

UNIVERSITY OF DERBY

EXPLORING THE LIVED
EXPERIENCE OF BEING AN
OCCUPATIONAL THERAPY
STUDENT WITH ADDITIONAL
SUPPORT REQUIREMENTS.

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Table of Contents

Glossary of Terms.....	I
Abbreviations.....	IV
Abstract.....	VII
Acknowledgements.....	IX
1. Introduction / Rationale.....	1
1.1 The Legal Context.....	4
1.2. The National Context.....	6
1.3. The Local Context.....	9
1.4. Students with Disabilities undertaking Health and Occupational Therapy Programmes.....	11
1.5. Local Occupational Therapy Statistics.....	13
1.6. The Higher Education Agenda.....	13
1.7 Local Policy and Procedures.....	19
1.8. Summary.....	20
2. Literature Review.....	22
2.1. Literature Search Strategy.....	22
2.2. Fitness to Practice and Reasonable Adjustments.....	23
2.3. Student Experiences.....	29
2.3.1. Occupational Therapy Student Experiences.....	35
2.3.2. Practice Placement.....	42
2.4. Barriers to Education.....	46
2.5. Practice Educator Experiences.....	48
2.6. Qualified Occupational Therapists Experiences.....	49
2.7. Summary.....	53
2.8. Research Aim and Objectives.....	55
2.8.1. Research Aim.....	55
2.8.2. Research Objectives.....	56
3. Methodology.....	57
3.1. Introduction.....	57
3.2. Philosophical Stance and Research Design.....	57
3.3. Interpretative Phenomenological Analysis (IPA).....	63
3.3.1. Phenomenology.....	63
3.3.2. Interpretative Phenomenological Analysis.....	66
3.3.3. Limitations of IPA.....	74
3.4. Insider Research.....	75
3.5. Research Method.....	77
3.5.1. Inclusion / Exclusion Criteria.....	78
3.5.2. Participants and Recruitment.....	78
3.5.3. Interviews.....	79
3.5.4. Pilot Interview.....	85
3.5.5. Ethics.....	85

3.5.6. Informed Consent	86
3.5.7. Confidentiality	87
3.5.8. Consequences of Participating in the Interview.	87
3.5.9. Quality, Rigour and Trustworthiness.	88
3.6. Data Analysis.....	89
3.7. Summary	93
4. Results, Analysis and Discussion.....	95
4.1. Introduction.....	95
4.2. Participant Information.....	97
4.3. Themes.....	103
4.3.1. Theme 1 – ‘It’s a bit of a Rollercoaster’.....	104
4.3.1.1. Sub –Theme 1: Doing, Being and Becoming an Occupational Therapist.....	105
4.3.1.2. Sub theme 2: Motivation to become an Occupational Therapist.....	106
4.3.2. Theme 2 – ‘Like a Bull at a Gate’: Demonstrating Determination for Success.	113
4.3.2.1. Sub theme 1 – ‘Boom or Bust’.....	114
4.3.3. Theme 3 – ‘That was When the Bubble Burst’ – Pivotal events which had negative consequences for participants.....	123
4.3.3.1.Sub Theme 1: Barriers to Learning.	123
4.3.3.2. Sub-Theme 2: Is Occupational Therapy for me?	131
4.3.3.3. Sub theme 3: Am I Good Enough to be an OT?	135
4.3.4. Theme 4 – ‘Heal Thy Self’	139
4.3.4.1. Sub Theme 1: Occupation as Therapy.....	139
4.3.4.2. Sub Theme 2: Disclosure, Reasonable Adjustments, Support Systems / Mechanisms and Coping Strategies.	145
4.3.4.3. Sub- theme 3: Identity Development.	166
4.3.5. Theme 5 – ‘The World is my Oyster’: Futures Thinking.	176
4.4. Summary.	180
5. The Relevance and Application of the Model of Human Occupation (Kielhofner, 1985)..	183
5.1 Introduction.....	183
5.2 The Relevance of a Conceptual Model of OT.	183
5.2.1 The Model of Human Occupation (MOHO) (Kielhofner, 1985).	186
5.2.2 Applying MOHO to those who had successfully completed the OT programme	199
5.2.3 Volition / personal causation / values.	200
5.2.4 Habituation.....	200
5.2.5 Coping strategies.....	201
5.2.6 Performance capacity.....	201
5.2.7 The Environment.	202
5.2.8 Occupational Identity, Occupational Competence and Occupational Adaptation.	202
5.3. Summary	204
6. Conclusion.....	205
6.1. Introduction.....	205
6.2. The Meaning of Disability.	206
6.3. The Student Journey and Experience.	207

6.4. Motivation to become an Occupational Therapist	208
6.5. Factors which Hindered and Supported the Successful Completion of the Programme.	209
6.6. Preparedness for the Workplace.....	211
6.7. Applying MOHO (Kielhofner, 1985).....	211
6.8. Limitations and Reflections of the Study	213
6.9. Summary.	214
7. Future Research.....	216
8. Recommendations for Future Practice.....	217
9. References.	219

List of Figures

Figure 1 – The Interconnectedness of Super-ordinate and Sub-ordinate Themes.....	103
Figure 2 - Super-ordinate Themes and MOHO.....	203

List of Tables

Table 1 - Total Numbers of Non-Disabled and Disabled Students in Higher Education.....	7
Table 2 - Comparing the Percentages of Non-Disabled and Disabled Students Studying Subjects Allied to Medicine.....	8
Table 3 - Student Population by Disclosed Disability within the Home University.....	10
Table 4 - Benefits and Limitations of Interviews.....	84
Table 5 - Participant Information Summary.....	99

List of Appendices

APPENDIX 10.1 Participation Information Sheet.....	248
APPENDIX 10.2 Advert for recruitment.....	251
APPENDIX 10.3 Interview Schedule / Topics and Questions.....	252
APPENDIX 10.4 Ethical Approval Documents.....	254
APPENDIX 10.5 Informed Consent Form.....	257
APPENDIX 10.6 Initial theme development spreadsheets.....	258
APPENDIX 10.7 Images of Transcript Analysis.....	265
APPENDIX 10.8 Images of Grouping and Regrouping Themes.....	267
APPENDIX 10.9 Example of Participant Summary Document.....	268
APPENDIX 10.10. Stage 2 Theme Development.....	287
APPENDIX 10.11. Stage 3 Theme Development.....	288
APPENDIX 10.12. Example of Application of Themes to Each Participant.....	289
APPENDIX 10.13 Participant Synopsis Document.....	290
APPENDIX 10.14. Reflection Example.....	305
APPENDIX 10.15 Participant in Brief Document.....	307
APPENDIX 10.16. Initial Application of MOHO to Participants.....	310
APPENDIX 10.17 Participant Vignettes Following Application of MOHO.....	330

Glossary of Terms.

Convergence - shared themes.

Dasein – ‘being in the world’, existence, ‘the uniquely situated quality of human being’ (Smith et al, 2009; p16).

Disability – ‘A physical or mental impairment that has a ‘substantial and long term’ negative effect on the ability to do normal daily activities’ (Equality Act, 2010 available at <http://www.legislation.gov.uk/ukpga/2010/15/contents> [accessed on 25/09/16]).

Divergence – differences between cases.

Double hermeneutic – how the researcher interprets how the participant makes sense of their experiences. ‘How the analyst thinks the participant is thinking’ (Smith et al, 2009; p80)

Environment – ‘refers to both the physical and social aspects of the context within which a person performs a given occupation. Ideally the physical and social aspects of the environment serve to facilitate a person’s engagement in occupation’ (Taylor and Kielhofner, 2017; p9).

Epistemology – ‘is a branch of philosophy that deals with the theory of knowledge or the study of knowledge’ (Blair and Robertson, 2005; p270).

Existential - worldliness and embodied nature of our ‘being’.

Habituation – ‘describes the emergence of a pattern of occupation over time. This pattern forms repeated habits and public and private roles’ (Taylor and Kielhofner, 2017; p9).

Hermeneutics – ‘the theory of interpretation’ (Smith et al, 2009; p21).

Idiography – ‘concerned with the particular’ (Smith et al, 2009; p29). Studying individual cases.

Iterative – repeating the action

Metaphor – ‘the use of a familiar object or phenomenon to stand in the place of the less understood event or situation’ (Melton et al, 2017; p138).

Methods - techniques and procedures.

Methodology - strategy, plan, design linking choice of method to the desired outcome.

Nomethetic – tendency to generalize.

Occupational adaptation – ‘making needed changes to continue to engage in ones chosen activities or developing new activities’ (O’Brien and Kielhofner, 2017; p36).

Occupational competence – ‘the ability to perform occupations with skill and ease’ (O’Brien and Kielhofner, 2017; p36).

Occupational identity – ‘the sense of who we are and wish to become as an occupational being based on our accumulated and reflected life experiences’ (O’Brien and Kielhofner, 2017; p36).

Ontology – ‘philosophical standpoint that looks at how we came to be. The conceptualisation of such a worldview provides a language that enables knowledge about it to be shared and lays the foundations for the way that knowledge is generated’ (Blair and Robertson, 2005; p270).

Paradigm – common theoretical understanding.

Performance capacity – ‘describes a person’s own experience and perception of the ability to perform an occupation as well as others’ perceptions of that person’s experience and perception of that ability’ (Taylor and Kielhofner, 2017; p9).

Personal causation – ‘ones sense of competence and effectiveness’ (Wook Lee and Kielhofner, 2017; p54).

Phenomenology – ‘a philosophical approach to the study of experience’ (Smith et al, 2009; p11).

Plot – ‘represents the intersection between the progression of time and the direction (for better or for worse) that life takes’ (Melton et al, 2017; p138).

Positivism – ‘an epistemological position that advocates the application of the methods of the natural sciences to the study of social reality and beyond’ (Bryman, 2008; p697).

Students with additional support requirements – students who as a result of disability or impairment have additional needs to support their learning and achievement within the university setting.

Volition – ‘describes how a person is motivated to perform a given occupation’ (Taylor and Kielhofner, 2017; p9). Includes values, interests and personal causation.

