN PART.

Q-18 This question has two parts. Below is a list of functions and activities that may be performed by mentors.

Part One: Using the following scale (1-5), indicate in the “**IDEAL**” column the importance you place on each item with regard to therapists mentoring other therapists.

1. Not at all important
2. Somewhat important
3. Important
4. Very Important
5. Extremely Important

Part Two: If you have been mentored as a therapist, place a checkmark in the “**ACTUAL**” column for each item that was/is a part of your most significant mentoring experience.

(If you have not been mentored as a therapist, answer only Part One of this question and proceed to Part 4, p.7).

Q-18a **Please use the following scale:**

	1 not at all important	2 somewhat important	3 fairly important	4 very important	5 extremely important
<u>FUNCTIONS/BEHAVIORS</u>				<u>IDEAL</u> (use scale)	<u>ACTUAL</u> (✓ only)
1. Friendship			_____		<input type="checkbox"/>
2. Career Guidance			_____		<input type="checkbox"/>
3. Constructive criticism and honest feedback			_____		<input type="checkbox"/>
4. Information source Re: organizational policies/procedures			_____		<input type="checkbox"/>
5. Help with integrating theoretical principles with practice			_____		<input type="checkbox"/>
6. Advice about resources, vendors, etc			_____		<input type="checkbox"/>
7. Emotional support			_____		<input type="checkbox"/>
8. Informed advice about people			_____		<input type="checkbox"/>

1	2	3	4	5
not at all	somewhat	fairly	very	extremely
important	important	important	important	important
				<u>IDEAL</u>

ACTUAL

	(Use scale)	(✓ Only)
9. Introductions to persons who could further career	_____	<input type="checkbox"/>
10. Flexibility, to allow protégé to do things differently	_____	<input type="checkbox"/>
11. Introductions to professional network	_____	<input type="checkbox"/>
12. Caring, committed relationship	_____	<input type="checkbox"/>
13. Belief in capabilities	_____	<input type="checkbox"/>
14. Help making difficult professional decisions	_____	<input type="checkbox"/>
15. Help with personal problems	_____	<input type="checkbox"/>
16. Nomination for important awards	_____	<input type="checkbox"/>
17. Social activities (i.e. meals, recreation)	_____	<input type="checkbox"/>
18. Defense from criticism by others	_____	<input type="checkbox"/>
19. Promotion of an equal and collaborative relationship	_____	<input type="checkbox"/>
20. Help with therapy practice	_____	<input type="checkbox"/>
21. Informal advice about committee work	_____	<input type="checkbox"/>
22. Fostering of professional visibility	_____	<input type="checkbox"/>
23. Encouragement and coaching	_____	<input type="checkbox"/>
24. Role model	_____	<input type="checkbox"/>
25. Review of documentation, reports	_____	<input type="checkbox"/>
26. Help with skill development	_____	<input type="checkbox"/>
27. Advice about research opportunities/activities	_____	<input type="checkbox"/>
28. Provide inspiration	_____	<input type="checkbox"/>
29. Facilitates active learning	_____	<input type="checkbox"/>
30. Keen interest in having the protégé succeed	_____	<input type="checkbox"/>
31. Willingness to share time	_____	<input type="checkbox"/>
32. Other:_____	_____	<input type="checkbox"/>

Part 4: My Experience as a Mentor

ANSWER QUESTIONS 19-23
ONLY IF YOU HAVE SERVED AS A MENTOR TO ANOTHER THERAPIST
 IF YOU HAVE NOT BEEN A MENTOR, PROCEED TO **PART 5**.

Q-19 Return to Question 18 and circle the numbers corresponding to the functions or activities you performed as a mentor in your most significant mentoring relationship.

Q-20 Indicate whether any of your protégés have been: (check all that apply)

1. Women
2. Men
3. Of a different race/nationality than you are
4. Restricted Practitioners
5. Occupational therapists
6. Occupational therapy assistants
7. From another discipline, specify: _____

Q-21 Estimate the average time **PER MONTH** that you spend (or have spent) mentoring the protégé(s).

1. Less than 1 hour
2. 2 to 5 hours
3. 5 to 10 hours
4. More than 10 hours

Q-22a The following is a list of possible reasons for becoming a mentor. Determine how important these reasons were/are for you by circling the appropriate number.

	1	2	3	4	5
	not at all important	somewhat important	fairly important	very important	extremely important
1. To make friends	1	2	3	4	5
2. To fulfill job responsibilities	1	2	3	4	5
3. To maintain professional standards	1	2	3	4	5
4. To enhance my professional status	1	2	3	4	5
5. To achieve success vicariously	1	2	3	4	5

	1	2	3	4	5		
	not at all important	somewhat important	fairly important	very important	extremely important		
6. To repay past mentors			1	2	3	4	5
7. To pass on the mentoring tradition			1	2	3	4	5
8. To make future favors more likely i.e. social exchange			1	2	3	4	5
9. To invigorate a spirit of community			1	2	3	4	5
10. To recruit people to your region			1	2	3	4	5
11. To experience satisfaction			1	2	3	4	5
12. To pass on my ideas to others			1	2	3	4	5

Q-22b Are there any other reasons for mentoring you would add to this list? If so, please list them below.

Q-23 In general, how did your mentoring relationships usually begin?

1. ___ I initiated them
2. ___ My protégé initiated them
3. ___ Mutual initiation
4. ___ Role assignment
5. ___ Other (explain: _____)

Part 5: Mentoring Responsibilities

EVERYONE IS ASKED TO COMPLETE THE FOLLOWING QUESTIONS.

Q-24 It has been suggested that senior therapists have a responsibility to mentor junior therapists. Therapists (junior and senior) have a responsibility to mentor restricted practitioners.

Q-24a Does this seem like a necessary suggestion to you? (check one)

1. Not at all necessary
2. Somewhat necessary
3. Very necessary

Q-24b Comments:

Q-24c Does this seem like a realistic expectation to you? (check one)

1. Not at all realistic
2. Somewhat realistic
3. Very realistic

Q-24d Comments:

Part 6: Mentoring Relationships

Q-25a If another therapist came into your office today and talked with you about entering into a mentoring relationship, which of the following would be important to guide you in developing a mentoring relationship with that person?

	1	2	3	4	5		
	not at all important	somewhat important	fairly important	very important	extremely important		
1. Shared professional goals			1	2	3	4	5
2. Same clientele served			1	2	3	4	5
3. Work in the same region			1	2	3	4	5
4. Work in the same organization			1	2	3	4	5
5. Same gender			1	2	3	4	5
6. Same racial or cultural background			1	2	3	4	5
7. Around the same age			1	2	3	4	5
8. Personal compatibility			1	2	3	4	5
9. Value peer relationships			1	2	3	4	5
10. Mutual emotional commitment			1	2	3	4	5
11. Have an open, teachable attitude toward learning			1	2	3	4	5

Q-25b Please identify any other considerations you consider important in developing mentoring relationships in the space below.

Part 7: Mentoring through Technology

Q-26 In Alberta, the distance between therapists may be vast, particularly in rural regional health authorities. Does a mentoring relationship supported through technology seem realistic using the following media?

	1	2	3	4	5			
	not at all	somewhat realistic	fairly realistic	very realistic	extremely realistic			
a. Telephone				1	2	3	4	5
b. Teleconference				1	2	3	4	5
c. E-mail				1	2	3	4	5
d. Electronic Bulletin Board (asynchronous)				1	2	3	4	5
e. Chat (synchronous)				1	2	3	4	5
f. Online Audio/Video Conferencing				1	2	3	4	5
g. Other (please specify)				1	2	3	4	5

Q-27 How frequently have you used computers in the past?

- a. Very frequently (generally daily)
- b. Frequently (regularly, at least weekly)
- c. Sometimes (when required)
- d. Seldom (just a few times)
- e. Never

Q-28 How comfortable do you currently feel working on computers?

- a. Not at all
- b. Slightly comfortable
- c. Somewhat comfortable
- d. comfortable
- e. very comfortable

Q-29a How **frequently** have you used the computer for the following?