Abbreviations

ADD – Attention Deficit Disorder

AHP – Allied Health Professions / Professionals

AJOT – American Journal of Occupational Therapy

AOTA - America Occupational Therapy Association

BAOT – British Association of Occupational Therapists

BERA – British Education Research Association

BJOT – British Journal of Occupational Therapy

CAW – Centre for Academic Writing

COT – College of Occupational Therapists

CQC – Care Quality Commission

CSP – Chartered Society of Physiotherapists

DDA – Disability Discrimination Act

DOH – Department of Health

DRC – Disability Rights Commission

DSA – Disabled Student Allowance

DWP – Department of Work and Pensions

DWPODI - The Department of Work and Pensions, Office for Disability Issues

GAD – Generalised Anxiety Disorder

HCPC – Health and Care Professions Council

HE – Higher Education

HEA – Higher Education Academy

HEE – Health Education England

HEI – Higher Education Institution

HEFCE – Higher Education Funding Council for England

HCPC – Health Care Professions Council

HPC – Health Professions Council

IPA – Interpretative Phenomenological Analysis

IT – Information Technology

NHS – National Health Service

NICE – National Institute for Clinical Excellence

NMC - Nursing and Midwifery Council

NUS – National Union of Students

OFFA – Office for Fair Access

OIA – Office of Independent Adjudication

OS – Occupational Science

OT – Occupational Therapy

PE – Practice Educator

PT – Physiotherapy

PTSD – Post Traumatic Stress Disorder

QAA – Quality Assurance Agency

RCN – Royal College of Nursing

RCOT - Royal College of Occupational Therapists

SENDA – Special Educational Needs and Disability Act

SHA – Strategic Health Authority

SHEFC - Scottish Higher Education Funding Council

SpLD – Specific Learning Difficulty

UCAS – University and Colleges Admissions Service

UN – United Nations

UNESCO – United Nations Educational, Scientific and Cultural Organisation

UK - United Kingdom

US – United States

USA – United States of America

VI – Visual Impairment

WFOT - World Federation of Occupational Therapist

Abstract.

This study explored the lived experience of being an occupational therapy student with additional support requirements. Individuals with disabilities have the right to access education and have unique skills and attributes which are highly desirable within Health and Social Care professions. The number of students with disabilities undertaking Health and Social Care programmes is increasing and Universities have sought to improve facilities, resources and support for these students. However, Occupational Therapy education which is truly inclusive remains elusive (Jung et al, 2008). No previous research exploring this phenomenon has been completed within the United Kingdom. Two small scale studies in USA (Velde et al, 2005) and in Canada (Jung et al, 2014) have been previously published, alongside a number of autobiographical descriptions of individual's personal experiences of OT education from those with disabilities (Archer, 1999; Bennett, 1989; Guitard and Lirette, 2005; Sivanesan, 2003). However, the age and predominant international context limits applicability within the UK.

Unlike previous studies, Interpretative Phenomenological Analysis (IPA) was used to investigate the phenomenon of being an Occupational Therapy student with a disability, from the individual's unique perspective. Viewing each individual participant as a unique occupational being allowed me to reveal findings which have been previously unidentified and unexplored. This study illuminated a journey that all participants experienced as they engaged in the occupation of studying to become an Occupational Therapist. The journey was described by two participants using the metaphor 'a rollercoaster' and this became the overarching theme. Other themes generated from individual participant journeys, as described in their own words, were 'like a bull at a gate', 'that was when the bubble burst', 'heal thy self' and the 'world is my oyster'.

The findings indicated that there was a therapeutic benefit of studying to become an Occupational Therapist for those who had successfully completed the programme. Whilst never the original intention of the research, when

interpreting the findings, I was drawn to how the concepts within Model of Human Occupation (MOHO) (Kielhofner, 1985) were evident within each participant's journey and thus applied MOHO to each individual. It is recommended that further research is undertaken to explore if the findings of this study are only applicable to those who participated in the study or if studying Occupational Therapy is indeed therapeutic and the Model of Human Occupation is applicable to all students who study OT with or without additional support requirements.

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1. Introduction / Rationale

It is important to afford those with disabilities, the same rights including that of education, as all other individuals. This introductory chapter will reflect upon my personal rationale and the legislative and political contexts for this study. Consideration will be given to the impact that National and local policy has had on enhancing services to students with disabilities within the United Kingdom (UK). Statistics indicate that increasing numbers of students with disabilities are entering Higher Education (HE). The potential influence this will have on the numbers of students with disabilities training to become health care professionals will be considered.

I am an Occupational Therapy (OT) lecturer with more than 20 years' experience of working with OT students. I have worked with students with disabilities throughout this time and have become increasingly interested in their experiences of studying OT. Some of these students have demonstrated high levels of success, whilst others experienced significant challenges, frequently resulting in an inability to successfully complete the programme. This fuelled my desire to better understand the individual's experiences of studying OT. I wanted to listen and understand the impact that each individual's disability had on their experiences of studying OT. I was interested to identify what had enhanced their experiences potentially resulting in successful completion of the programme. I also wanted to understand the barriers which hindered their personal success whilst studying. I hoped to identify good practice but also to consider how practice could be further enhanced. I hoped through data collection, analysis and interpretation that it may be possible to predict those students who may experience significant challenges during their studies. This would allow appropriate support to be targeted enabling students, where possible, to achieve success and complete the OT programme.

Reflecting on my personal experiences of working with students with disabilities, I recognised that many of the students, particularly those with a

mental health condition seemed to make the decision to study OT as a result of their personal experiences of OT. This intrigued me and left me wondering what motivated students with disabilities to become an Occupational Therapist, a question it appeared had not been studied within the existing literature.

As a practice placement coordinator, the practice experiences all students encounter is of particular interest. The quality of the experience for both the student and the educator is of prime concern. Having a supportive educator is reportedly crucial to the success of a placement (Rodger et al, 2011). The findings of Hirneth and Mackenzie (2004) suggest that some educators experience reservations and even fear surrounding the facilitation of a practice placement for a student with a disability. Frequently believing that the experience would be time consuming and that the student would require unreasonable levels of support to be successful within the placement. Anecdotally, some students with disabilities have reported experiencing limited support during their placements along with a perceived lack of understanding of their needs. Interestingly, the literature suggested that students (Sivanesan, 2003; Velde et al, 2005) and qualified Occupational Therapists (Bevan, 2014; Chacala et al, 2014) with disabilities believed that their personal experiences of disabilities offered them a unique insight and understanding of disability which enhanced their skills and abilities. This literature will be further explored within the following chapter. I became interested to explore the individual's experiences of practice placement, aiming to gain a greater understanding of the potential support requirements and barriers experienced, with a view to proposing recommendations to enhance future practice.

My interest lay in understanding the individual's experience of disability and how this impacted upon them whilst studying OT. I wanted to understand their personal motivations to become an Occupational Therapist and if this was linked to their experience of impairment. I was interested in exploring the factors that hindered or supported their experiences of being an OT student and to particularly explore the participant's experiences of their practice

placements. Understanding, how participants envisaged their future was also important to me.

Initially, when planning and proposing this research I utilised the terms 'students with additional support requirements' to describe the potential participants within the study, those whose lived experiences I wanted to explore. This term is one used within the institution in which the participants were situated, and thus potential participants would be familiar with the term. I was also cautious about using the term disability as I am aware that this term can have medical model connotations for some and I did not wish to offend or exclude potential participants. The use of such terms may also have excluded those students who possibly did not perceive themselves to have a disability or impairment. I have however, used the terms students with additional support requirements and students with disabilities within the final thesis as this is congruent with the existing literature. Within this study, disability or additional support requirements were defined using the Equality Act (2010) (see section 1.1).

Significant changes to the practices, attitudes, policies and procedures within HE was required following the introduction of the disability rights movement within the UK in the late 1980s and early 1990s (Gibson, 2017). Hearing the voices of students with disabilities has become increasingly important since this time, as it allows for the experiences of a minority group to be heard and understood from their own perspective. Thus, enabling Higher Education Institutions (HEIs) to gain an insight into lived experiences of this marginalised group (Lane, 2017). The stories they tell should then be used to inform and enhance practice, services and education, as supported by the UK Government (Gibson, 2015). Also ensuring that policies and practices are responsive and address the issues and challenges faced when accessing educational services (Vickerman and Blundell, 2010). The distribution of their stories support empowerment and allow others to advocate their views (Vickerman and Blundell, 2010). However, whilst the numbers of students with disabilities entering HE are increasing, research continues to suggest that

those with disability and impairment continue to be marginalised and under-represented (Bulk et al 2017; Gibson 2015; Vickerman and Blundell, 2010).

1.1 The Legal Context

The rights of disabled people have been championed globally. The United Nations (UN) have been instrumental in recognising the need to ensure that individuals with disabilities are facilitated to participate equally and achieve their full potential through inclusive education and life-long learning (UN, 2008).

Within the United Kingdom, The Human Rights Act (1998) declared that everyone has the right to education and anti-discriminatory legislation such as the Disability Discrimination Act (DDA) (1995), Special Educational Needs and Disability Act (SENDA, 2001) and the amended Disability Discrimination Act (2005) have been instrumental in leading to increased numbers of students with disabilities attending HEIs (Disability Rights Commission (DRC), 2007; Jung et al, 2014; QAA, 2010). This legislation forced universities to become more inclusive and to recognise the potential that students with disabilities have and could bring to society, the workforce and more specifically the health professions. However, Gibson (2015) presents a belief that whilst the introduction of legislation and the disability rights movement may have resulted in policy change, the practical application of these policies has been 'tenuous' (p877). She further argues that this has resulted in greater challenge and disadvantage, socially and economically, as these policies have 'failed to deliver' (p878).

The introduction of the DDA (1995) and SENDA (2001) saw discrimination against disabled people because of a medical diagnosis become unlawful (DDA, 1995; Kloss, 2008). SENDA was introduced to legislate against discrimination for individuals with disabilities in pre or post 16 education. The DDA (1995) was further amended in 2005 to include a responsibility for public authorities, including the NHS, a key employer of OT graduates, to promote

disability equality. In 2015, it was reported that 31,322 (2.6%) of NHS employees had disclosed a disability (<https://www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce/need-to-know/experience-of-disabled-staff-working-in-the-nhs> [accessed on 18/8/16]). However, it is also suggested that the NHS needs to do more to demonstrate its 'commitment to corporate social responsibility' (Bain and Licence, 2015; available from <https://www.hsj.co.uk/comments/the-nhs-must-employ-more-people-with-disabilities/5090449.article> [accessed on 18/8/16]).

The Equality Act (2010) superseded the DDA and SENDA and aimed to simplify previous legislation by removing inconsistencies within existing legislation and strengthening the law to protect against inequality, prejudice and discrimination (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85011/disability.pdf [accessed on 18/8/16]). The Equality Act (2010) outlines the requirements for HEIs in the UK and protects students from discrimination based upon the nine 'protected characteristics' including disability. The Act (2010) defines 'disability' as a

Physical and / or mental impairment which has what the law calls a substantial and long term adverse effect on their ability to carry out normal day to day activities. There is no need for a person to have a medically diagnosed cause for their impairment; what matters is the effect of the impairment not the cause. (The Equality Act, 2010; p4).

Within this definition examples of impairments include dyslexia, autism, depression, schizophrenia, arthritis, diabetes, epilepsy, HIV, loss of limb, severe disfigurement. The Equality Act (2010) emphasizes the legal duty of the HEI is to anticipate and provide reasonable adjustments for any students with a disability.

The introduction of anti-discriminatory legislation such as SENDA (2001) and the Equality Act (2010) challenged the historical discrimination within the health care professions that was highlighted by French (1988). She identified discriminatory practice by both the Chartered Society of Physiotherapists

(CSP) and Royal College of Nursing (RCN), who listed a number of conditions and disabilities which they viewed to be 'unsuitable' (French, 1988; p173) for entry to the physiotherapy and nursing professions. French (1986, cited in French, 1988) also conducted an analysis of the career literature pertaining to 26 health care professions including OT. She concluded that applications from disabled individuals were not actively sought. This was despite 10 of the professions actively looking to recruit people who displayed characteristics such as empathy and an understanding of ill health and disability. However, since the introduction of the legislation to decrease marginalisation of groups and communities, such prejudice and discrimination would be deemed unfair and unlawful. The legislation also supports the eradication of discriminatory practices within healthcare programmes based on disability which were also previously possible (Wright & Eathorne, 2003). It is, however, currently unclear if the legislation has impacted on the experiences of those with disabilities studying on healthcare programmes and specifically those studying to become an Occupational Therapist in the UK.

1.2. The National Context

In 2011-2012 there were 5.7 million disabled people of working age in the UK (<http://odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures.php> [accessed on 31/1/13]). According to the Department of Work and Pensions Office for Disability Issues (DWPODI), disabled people are half as likely to hold a degree level qualification as non-disabled people. Potentially indicating there has been an existing discriminatory attitude to the entry of individuals with disabilities into HE but also that those with disabilities offer an untapped potential for universities and the future working population (<http://odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures.php> [accessed on 18/8/16]).

Minority and disadvantaged groups such as those with disabilities have been targeted by HEIs and therefore numbers of students with disabilities have increased significantly across the HE sector in the last 15 years. Year on year,

statistics have increased since 2003 – 2004 when 5.4% of the 2,200,180 students in HE within UK declared a disability (see Table 1) (<http://www.ecu.ac.uk/wp-content/uploads/2015/11/Equality-in-HE-statistical-report-2015-part-2-students.pdf> [accessed on 18/08/16]).

Table 1 - Total Numbers of Non-Disabled and Disabled Students in Higher Education (adapted from <http://www.ecu.ac.uk/wp-content/uploads/2015/11/Equality-in-HE-statistical-report-2015-part-2-students.pdf> [accessed on 18/08/16]).

Academic Year	No. of disabled students	No. of non-disabled students	% of total numbers of students who have a disability
2003 - 2004	119,545	2,080,635	5.4%
2011 - 2012	215,370	2,281,275	8.6%
2012 - 2013	221,190	2,119,090	9.5%
2013 - 2014	229,215	2,070,140	10.0%

There has also been an increased interest in studying subjects allied to medicine, of which OT is one, for those who have a disclosed disability. This can be seen in Table 2, which demonstrates a proportional increase in the number of students studying subjects allied to medicine who have a disclosed disability (<https://www.hesa.ac.uk/data-and-analysis> [accessed on 18/08/16])

Table 2 - Comparing the Percentages of Non-Disabled and Disabled Students Studying Subjects Allied to Medicine (adapted from multiple annual reports available from <https://www.hesa.ac.uk/data-and-analysis>).

Subjects Allied to Medicine	Disabled Students	Non-Disabled
2011 - 2012	9.5%	90.5%
2012 - 2013	10.4%	89.6%
2013 - 2014	11.4%	88.6%

As table 2 demonstrates in 2013 – 2014, 11.4% of first degree students, who studied subjects allied to medicine were disabled (<http://www.ecu.ac.uk/publications/equality-higher-education-statistical-report-2014> [accessed on 18/08/16]). However, limited statistical data is available identifying actual numbers of individuals with disabilities who are studying specific health and social care programmes.

Given the overall increased numbers of students with disabilities in HE and studying subjects allied to medicine, including OT, it is crucial that their experiences of HE is understood.

Since 2007-2008 increased numbers of students have disclosed a mental health condition, rates have risen from 5.9% to 12.8% in 2013-2014. Representing 1.1% of the entire student population within the UK (<http://www.ecu.ac.uk/publications/equality-higher-education-statistical-report-2014> [accessed on 18/08/16]). Making it the second most disclosed disability, after Specific Learning Difficulty (SpLD) across all UK universities, in 2013-2014 (<http://www.ecu.ac.uk/wp-content/uploads/2015/11/Equality-in-HE-statistical-report-2015-part-2-students.pdf> [accessed on 18/08/16]). Whilst this shows a significant increase it is widely reported that those with a mental health condition continue to fear stigmatisation and discrimination and as a result of this fail to disclose, thus suggesting that these figures may significantly underestimate current true statistics. The increase in the numbers

of students who experience and report mental health conditions is a cause for concern. The wellbeing of all HE students is essential. However, those undertaking professional courses are required to support the recovery of those with whom they are working and therefore their personal health and wellbeing is paramount. HCPC (2016) clearly articulate the need for students and registrants to self-regulate their health and disability requirements and thus demonstrate insight into their own fitness for practice. The increased prevalence of mental ill health has become evident in more recent years as prior to 2010 – 2011 Universities and Colleges Admissions Service (UCAS) did not specify a disability coding category for mental health conditions. It is also hypothesised that the stress associated with the pressures of studying and high academic achievement can also be a contributing factor to the increased prevalence of poor mental health. Therefore, having an enhanced understanding of the barriers those with a disclosed mental health condition experience and the support they find beneficial will be of benefit to those supporting these students.

1.3. The Local Context

When comparing the data generated within the university in which the research was conducted, with that of other universities, the overall percentage of those with disabilities was lower at the time the research was undertaken. Following national and international trends those with a SpLD were proportionally the largest group who disclosed a disability within the university at this time. Perhaps also indicative of the prevalence of research and literature focussed on SpLD (Betz et al, 2012; Velde et al, 2005) but also the potential for an increased number of participants with SpLDs. Table 3 shows the student population by disclosed disability within the university in which the research was conducted, in the year in which the data for this study was gathered.

Table 3 - Student Population by Disclosed Disability within the Home University (adapted from <https://www.coventry.ac.uk/Global/06%20life%20on%20Campus%20section%20assets/The%20University/Key%20Information%20Page/Equality%20and%20Diversity/statistics-2014-15/cu-student-demographics-2014-2015.pdf> [accessed on 18/8/16]).

	2013-2014
Specific Learning Disability	46.84%
2 or more disabilities	12.77%
Blind or significant visual impairment	1.75%
Deaf or significant hearing impairment	1.75%
Mental health	7.76%
Long standing illness / condition	7.64%
Another disability / impairment not listed	16.84%
Social communication disorder / ASD	2.32%
Physical impairment	2.32%
Total of total student population	6.71%

Debate exists within the literature, with some suggesting the existence of a hierarchy of disability (Taylor, 2007), with dyslexia being the most favoured within HE. Others, however, suggest that students with invisible disabilities face greater challenges than those with visible impairments. They hypothesise that this is due to the scepticism of some staff regarding the disability, thus leading to an increased risk of failure (Beilke and Yssel 1999). Velde et al (2005) warn that these prejudices should be a significant concern to universities given the increased numbers of students with a SpLD and therefore it was deemed important to understand the specific experiences of those with SpLDs and other invisible disabilities in the context of studying OT in the UK.

1.4. Students with Disabilities undertaking Health and Occupational Therapy Programmes.

Between 2000 and 2012, overall numbers of frontline staff within the National Health Service (NHS) increased, with Health Education England (2013), indicating an overall 31% increase in the AHP workforce during this time (<http://www.cfwl.org.uk/documents/allied-health-professionals-workforce-risks-and-opportunities> [accessed on 18/8/16]).

Following reports investigating the quality of care and patient safety within the NHS (Francis Report, 2013; Keough Review, 2013; the Berwick Review, 2013) a greater interest and priority was placed on safe staffing levels by those reviewing quality within the NHS and Social Care e.g. CQC and NICE. Thus, leading Trusts to suggest the need to significantly increase the numbers of staff employed (HEE, 2013). Whilst, the reports did not specifically indicate the need to increase the numbers of Occupational Therapists, they did suggest the need for sufficient staff to provide safe levels of care and the continued training and education of all staff working within the NHS. In order to recruit the increased numbers of students proposed following the review of NHS, new or under established populations for example individuals with a disability, potentially needed to be targeted (Betz et al, 2012).

As indicated previously, the numbers of students with disabilities, wishing to, and undertaking health programmes are increasing nationally and internationally (Bevan, 2014; Jung et al 2014; Hirneth and Mackenzie, 2004; Storr, Wray and Draper, 2011). There is, however, very limited reliable statistical information to support this increase. Jung et al (2014) suggest that the reasons for the increase in numbers include the

...increased frequency of diagnosis, introduction of legislation mandating student rights and improved policies and procedures for accommodating students with disabilities (p147)

The increase may also be attributable to a greater number of students being willing or prepared to disclose health conditions and disabilities in-order to

access support and reasonable adjustments. Earlier diagnosis of SpLDs could also be a contributory factor.

Neither the Health and Care Professions Council (HCPC) or the Royal College of Occupational Therapists (RCOT) routinely gather statistical information regarding the diversity of registrants or members and therefore the accuracy of data within the literature is difficult to confirm (Bevan, 2014; Taylor, 2007). Gathering accurate statistical data on the sensitive issue of health and disability is also challenging and problematic (Betz et al, 2012). Reasons for this include; how disability is defined and if and how individuals align themselves with these definitions; how statistics are gathered and interpreted; as well individual's fears regarding disclosure and concerns regarding their fitness for practice (Bevan, 2014; Jung et al, 2014).

Betz et al (2012) conducted a survey of 130 nursing programmes across one State in the USA. They too recognised that whilst there has been an increase in the numbers of nursing students with disabilities since 1995-1996 the figures had fluctuated and were only estimated given that data is difficult to collect with no national surveys collecting prevalence data across health professions. Following a 50% (n=65) response rate, Betz et al (2012) concluded that the most frequently reported disability was a learning disability. Similar statistical surveys do not appear to have been conducted within OT nor within the context of the UK and therefore it is difficult to make comparisons. However, in 2002, the College of Occupational Therapists (COT), conducted a membership survey and reported that only 4% of students studying OT in the UK had a disability (COT, 2002). Clearly, this statistic is dated and does not reflect that of the university in which this study was conducted (see section 1.5). However, more recent data has not been published to contextualize the increase in the numbers of OT students with disabilities nationally. In comparison, however within the USA, Velde (2000) identified that statistics from 1997 indicated that 16.6% of health care professionals e.g. OT's, Physiotherapists had a disability. Again, given that this data is 20 years old it is anticipated that these statistics have significantly increased. Jung et al (2008) completed an international survey to identify the

inclusive education practices within World Federation of Occupational Therapist (WFOT) accredited programmes. They identified that 64% (n =115) of respondent programmes reported that they had between 1 and 32 disabled students enrolled. From the data collected, it is impossible to further compare the national average as described by COT (2002) with the numbers indicated in the Jung et al (2008) study as insufficient detail is provided. Of the responding programmes 13 were however, unsure how many students with disabilities were enrolled indicating that data of this nature was either not collected or they were unable to confirm the accuracy of the data.