	1	2	3	4	5		
	not at all	somewhat	fairly frequently	very frequently	extremely frequently		
a. Internet Search			1	2	3	4	5
b. E-mail			1	2	3	4	5
c. Electronic Bulletin Board			1	2	3	4	5
d. Chat			1	2	3	4	5
e. Online Audio/Video Conferencing			1	2	3	4	5
f. Other (please specify)			1	2	3	4	5

Q-29b Comments:

Part 8: Career Pressures

Q-30a Using the following scale, please indicate to what extent the following conditions might affect the development and maintenance of mentoring relationships among therapists:

	1	2	3	4	5		
	not at all important	somewhat important	fairly important	very important	extremely important		
1. Heavy workload			1	2	3	4	5
2. Large client caseload			1	2	3	4	5
3. Demands from work (outside of work hours)			1	2	3	4	5
4. Committee work			1	2	3	4	5
5. Social isolation			1	2	3	4	5
6. Travel distance			1	2	3	4	5
7. Demands from the local community			1	2	3	4	5
8. Demands from my supplemental Work involvements			1	2	3	4	5
9. Responsibilities for my family or personal network			1	2	3	4	5
10. Lack of skills in negotiating workload, time off, etc.			1	2	3	4	5
11. No prior experience in a mentoring relationship			1	2	3	4	5
12. Individualistic/competitive mindset			1	2	3	4	5
13. Emphasis on being experts			1	2	3	4	5
14. No formal development or training for mentoring			1	2	3	4	5
15. Unsure of how to mentor			1	2	3	4	5

16. Fear of opening up to another person in an honest way	1	2	3	4	5
17. High task performance expectations leave little time for developing personal relationships	1	2	3	4	5
18. Humility & freedom to admit need	1	2	3	4	5
19. Lack of <i>awareness</i> about mentoring process	1	2	3	4	5
20. Lack of <i>knowledge</i> about the Mentoring process	1	2	3	4	5
21. No institutional value placed on mentoring	1	2	3	4	5
22. Lack of an organized, <i>formal</i> mentoring Program in place	1	2	3	4	5
23. Personal problems	1	2	3	4	5
24. Lack of funds for stipends and/or substitute wages	1	2	3	4	5
25. Unwillingness to serve as a mentor	1	2	3	4	5
26. Poor communication skills	1	2	3	4	5
27. Potential of a bad match	1	2	3	4	5
28. Unrealistic expectations	1	2	3	4	5
29. Problems in taking initiative	1	2	3	4	5
30. Fear that the protégé may leave the organization after a great deal of time/effort	1	2	3	4	5
31. Mentor may feel threatened by talent And ambition of the protégé	1	2	3	4	5
32. Mentor may not want to be held Responsible for the performance of the protégé	1	2	3	4	5
33. Limited # of therapists with sufficient age, experience & expertise to be mentors	1	2	3	4	5
34. High rate of turnover	1	2	3	4	5

Q-30b Please identify any other conditions that may inhibit the development of mentoring relationships in the space below.

Part 9: Demographic Information

Q-31 What is your gender?

1. Female 2. Male

Q-32 What is your age?

1. Under 25 2. 25 –34 3. 35 – 44 4. Over 45

Q-33 Do you currently work:

1. Full-time 2. Part-time 3. Not currently working

Q-34 The Regional Health Authority that you currently work in is _____

Q-35 What setting do you currently work in (check all that apply)

1. Acute Care
2. Home Care
3. Community Rehabilitation
4. Student Health Initiative
5. Continuing Care
6. Specialized Program
7. University
8. Private Practice
9. Other, specify _____

Q-36 How many years have you worked in the field of occupational therapy? _____

Q-37 What is your current position? _____

Q-38 What type of personal computer do you own?

1. A PC 2. A Mac

Q-39 Has this computer been manufactured in the last two years?

1. Yes 2. No 3. Not Sure

Q-40 Do you currently have an Internet connection at home?

1. Yes 2. No 3. Not Sure

Q-41 Do you currently have an Internet connection at work?

1. Yes 2. No 3. Not Sure

Thank –you for your cooperation !