1.5. Local Occupational Therapy Statistics

Locally, unpublished OT programme data indicates that the number of students with additional support requirements is increasing, rising from 15.2% declaring a disability in 2010 to 21.5% in 2013. This reveals a much higher percentage of individuals declaring a disability than those identified nationally. However, as this data is based on unpublished locally held statistics of student self-reported additional support requirements / disabilities some caution is suggested when reviewing the accuracy of this data.

1.6. The Higher Education Agenda.

Currently the HE system within England and the UK is undergoing major change as the need for economic development and growth is becoming recognised alongside teaching and research as the 'third mission' for HEIs (Moore et al, 2013). The HE system has a responsibility to facilitate the development of future generations whilst promoting the inclusion of equality for those from disadvantaged backgrounds. United Nations Educational, Scientific and Cultural Organisation (UNESCO) (2005) believes

Education is an important vehicle through which economically and socially marginalised adults and children can be empowered to

change their life chances, and obtain the means to participate more fully in their communities (p28)

Following the expansion of the numbers of HEIs and the introduction of the Further and Higher Education Act (1992) which allowed polytechnics to apply for university status and removed the binary system, a greater interest in equal access was identified. Further changes occurred following the Dearing Report (1997) which led to a commitment to increase student numbers and diversity within universities. The report identified widening participation and life-long learning as key factors and 1998 saw the initial investment in the widening participation agenda from Higher Education Funding Council for England (HEFCE).

In 2003, Harrison and Swee Hong, wrote an editorial, in the European Year of Disabled People, encouraging Higher Education Institutions (HEIs) to consider widening participation and diversity, including increasing the numbers of disabled people upon all programmes including health. They recognised that increasing diversity would require adequate resources but acknowledged that COT (2002) had identified that OT programmes within the UK were responding favourably to the introduction of the DDA.

Widening participation is a strategic priority supported by government policy to improve access to HE for those from disadvantaged under-represented groups and backgrounds. These include those from lower socio-economic classes, ethnic minority groups, mature students, part-time students and students with disabilities. The widening participation agenda not only considers gaining entry to higher education but also includes retaining the place on the programme and being successful in completion and graduation from the programme of study. Many strategies have been implemented to support the success of those from disadvantaged backgrounds including access to information, support services and networks, summer schools to support transition, peer mentoring and tutoring. There is evidence to suggest that some of these strategies have had a positive impact on recruitment and retention of those from minority backgrounds (Sanders and Higham, 2012;

Moore et al, 2013). Therefore, identifying strategies which have supported or potentially may have supported the participants of this study from entry to graduation was of interest.

The threat of marginalisation and exclusion from meaningful participation in roles and occupations, including education, is real for those with disabilities nationally and internationally (UNESCO, 2003; UNESCO, 2005). The belief that education is a 'non –negotiable' human right is key to inclusive education (UNESCO, 2005; World Federation of Occupational Therapists, 2008).

In 1994, during the World Conference on Special Needs Education, 92 governments and 25 international organisations agreed

Inclusive quality education is based on the right of all learners to a quality education that meets basic learning needs and enriches lives. Focusing particularly on vulnerable and marginalised groups, it seeks to develop the full potential of every individual. The ultimate goal of inclusive quality education is to end all forms of discrimination and foster social cohesion (UNESCO).

It is a 'holistic approach to education' (UNESCO, 2003; p30), that requires HEIs to respond to the diversity of the populations it serves. It is recognised that with diversity comes challenges, but that diversity also enhances and enriches the learning experiences for all (UNESCO, 2003). The adoption of inclusive education for those with disability and impairment within the UK has been disputed by disability rights activists. They argue that the legislation and policy supporting inclusive education has failed to deliver in its intention as a result of the predominance of the medical model and its view that disability is individualistic and as a result of impairment, rather than resulting from socially produced and environmental barriers to participation (Allan, 2010; Bulk et al, 2017; Kielhofner, 2005). In exploring the barriers to the perceived failure of inclusive rights and legislation in HE, Gibson (2015) identified that cultural change is required. A cultural shift involving more than the provision of technical guides which offer strategies for inclusion, physical adaptations such as the provision of ramps or hearing loops and the provision of support staff such as note takers was called for to tackle marginalisation, oppression and

inequity (Allan, 2010; Gibson, 2015; Kielhofner, 2005). Gibson (2015) suggests that HE structures are rooted in a culture that promote hegemony, exclusion, silence, marginalisation and ableism. She further argues that academics need to engage with a culture of difference and critically consider the overall experiences of their students in an attempt to truly understand their values, beliefs and attitudes (Gibson, 2012). Gibson (2015) implored academics to 'dance with cultures of difference in order to explore the possibilities of a meaningful pedagogy for inclusion' (p883) suggesting that

...by working with and learning about the life experiences of people with disability, society might be better equipped to understand and respond inclusively (p884).

Thus, reinforcing the need to not only listen to the voices of students with disabilities but to empower them and respond to their lived experiences by enhancing practice and promoting cultural change. An aim of this study was to provide an opportunity for 'previously silenced voices [to] tell their diverse stories and, in so doing, challenge hegemonic power constructs' (Gibson, 2015; p884).

Recently, Bulk et al (2017) completed a study exploring the inclusion of disabled people within education programmes for health professions in Canada. They completed in-depth interviews and focus groups with students, clinicians and university academic staff. Their results indicated that stigmatisation and marginalisation exist within AHP programmes and that these create a major barrier to participation for those with disabilities.

Bulk et al (2017) suggest that despite the rhetoric, disabled individuals remain under-represented within the Health and Social Care (H&SC) service (in Canada) and they suggest this is an 'injustice' (p617) as the population of professionals lacks diversity and 'is being deprived of professionals who may offer unique and valuable insider perspectives' (p618). Easterbrook et al (2015) also advocated for greater diversity within the student population believing that those with disabilities would better understand the challenges facing other marginalised and oppressed populations.

Literature suggests that individuals with disabilities are viewed as 'inferior' (Bulk et al 2017; p619) and that these views have underpinned the belief that those with disabilities are unable to meet the requirements and demands of being a health professional.

Disabled people are perceived as inherently flawed and unidimensional and therefore unfit to become multi-faceted professionals (Bulk et al, 2017; p619)

Bulk et al (2017) concluded that those undertaking professional programmes described the programmes as being

...designed for the prototypical, hegemonic ideal enabled student, with little room for flexibility beyond prescribed accommodations (Bulk et al, 2017; p623)

Within my study I sought to explore if this Canadian finding was similarly reflected within the UK.

Kielhofner (2005) supported by McCormack and Collins (2010) suggested that despite good intentions the OT profession guided by the medical model and principles of rehabilitation frequently perpetuate a negative perception of disability and impairment. Further suggesting that this can lead to a disruption of the individual's identity, oppression and marginalisation. Kielhofner (2005) argues that the principles of rehabilitation serve to reinforce the reduction of impairment or disability which can further reinforce the belief that impairment and disability is 'abnormal' (Kielhofner, 2005; p489). McCormack and Collins (2010) further argued that Occupational Therapists need to understand the concept of 'disability' from the perspective of the individual with a disability in order to be, as they profess, client centred. McCormack and Collins (2010) challenged Occupational Therapists to listen to the individual's experiences of disability and respect their values and beliefs in order to be client centred. They invited Occupational Therapists to develop a partnership where they

understand the lived experience of disability from the individual's perspective, reinforcing the need to listen and respond to the needs of those with disabilities to address barriers which exist within society. I, within this study, wanted to understand the experiences of studying OT with a disability and / or impairment with the intention of highlighting good practice and eliminating barriers where possible.

In 2008, Jung et al reported on a survey that the World Federation of Occupational Therapists (WFOT) had completed together with McMaster University in Canada. The survey was sent to all HEIs that offered WFOT accredited pre-registration OT programmes (n=568). The survey aimed to gain an understanding of 'inclusive education' (p33) within OT internationally. Prior to completing the online survey, Jung et al (2008) identified that no previous research of a similar nature had been undertaken and no similar research appears to have been completed since. The most frequently identified barriers to 'inclusive education' (p33) were physical, attitudinal and social issues which is consistent with the wider literature (Archer, 1999; Paul, 1999; Wright and Eathorne, 2003). However, it was suggested that the omission of significant changes to the physical environment may be related to cost rather than 'a lack of desire' (Jung et al, 2008; p40). The study positively highlighted the endeavours that institutions and programmes had made in enhancing inclusion, such as environmental adaptations and the development of student support services but reported that challenges remain for individuals with disabilities who are frequently required to advocate for themselves in order to be recognised and accommodated (Jung et al, 2008). This again reflects wider concerns for those who need to self-advocate but who frequently feel disempowered to do so (Kettle, 2007; Moore et al 2013).

There were a number of limitations to the study including a low response rate (32%), which could have been compounded by the complexity of the method of distribution. Whilst anonymity was guaranteed, the sensitive nature of the information requested may also have deterred some potential respondents, specifically if reporting on areas of poor inclusivity, a lack of knowledge and / or policy and procedures.

In conclusion it was suggested that the majority of those who responded felt that 'there is still a long way to go before OT education can truly be inclusive' (Jung et al, 2008; p41). The results of the study were used to develop a position statement from World Federation of Occupational Therapists (WFOT). The position statement (WFOT, 2009) recognised the importance of OT education programmes specifically being inclusive to those with disabilities, given our philosophy of facilitating individuals to achieve their potential through engagement in occupations which are important and meaningful. The Position Statement (WFOT, 2009) advocates the commitment to inclusive education from all OT Education Providers.

Nationally, university wide processes and procedures have been developed following legislation and guidance from a range of organizations including the government, statutory and regulatory bodies, commissioners, funding bodies. Many universities and educational organisations have also developed good practice guides which include information about support services offered, the importance of and advice regarding disclosure and the provision reasonable adjustments (Department of Education and Skills, 2002; Dunbar et al, 2012; Jacklin et al, 2007; OIA, 2017; QAA, 2010; Stanley et al, 2008; University of Southampton, 2008). Understanding how these processes and procedures and support services are experienced by those for whom they were developed is required.

1.7 Local Policy and Procedures.

Local university wide policies and procedures for students with disabilities have been guided by the QAA (2010). The University is committed to providing 'equality of access and progression opportunities' to all students (Coventry University, 2015; p1). The Charter provides an outline of the values 'that will allow any and every student to reach their full potential' (Coventry University, 2015; p1). The local university also has a policy, approved by the Academic Board, specifically related to disabled students (Coventry

University, 2010). Originally developed in 1991 and now in its 6th iteration, the policy outlines the University's commitment to provide education for all and reasonable adjustment to facilitate this. Integration is identified as an important contributory factor within education and social activities, although inclusion is viewed more positively nationally and internationally (UNESCO, 2005; UNESCO, 2009; WFOT, 2009). The Policy also reinforces equality in performance and assessment based on the quality of the work. Within the Policy, students are actively encouraged to disclose and seek reasonable adjustments to support their learning and assessment and integration within the university.

As recommended by QAA (2010), the University has an Equality Scheme and Action Plan highlighting key equality objectives for the institution, along with specific training and development sessions and short guidance documents to support academics to develop knowledge, understanding and skills when working with a range of individuals with disabilities.

Whilst no formal OT policies exist locally, there is a specific individual who has responsibility for supporting students with additional support requirements within the team.

1.8. Summary

Within this chapter, I have outlined my personal interest in the research topic and I have considered the legal, political and statistical context in which the research was set.

The number of students who are accessing HE who may not have previously had the opportunity to complete a degree or similar qualification is increasing nationally and internationally (Sanders and Higham, 2012; Moore et al, 2013; QAA 2010). Individuals with disabilities have the right to access education and have unique skills and attributes which are highly desirable within Health and Social Care professions. Whilst it appears that the number of students with

disabilities undertaking Health and Social Care programmes is increasing and that universities and educational organisations are seeking to improve facilities, resources and support for these students, there continues to be a strong argument that suggests that inclusive education within HEIs is failing to deliver its intentions (Bulk et al, 2017; Easterbrook et al, 2015; Gibson, 2015). It also is recognised that OT education which is truly inclusive remains elusive (Jung et al, 2008). This study aimed to explore how inclusive education was from the perspectives of undergraduate students engaging in studying BSc (hons) OT at one university within the UK.

The importance of hearing and understanding the student voice and responding to their needs is evident and is of significant importance when considering the needs of marginalised groups, such as those with disabilities (Allan, 2010; Gibson, 2012; Gibson; 2015; Lane, 2017, McCormack and Collins, 2010).

This chapter has provided a rationale for why I undertook this study, exploring the lived experiences of Occupational Therapy (OT) students with additional support requirements whilst studying OT in one Higher Education (HE) institution within the United Kingdom (UK). Within the remainder of the thesis I will provide a review of the existing literature within both OT and the wider context. My decision to choose to investigate the phenomenon using Interpretative Phenomenological Analysis (IPA) will be justified. I will also debate the merits and limitations of IPA when undertaking such a study and analyse, interpret and discuss my findings in the context of the existing body of knowledge. Before drawing conclusions and considering the findings in terms of recommendations for future practice and future research.

2. Literature Review.

The introduction reviewed the legislative, political and economic contexts in which this research is set. This literature review will now provide a context and rationale for why it was important to explore the lived experiences of students with additional support requirements whilst studying Occupational Therapy within the UK. The chapter will contextualise the research by reviewing the existing literature, nationally and internationally. Initially considering the wider research identified exploring the experiences of individuals with disabilities in HE, before reviewing literature exploring the experiences of nursing and health care students and finally exploring the literature which primarily focusses on the experiences of OT students in HE. The chapter will conclude with the research aims and objectives.

2.1. Literature Search Strategy.

A comprehensive search of electronic databases was completed. This was supported by citation tracking and hand searching to identify the breadth of literature used within this literature review. Searches were completed on multiple occasions to identify any new literature which had not been previously retrieved. Initially search terms specific to the field of Occupational Therapy were used but when little evidence was identified, the search was widened to include other health professional groups.

The search terms used were students with a disability, disabled students, Occupational Therapy, Occupational Therapy student, higher education, college and university, inclusive education, allied health professional, nursing, physiotherapy, physical therapy, dyslexia, specific learning difficulty. The EBSCO host database, specifically AMED, Medline, CINAHL, British Education Index, e-book collection, Psych articles and Psych INFO were searched along with ERIC, Education line, Ingenta Connect, ASSIA, Social Care online and Care Knowledge. All titles and abstracts of articles and texts were reviewed and those that were of relevance have been included.

Other website searches were conducted to identify further research, guidance and policy relevant to the education of students with disabilities such as QAA, HEFCE, HEA, DRC, UKGOV, Researchgate, Academia.edu and Dawsonera.

As has been indicated within the introduction, there are an increased number of students with disabilities applying for, attending and completing undergraduate degree programmes within Higher Education (HE) and this includes those choosing to study to become an Allied Health Professional (AHP), including Occupational Therapy. Anecdotally, the complexity of the support needs required by individuals accessing programmes allied to medicine appears to be growing. Disabilities are more varied and complex and existing research does not appear to reflect these current changes within the student cohort. Improvements and advancement in technologies have enabled more individuals to access higher education more easily (Betz et al, 2012). Information Technology (IT) e.g. computers, voice recognition software, adapted keyboards, Dictaphones etc. and other reasonable adjustments specifically have been used to overcome some of the pre-existing barriers to education. One reason attributed to the increase in the number of students with disabilities attending university is the advances within health and technology which have significantly improved the life expectancy and quality of life of many individuals with illness and disability (Betz et al, 2012).

2.2. Fitness to Practice and Reasonable Adjustments

Wright & Eathorne (2003) recognised as a result of the 'social and political shifts in the meaning and nature of disability' (p37) and the introduction of anti-discriminatory legislation and policy, such as the DDA (1995) and SENDA (2001), along with non-discriminatory local policy within HEIs; that increased numbers of individuals with disabilities would wish to train to become nurses and health professionals of the future. There is also an expectation that all HEIs within the UK, should anticipate the requirements of students with a

disability, thus promoting equal opportunity and inclusivity and making reasonable adjustments to ensure that individuals are not disadvantaged or discriminated against irrespective of their disability (Equality Act, 2010). However, Bulk et al (2017) identified that as many policies and reasonable adjustments have not been designed in collaboration with those with disabilities, they may not meet the needs of the population for which they were developed. Within this study, I wanted to explore if the experiences of OT students with disabilities, was congruent with the rhetoric of the legislation and the local policy.

Professional and Regulatory Bodies along with employers of health care professionals, for example the NHS and disability rights organisations all support the inclusion of those with disabilities within health care recognising the need for a diverse workforce which reflects the populations they serve (COT, 2002; DRC, 2007; HCPC, 2015; WFOT, 2009). There is also a growing body of evidence which suggests that both nurses and AHP's with disabilities offer a unique perspective to healthcare and the clients they work with (Bevan, 2014; Bulk et al, 2017; Chacala et al, 2014; Easterbrook et al, 2015; Wright and Eathorne, 2003). With those who experience disabilities identifying 'a unique rapport' with patients as they were able to empathise and understand the impact of disability (Brown et al, 2006; p35). Velde (2000) also recognised the potential for more widespread benefits to the OT profession, if we are able to gain 'insight into the experience of work as an employee with a disability' (p187). However, people with disabilities have been viewed by some within healthcare to require similar levels of support and care as those who are ill. Thus, resulting in a distorted view that disabled individuals are 'unfit for entry into health care professions' (Wright and Eathorne, 2003; p 39).

All students on professional programmes are required to demonstrate fitness for practice and achievement of competence standards (HCPC, 2013). The requirement from HCPC (2015) is that individuals have met the Standards of Proficiency (HCPC, 2013) in order to be eligible for registration. They also require references to support an individual's character and health. The expectation from HCPC is that the individual can practise safely and

effectively within their scope of practice, presenting no danger to themselves or others. HCPC recognises that an individual's scope of practice can change as a result of a career move or a health condition or disability.

Literature suggests that academics, as well as practice educators and mentors experience a sense of responsibility, when assessing those with disabilities to ensure that they are fit for and competent to practice (Jung et al, 2008). With Velde et al (2005) suggesting, from an OT perspective, that teaching individuals with disabilities challenges educator perceptions and beliefs of the required characteristics and skills of a competent professional. Students with disabilities appear however to dispute this when they consider their own professional competence believing they will be better Occupational Therapists as a result of their disabilities and experiences (Jung et al, 2014). Evidence demonstrates a willingness to provide reasonable adjustments (Jung et al, 2008; Jung et al, 2014; WFOT, 2009), but concerns remain about maintaining health and safety, academic and competence standards (Verma and Patterson, 1998; Wright and Eathorne, 2003) and as Bevan (2014) acknowledges this can therefore impact on the assessment of competence and ultimately eligibility for registration.

It has however been recognised that strict adherence to policy guidance governing the admission to university, registration with professional bodies and the achievement of professional competency standards may result in unlawful behaviour such as direct or indirect discrimination if reasonable adjustments have not been considered (DRC, 2007; Kloss, 2008). There has been considerable debate and concern identified within the literature related to the assessment of competence and the provision of reasonable adjustments (Hirneith and Mackenzie, 2004; Maheady, 1999). Whilst, this debate provides an interesting perspective, it is not the intention of this research to examine the practice educator's experiences of assessment of competence and provision of reasonable adjustment, but to focus on the experiences from the student's perspective.

In 2007, the Disability Rights Commission (DRC) published a report following an investigation into the regulation of teachers, nurses and social workers. Whilst the DRC (2007), did not dispute the regulation of professions such as social work and nursing, its investigation demonstrated that much of the statutory guidance and legislation governing these professions at the time, neither reflected the DDA nor did it support the equality of individuals with disabilities. They also claimed that the health standards, applicable to nursing, social work and teaching programmes

...foster the perception that they are there to prevent people who are disabled or have long term conditions from applying to HE courses (DRC, 2007; p13).

The DRC investigation did not include any allied health professions, but they did briefly review the HPCs regulatory and statutory guidance documents as a means of comparison and recognised that HPC also included discriminatory standards for health and fitness and a requirement to disclose health conditions and disabilities. HPC were, however, commended for the distinction they make 'between fitness to practice and fitness for a particular job in a particular setting' (DRC, 2007; p22). Clearly identifying that registration does not guarantee safe and effective practice in all clinical areas.

The DRC (2007) disputed the legitimacy of the regulatory frameworks ability to assess the competence of the individual with a health condition or disability. The report identified that as a result of a number of cases, including that of Beverley Allitt, there is a perception that those with disabilities or health conditions 'pose a risk to the public' (p7), resulting in a greater spotlight on professional regulation. Taylor (2007), however, argued that individuals with disabilities pose no greater risk to the public based on their knowledge and experience than any other student. The DRC (2007) purported that as a result of the Clothier Report (1994) greater stigmatization and discrimination has occurred for those with mental health conditions wishing to enter the health professions. Following their investigation, the DRC recommended the removal of 'regulations and statutory guidance laying down requirements for good health or fitness of professionals' (p2) as these negatively impact on

individuals with disabilities and are not believed to offer public protection, a reason for which they were introduced (DRC, 2007). The investigation panel recommended that what was required was 'a framework of professional standards of competence and conduct, coupled with effective management and rigorous monitoring of practice' (DRC, 2007; p26). Subsequently HCPC have updated their regulatory and statutory guidance documents and these now appear to reflect some of the recommendations proposed by the DRC.

The DRC (2007) also highlighted concerns regarding disclosure, indicating that some regulators of professional courses require individuals to disclose and claim that it is a professional issue if an individual does not disclose. The DRC (2007) argue that this 'undermines the DDA' (p13) and that forced disclosure can cause unnecessary fear and anxiety particularly for those individuals with mental health conditions. It is recognised that many individuals choose only to disclose if and when they experience a crisis during their training and education (DRC, 2007) and that this can further lead to a lack of appropriate adjustments and support for these individuals which may ultimately result in issues with effective safe practice (Kloss, 2008).

Maheady (1999) conducted a study exploring the experiences of student nurses with disabilities and questioned the universities potential liability for allowing students to graduate who had not demonstrated their ability to successfully complete all of the tasks required for entry to the profession. Thus, suggesting that their competence to practice had not been fully demonstrated. In contrast, Velde (2001) expressed her concerns that some OT educators held the belief that students with disabilities are required to demonstrate competence in any potential clinical area. A belief that she disputed, given the breadth of OT practice and therefore the job opportunities and choices that Occupational Therapists have. Whilst this view is indeed accurate, once licenced to practice Occupational Therapists are licensed to work in any setting and therefore need to understand their skills, strengths and potential limitations. In support of Velde, Kloss (2008) reiterated her belief that given a range of career options exist

...it is not necessary that a student should be trained in every procedure as long as his or her general education is satisfactory (p231).

Kloss (2008) proposed that the solution is within the negotiation and implementation of reasonable adjustments. Similarly, Arndt (2004) considered the essential skills and competencies of a nurse and questioned if all skills are required to be demonstrated by the individual or was providing competent instruction for someone else to complete the task sufficient. She argued that attributes and skills such as integrity and caring, interpersonal and cognitive skills were essential, rather than having the ability to complete all of the work activities. Following a study of practice educators who had experience of supervising OT students with disabilities, Hirneth and Mackenzie (2004) suggested that further debate and research was required to consider how professional competencies can be interpreted, how 'flexible' these can be and if all competencies need to be demonstrated by students with disabilities. Participants within the study expressed their personal difficulties identifying what is a 'reasonable' adjustment. They questioned their personal levels of leniency and in some cases if the adjustment had been sufficient to enable success. Chacala et al (2014), whilst exploring the views of 2 qualified Occupational Therapists with disabilities, argued that a major concern for practice educators is 'that accommodations jeopardize academic standards or student learning' (p109). However, as Jung et al (2008) identified, when collating the view of WFOT accredited HEIs, staff are also concerned 'that they may be held accountable for disability discrimination' (p40) and Wright and Eathorne (2003) highlighted the moral responsibility of ensuring that individuals are supported to be successful but 'not set up to fail' (p40).

Maheady (1999) also recognised that the nursing profession would have been denied the uniqueness of some individuals if admissions criteria had been strictly adhered to but advocated for 'enforceable guidelines for admission and retention' (p169) which were objective and measurable and provided examples of essential activities. Similarly, the participants in both Betz (2012) and Hirneth and Mackenzie's (2004) studies requested specific guidance for

assessment of students in practice which incorporated information about individual disabilities, legislation and maintaining professional standards.

The debate surrounding the challenges of demonstrating competence and establishing what are reasonable adjustments from the perspective of those assessing students with disabilities is evident within the literature. The debate appears to have been ongoing nationally (in nursing) and internationally (in OT) and is largely unresolved. However, it appears that adequate risk assessment is key to

...balancing the aim of encouraging the employment of people with a disability against the need to protect them and others, with emphasis on doing what is reasonable to enable them to work (Kloss, 2008; p232).

It was not the intention of this research to explore OT students with disabilities fitness to practice from the perspective of practice educators or academics. It was however, important to understand, how the students perceived their disability in the context of their studies and their practice experiences. It was also important to consider how the individual experienced academic reasonable adjustments and if and how these had influenced their progression and ultimate success. Exploring disclosure from the perspective of the individual with a disability was deemed crucial, as was a consideration of their future career, once qualified.

2.3. Student Experiences

An expanding body of literature has been published across the HE sector exploring the experiences of students with disabilities in Higher Education. The appearance of which appears to coincide with the introduction of the DDA (1995) and subsequent legislation. Studies have been completed within individual institutions and across HEIs, nationally and internationally (Hall and Tinklin, 1998; Jung et al, 2014; Maheady, 1999; Paul, 1999; Velde et al, 2004).

One of the first studies identified within the UK was published in 1998. Hall and Tinklin (1998) produced a report considering the experiences of 12 disabled students studying at a range of universities across Scotland. The study was conducted prior to the Equality Act (2010) but the report did contextualise the student experiences, as related to the DDA (1995) and in light of developments and initiatives of the Scottish Higher Education Funding Council (SHEFC) at the time. A variety of institutions across Scotland participated; students from various courses with various disabilities were involved. The project was comprehensive and multi-faceted. It involved interviewing 12 students, following each student for a typical day, surveying disability coordinators and interviewing relevant staff including disability coordinators. None of the students, who participated within this study, were studying health related programmes.

Hall and Tinklin (1998) described the positive and negative experiences of 12 students, from varying backgrounds, whose impairments included dyslexia, visual impairment, hearing impairment, cerebral palsy and one student who had chronic back pain and depression. All of the students had experienced reasonable adjustments and support to meet their individual needs.

Hall and Tinklin (1998) warned of the need for caution regarding generalisation of their findings but suggested that their results provided information regarding the existence of policies and equitable practices at the time. They identified that whilst policies were in existence some had been developed as a reaction to an individual's requirements. They suggested reviewing policies to ensure they were based on equitable principles whilst respecting the individual's needs. They suggested the importance of taking advice from disabled students on disability issues and policy development. Thus, supporting the need for research which explores the views of students with disabilities and aims to enhance practice as a result.

Participants within the study identified enablers and barriers to learning. They reported positively on the impact of support systems such as the employment

of disability coordinators but recognised that institutions still had a considerable journey to achieving equity for all. When aspiring for equity for all, they felt that staff knowledge, understanding and awareness linked to disability and disability issues could significantly impact on this. It would perhaps be expected that staff supporting AHP programmes would have existing knowledge of disability and disability issues and thus be at an advantage. However, Hall and Tinklin suggested greater staff training to address this and further support with transitioning into HE could have enhanced their participant's experiences.

Hall and Tinklin (1998) also recognised the concerns of the participants related to disclosure. The participants feared prejudice and discrimination but recognised that it was their choice to disclose or not. The physical barriers to inclusion e.g. the accessibility of buildings was highlighted by participants, as were concerns regarding social integration and the financial burden. Thus, providing support to explore the participant's personal experiences of being an OT student and becoming an Occupational Therapist in the context of exploring their attitudes to disclosure and the factors that supported and hindered their journey.

Similarly, Paul (1999) conducted a qualitative study, with 6 undergraduate and post-graduate students from one large urban university, who used a wheelchair in the United States of America. This study was again set in the context of the increased numbers of students with disabilities including those who are wheelchair dependent going to college and university and was conducted post ADA (1990) legislation. Paul (1999) hypothesised that students who are wheelchair dependent and transitioning to university need to contend with similar life changes to other students e.g. living alone, managing their finances etc. but also have to manage the complexities surrounding their disability.

The purpose of the study was to understand the experiences of students who were wheelchair dependent, identifying barriers and enablers to success for this student group. A further aim of this study was to potentially inform future

OT practice, when working with these students and to propose future service improvement. Two of the post graduate students who participated were studying health related subjects. Participants were interviewed on 3 occasions, using open questions to gather data.

The results of the study indicated that university life is complex. There was a recognition from participants that being a student and attending university held meaning that was linked to their place and value within society. They valued the experiences that university life had to offer, recognising that it was not just about the qualification, but preparation for life. Paul an Occupational Therapist likened this to the process / product debate within OT, where the degree may be the product but academic experience is the process. Participants recognised both their personal aspirations to excel and the pressure for success from others as motivating factors. They advocated that their physical impairment should not limit their achievements and sought social networks and integration. They recognised their own roles in not only promoting themselves but in ensuring that the experiences of wheelchair users of the future were positive.

Participants within the study identified factors which had influenced their decisions and choices such as accessibility, access to disability services, public transport links, accessible accommodation, accessibility of personal support networks such as family and friends. I similarly wanted to explore, the motivations of the participants I recruited and to understand the value they placed on the experience of being an OT student. My intention was to understand if similar barriers existed and if and how support networks influence the individual's experience.

Other Occupational Therapists have also described their experiences of working with students with disabilities within HE (Ko 2014; Llorens et al, 1999). Ko (2014), an Occupational Therapist working within student support services in Canada, advocates the skills and the potential that Occupational Therapists possess to enhance the occupational potential, health and wellbeing of students with disabilities in HE settings. She recognised the

congruence between the philosophy and core skills of an OT and that of university support services. She questioned why more Occupational Therapists were not working within similar services and demonstrated how her skills in activity analysis, grading and adaptation, assessment, clinical reasoning, problem solving, risk assessment, intervention planning and measuring outcome were valuable in her work with students with disabilities specifically those with mental health conditions. Llorens et al (1999) also advocated that Occupational Therapists were ideally positioned to support students with disabilities in HE to prepare them for the work environment.

Llorens et al (1999) described how the staff within one OT programme, within the US, collaborated with student support services to facilitate reasonable adjustments for OT students with disabilities in order that their opportunities for success during their education and in their futures were optimised. Llorens et al (1999) recognised that students with disabilities frequently require reasonable adjustments which address occupational deficits and aim to reduce occupational risk factors. Whilst Llorens et al (1999) used OT theory to provide a context to the support and reasonable adjustments they had offered OT students they had not completed any primary research. They used case examples to demonstrate how adjustments have been made and utilised within their specific institution with individuals with a range of disabilities and suggested that practice placements required planning and preparation. They concluded their article by considering the unique position of the OT student with a disability whose learning about their own need for adjustment and supporting legislation could be of benefit in their future career.

In a very recently published systematic review, Lane (2017) suggested that despite the introduction of anti-discriminatory legislation nationally and internationally and the development of local policy, students with disabilities 'continue to perceive barriers to education' (Lane, 2017; p3). Lane (2017) hypothesised that this is a result of a lack of inclusion of those with disabilities when policies are developed and therefore planned the review to establish if the views of students with disabilities are heard and actioned. Thus,

supporting the importance of conducting research which explores the views of those with disabilities in order to enhance their experiences.

There is a growing body of evidence and knowledge which seeks to understand the experiences of students with impairments in HE. However, there are significantly less studies which explore the views of those studying health and social care programmes and fewer still which explore the experiences of these students whilst on practice placement (Walker et al, 2013), something that I was specifically interested in.

One of the early studies in nursing, was completed in the United States (US) and considered the experiences of 10 students with physical and auditory disabilities (Maheady, 1999). She conducted a comprehensive qualitative study, in which she triangulated her findings, using documentary evidence, through observing the students in practice and interviewing fellow students, patients and staff who worked with the individuals with disabilities. Maheady defined 'disability' within her study as a visual, auditory or physical impairment. However, the study then failed to recruit students who were visually impaired. Interviews were completed with questions posed regarding the students' performance in the clinical setting, relationships with staff, patients etc. and competence in practice. Six themes emerged; participants were supported in diverse ways; they encountered greater attitudinal barriers than physical barriers; they needed to 'jump through hoops' (p 168) to be successful and felt they 'walked on eggshells' (p168) as related to the consequences of disclosing; have personal experience which is of benefit to the patients they work with as well as themselves; deemed themselves in terms of their successes and, fears and challenges as similar to their peers. Maheady (1999) also highlighted the importance of support both from a personal perspective – friends, family, staff, faith etc. and an adjustment perspective e.g. technology attitudinal barriers related to staff, peers, colleagues and employers.

Determination for success was evident within the students in the study with some going to great lengths, pain, self-control and persistence to 'jump

through hoops' (p168). Most participants feared disclosure and its consequences with one student being dismissed from a previous institution following a back injury. Participants believed that their disabilities offered them insight and empathy with the individuals they worked with, which in turn made them 'better nurses' (p168). The final theme identified within the research related to the individual's desires and experiences of wanting to be treated like their peers.

The early research that was conducted in HE following the introduction of the DDA (1995) appeared to be focussed on individuals with dyslexia or physical impairments. More recent research (Jung et al, 2014) has also included students with experiences of mental health conditions perhaps indicative of the increased prevalence of mental ill health with the HE student population.

2.3.1. Occupational Therapy Student Experiences.

Whilst equality for all is essential within Higher Education, as has already been established, for many it holds even further significance within OT. OT as a profession recognises the relationship that participation and engagement in meaningful occupation has on an individual's health and wellbeing (Wilcock, 1998). Wilcock (1999) suggests that Occupational Therapists enable individuals to transform their lives through a process of doing, being, becoming. Occupational Therapy

...embraces a unique understanding of occupation that includes all the things that people do, the relationship of what they do with who they are as humans and that through occupation they are in a constant state of becoming different (Wilcock, 1999; p2).

Therefore, understanding that studying OT as a meaningful occupation would influence the individual's health and wellbeing and change who they were becoming were important factors for consideration.

We strive to support individuals to achieve their potential and Salvatori (1999) considers the similarities between OT students and patients suggesting that within education we should also be client centred and ensure that our education and practice is underpinned by our philosophy. Hirneth and Mackenzie (2004) considered that there is a perception that Occupational Therapists are caring, nurturing and compassionate and have skills to analyse activities, grade and adapt environments and activities to enable individuals to be successful and achieve their potential. All of which appear to be essential when working with an OT student who has a disability. Within this research, it was important to explore if participant's experiences of OT education reflected the philosophy that underpins the profession.

The previous work which has been undertaken with OT students with disabilities is extremely limited and includes one small study conducted in the USA which aimed to gain an understanding of the experiences of students with disabilities in OT across HEIs (Velde et al, 2005). Only 5 students were involved in the qualitative phenomenological study and whilst 5 is an acceptable number of participants within a phenomenological research, this would limit the transferability of the results. Participants were recruited using purposive and snowballing sampling methods. They were current OT students or recent graduates (within 1 year of qualification), who self-declared a disability. They were interviewed via telephone or email. One participant responded by telephone and email and all others by email alone. This method of data collection may have deterred some participants from participation in the study. Others however may have preferred it, allowing them greater time to think and respond to questions honestly whilst not faced with the interviewer. The interviews were transcribed and data analysed using constant comparison method. The use of an audit trail, member checking and triangulation of data analysis were all methods used to enhance rigour and trustworthiness of the research. However, ethical approval was not reported within the study.

The results identified students want to 'work around it' (p85) recognising the need to work around their disability in order to fulfil the demands of the

programme both academically and from a placement perspective. Velde et al (2005) also identified that participants required support within the university and beyond, recognised that their disability was part of their identity and who they were and believed that having their impairment would enhance their practice as an Occupational Therapist.

The study highlighted that participants were highly motivated to be successful but had to work hard with what they perceived to be limited rewards for their efforts. Participants recognised their strengths and preferred learning styles and developed coping strategies to enhance their experiences of learning. I planned to use similar inclusion criteria to recruit those who were studying or had recently completed their OT training and had a self-declared disability. My intention was also to explore the student's experiences of education and practice placement and was designed from a phenomenological stance.

The need for support was highlighted as a theme for success. Participants within the study by Velde et al (2005) described their disability as being part of who they were. Three of the participants were diagnosed with SpLDs whilst undertaking their training. These participants acknowledged that they had found disclosure difficult and this was attributed to the stigma attached to the learning difficulty label. Again, making an interesting point which I wanted to explore with my participants in the context of OT education within the UK. I intended to discover, when participants were diagnosed and explore how they felt about disclosure.

It has been suggested within the literature that staff attitudes to disability can depend on the types of disability an individual has (Gitlow, 2001; Jung et al, 2014; Taylor, 2007). Gitlow (2001) investigated the attitudes of OT educators / lecturers to students with disabilities on OT programmes. The results indicated that overall educators had a 'favourable' (p115) attitude. However, the research used an adapted standardised tool to identify the attitudes, which would impact on reliability and construct validity. There was a 55% (n=166) response rate to the survey. Whilst this is a reasonable response rate, it could

be argued that those who chose not to respond could have had significantly different views.

Gitlow (2001) identified that the least favourable attitudes were identified about students with behavioural difficulties, particularly those who were physically aggressive. The most favourable attitudes were shown to those with social or academic difficulties. A favourability hierarchy was identified based on disability, with those perceived to be most disruptive or requiring most adjustments or with a more visible disability deemed to be least favourable. The most favourable attitude being toward those who are shy or withdrawn, or have difficulty expressing thoughts verbally and difficulties with speech.

Gitlow (2001) suggested potential reasons for the hierarchy which included the perceived increase in workload, the program size, the institutional environments or the level of experience the staff had with students with disability.

This research was published as widening participation became a priority within HEIs. The research was set in the context of the recommendations made by the American Occupational Therapy Association (AOTA) to expand the workforce to become more reflective of the wider population encompassing those of differing gender, disability, race, age, sexual orientation, ethnicity and location across the States. This research was conducted within the USA, limiting generalisation of the results due to the differences within the education systems. Taylor (2007), similarly, supported the existence of a hierarchy of disability acceptance within OT in the UK. She suggested that those with dyslexia were most accepted, with those who use a wheelchair, are blind, having an eating disorder, depression or schizophrenia least accepted.

Gitlow (2001) hypothesised that 'negative attitudes and non-inclusive values' (p117) along with physical and social barriers that exist within HE preclude individuals with disabilities from entering HE. She also hypothesised that OT

staff should have favourable attitudes to individuals with disabilities. However, it is suggested that as a result of the influence of the medical model, the attitudes of health professionals can be stereotypical and disempowering of those with disabilities (Bevan, 2014; Hill and Roger, 2016; McCormack and Collins, 2010). Exploring this from the OT student's perspective was deemed important and was planned to be addressed within this study.

Jung et al (2014) rationalised that there was a need to explore OT students' experiences of

...an inclusive educational experience that fits with the philosophical and theoretical principles of the profession and the cultural expectations of our diverse society (p146).

They therefore conducted a more recent qualitative study exploring the lived experience of OT students with disabilities enrolled in Canadian universities. Jung et al (2014) employed a purposive sampling strategy. Interviews were completed with 14 respondents, who had a range of disabilities, as defined by Ontario Human Rights Commission. Most participants had mental health conditions including major depressive disorder, Post-Traumatic Stress Disorder (PTSD), Generalised Anxiety Disorder (GAD) and eating disorder. No participants had a visible physical disability.

Interview data was collected using a range of methods. Most interviews were conducted via the internet. However, some participants were, interviewed face to face (2), via email (1), over phone (1), or via written responses (1). Using a range of methods to gather data may have offered greater choice to participants but may also have compromised the depth of data gathered.

Data was analysed using content analysis and themes identified. Credibility was enhanced within the study via triangulation and verbatim transcription. Two themes and six sub themes emerged with participants recognising their strengths and needs and navigating the environment as the two major themes. Within the strengths and needs theme participants identified the importance of external support for health and wellbeing but they also

recognised their own personal characteristics and coping strategies and believed these to be their strengths.

Turpin and Iwama (2011) suggest that when philosophical assumptions become embedded and shape our perspectives they become accepted and implicit in our being and this is how I believe I began to view the existing literature. Recognising that whilst Jung et al (2014) did not explicitly link their findings to OT philosophy and theory, I began to consider how the themes appeared to demonstrate a dynamic interaction between the person, the environment and the occupation of studying OT, as would be expected if applying a model of OT practice e.g. Person-Environment-Occupation-Performance (Christiansen and Baum, 1991), Canadian Model of Occupational Performance (Townsend and Polatajko, 2007) or Model of Human Occupation (Kielhofner, 1985) to the scenario. I was however, also conscious that traditionally a model of practice is used to guide interventions with clients and was therefore cautious in my consideration of this at this stage. Occupational Therapy models of practice do however also

provide an overarching context of occupation that emphasizes the occupational therapist's unique perspective on a client's ability to engage in activities and participate in life and attempt to explain the relationship of occupation, person and environment (Cole and Tufano, 2008; p61).

Therefore, my consideration of a model of practice at this stage was purely theoretical. Turpin and Iwama (2011) contest that no single OT model of practice is 'universally applicable' in all OT contexts and situations, suggesting that it is the therapists reasoning process which determines the appropriateness and relevance of the model. Initially I was broadly considering the concepts that all OT models have at their core, the person, the environmental contexts and the occupation of studying to become an Occupational Therapist and did not focus on one specific model.

Jung et al (2014) concurred with others (Bevan, 2014; Chacala et al, 2014; Velde et al, 2005), recognising disclosure as a complex issue, identifying that many factors impacted on decisions to disclose including fear of being judged,

discrimination and to whom disclosure was to. They identified it was easier to disclose to those who shared similar experiences or within the university, to those who demonstrated understanding, empathy, respect and acceptance. They acknowledged that it was more challenging to disclose within the placement setting, where they feared 'possible penalisation' (p150). It was important to establish if similar fears existed for students with disabilities who were studying within the home university.

Within the navigating the environment theme, participants in this study highlighted the importance of support from university wide support services and faculty staff. They explored how 'overt stigmatisation and lack of sensitivity by faculty toward participants resulted in feelings of frustration and anger' (p150) and considered how participants were 'shocked to find this in a profession that adheres to a philosophy of inclusion and acceptance regardless of ability' (p150). Exploration of how inclusive OT students within the home university felt their education was, including exploring the attitudes of staff from the student's perspective was also deemed important and therefore explored within this study.

Participants also highlighted that their social activity was limited with some reportedly wanting to connect with other students with disabilities in order to feel less isolated. Participants considered their future working environments and justified their decisions about working in specific clinical areas or part time. Exploring how OT students with disabilities within this study viewed their future practice was also an objective of the study.

The findings of both Jung et al (2014) and Velde et al (2005) had distinct similarities including the complexity of disclosure, the identification of personal strategies and characteristics to support success and the belief that participants held regarding how their disability experience would enhance their future practice. Jung et al (2014) suggested similarities may be as a result of similar contexts but also suggested that similarities could indicate that there may be some trends / common themes occurring for OT students with disabilities across the nations. Thus, suggesting that the individual

attributes may be worthy of consideration prior to beginning OT education to ensure 'a strong sense of fit' (p151). This study aimed to further corroborate or dispute the findings and suggestions of Jung et al (2014) within the UK.

Jung et al (2014) made recommendations for future practice which included ensuring that HEIs and OT departments have appropriate processes and procedures that staff understand and implement appropriately. They also recommended that student support services are accessible and that education is provided to staff and students to increase disability and reasonable adjustment awareness. Whilst, it was not the intention to explore or evaluate the procedures, services and the education of staff and students in the institution in which this research was undertaken from the institutional perspective, the student's views of these were canvassed.

2.3.2. Practice Placement

There is an obvious need for equality during placement (Brown et al, 2006) and as has been previously suggested it could be hypothesised that there is an expectation that OT practice educators are enthusiastic to work with students with additional support requirements, given their professional philosophy and skills (Hirneith and Mackenzie, 2004).

Very little has, however, been written in terms of OT students or other allied health students with disabilities experiences during practice placement (Hill and Roger, 2016). Brown et al (2006) completed a phenomenological qualitative pilot study exploring the experiences of health professional students during their placements in Australia. The participants were recruited from one university and data gathered using semi structured face to face interviews. Reflections and observations were recorded to increase the credibility and rigour of the study, whilst enhancing data analysis. Potential participants were required to have completed at least 1 practice placement and have a self-disclosed disability.

Ethical approval was gained and 10 students expressed an interest in participating but only 5 consented to participate. Of the 5 students one was male, 2 were nursing students and 3 were OT students. The participants had a range of disabilities that included hearing loss, dyslexia, cystic fibrosis and bipolar disorder. They had completed between 1 and 8 placements.

Data was analysed, via coding and 3 themes identified. However, little information was provided regarding data analysis and how the themes were therefore identified. The themes identified were the impact of their disability, including barriers and strategies for overcoming these, the practice placement experience and the support from the educator, friends, family and university staff. As an Occupational Therapist reviewing these themes, I again, saw the potential dynamic interaction between the person, the environment and the occupation of participation in practice education. This further fuelled my desire to consider if there would be a similar interaction for the participants in my study.

Each student described their unique experiences. Students reported needing to be highly motivated to succeed. As in previous studies they also expressed concerns regarding disclosure and attributed this to a perceived lack of knowledge and awareness by educators, university staff and peers. However, Sivanesan (2003) believed that honesty about her visual impairment, when undertaking practice placements, was key to her success. This can also influence the individual's perception of their identity. This study sought to explore the participants experiences of disclosure.

Brown et al (2006) described how participants had personal strategies to overcome barriers in placement such as preparation and planning. The importance of adapting to their own limitations, having a positive outlook and using personal coping mechanisms was also considered. It was also evident that these participants did not believe that the barriers they experienced impacted negatively on their performance from a competence perspective, and this view is echoed by many (Maheady, 1999; Sivanesan, 2003; Velde et al, 2004). My objective was to understand how the students within my study

viewed their placement experiences, exploring the factors they perceived to have enabled or hindered their experiences.

When asked to describe their feelings about practice placements, participants in the study by Brown et al (2006), identified 'nervousness, apprehension, uncertainty, worry and anxiety' (p35) with 2 participants reporting feeling excited. One participant emotively described 'surviving placement' (p35) and the feelings of 'dread' (p35) about another one. The support from the placement educator was described as 'pivotal' in developing confidence, reducing anxiety and developing coping strategies. Similarly, Sivanesan (2003) highlighted the role of the educator as crucial to her development, whilst an OT student. She described a naivety from one of her educators who she felt became overprotective and treated her like a patient, but others were 'open minded and flexible' (p569) enabling independent working and autonomy. Further, supporting the need to explore the experiences of practice placement from the perspective of OT students with disabilities in the home university.

In contrast to the studies by Jung et al (2014) and Velde et al (2005) participants within Brown et al (2006) indicated that they had little contact with wider university disability support systems. However, they proposed similar recommendations.

The small pilot study conducted by Brown et al (2006) has its limitations including the potential for recruitment bias. There were only 3 OT students included within the study and in-order to maintain confidentiality and anonymity it is impossible to identify if any specific trends can be noted as applicable to OT specifically.

A further study conducted more recently compared the experiences of disabled and non-disabled student during their practice placements (Hill and Roger, 2016). The study did not include any OT students, but did include students on other health and social care courses such as medicine, nursing and social work. The results of the study identified that both disabled and non-

disabled students experienced some similar difficulties during their practice experiences. However, the difficulties experienced by those with disabilities were exacerbated by their impairments. Supporting the findings of Brown et al (2006), disclosure proved challenging for those who participated in the study, but this was eased with the support of the practice educator. Supporting previous research, Hill and Roger (2016) also identified that those who were entering a profession underpinned by the medical model e.g. nursing or medicine were more reticent to disclose. Hypothesising that this was as a result of their fears of identifying 'with a disability label' (p1216). Understanding disability and disclosure from the OT student perspective was deemed important and therefore explored within this study.

Archer (1999) wrote of his personal experiences as an individual with Attention Deficit Disorder (ADD), dyslexia and a hearing impairment studying OT in the USA. Archer provided an account of his journey, including his expulsion from his OT programme following failure within a practice placement and prior to being diagnosed with ADD. His dismissal was linked to an inability to demonstrate clinical reasoning, problem solving and to think on his feet.

Archer (1999) identified the disparity in expectation, when it is the student's responsibility to request adjustments but the student is unaware of their disability. He was unaware of his ADD diagnosis when he originally enrolled on the OT programme.

Archer (1999) articulated differences between the university environment and that of the practice environment. As an academic high achiever, Archer (1999) felt he had learnt to compensate for his 'weaknesses' (p69). However, within the practice environment he described feeling overwhelmed, with difficulties organising and retaining information, with limited time and an expectation of speed. Botham and Nicholson (2014) suggest that there is a greater level of experience of making and applying reasonable adjustments for individuals with disabilities.

Archer (1999) described how his expulsion from the OT programme destroyed 'the image of OT as a caring profession' (p71). Following the diagnosis of ADD, Archer (1999) fought hard to understand his own needs and developed strategies that provided structure for his learning and demonstration of his skills in practice.

Archer battled for reinstatement and with support was able to return to studies. He expressed disappointment at the system but recognised how he felt better equipped to return to study with structures, strategies and adjustments in place. Archer's personal account was documented almost 20 years ago and therefore it was important to explore the current day experiences of OT students with disabilities in the UK.

2.4. Barriers to Education

All of the literature identified which explored the experiences of the individuals or groups of students with disabilities described barriers and enablers throughout their education (Jung et al, 2014; Lane, 2017; Velde et al, 2005). There is a consensus of opinions regarding many of the barriers and suggestions for the removal of these barriers are repeated frequently.

The most commonly cited barriers, which are also recognised to be the most difficult to overcome are attitudinal barriers (Bennett, 1989; Jung et al, 2008; Sivanesan, 2003; Wright and Eathorne, 2003). The attitudes of individuals are reportedly more disabling than impairment itself (Jung et al, 2014). Other barriers which have been identified include organisational, institutional, physical, cultural and social barriers (Jung et al, 2014). It is however acknowledged that these barriers are frequently inextricably linked and therefore it is difficult to separate them (Wright and Eathorne, 2003).

Sivanesan (2003) wrote of her personal journey as an OT student within the UK with visual impairment. Her perception was that she frequently encountered concerns regarding her abilities to succeed as an Occupational

Therapist and she acknowledged that whilst there are laws which prevent discrimination; individuals and society are required to 'uphold these laws' (p568).

Sivanesan (2003) described her personal experiences of university and practice placement. She acknowledged underestimating the volume of academic work required whilst training, recognising the need for reasonable adjustments such as magnified screen or note taker and support from peers and tutors.

The findings of the survey completed by Jung et al (2008) identified that attitudinal barriers were frequently cited by leaders of OT programmes internationally. Stigma was recognised as a barrier for 18% of respondents, specifically for those with mental health conditions. The results of this survey also supported the findings previously identified, indicating that practice educators are fearful of supervising students with disabilities as this can impact upon productivity in the workplace. It was highlighted that this can impact upon the willingness to offer placements, a point which was also reflected in an editorial in British Journal of Occupational Therapy (BJOT) by Awang and Taylor. Awang and Taylor (2005) described the challenges and barriers faced by disabled students studying OT within the UK particularly in relation to their practice placements. The editorial aimed to provoke practice educators to consider how their professional skills and OT philosophy could be used to support and facilitate the practice experience for students with disabilities. Whilst it was not the intention of this study to explore the practice educator's perspective of supporting students with disabilities in practice, understanding the experiences from the student's perspective was an objective of this study.

Wright & Eathorne (2003) facilitated workshops which aimed to explore the support and education of healthcare students with disabilities. During the workshops participants acknowledged that 'unintentional organisational discrimination' (p40) as a result of a lack of understanding and / or interpretation of the DDA could occur. Examples were provided such as

insufficient communication between HEIs and placement settings, inadequate local equality policy and procedures within organisations, perceived insufficient funding and knowledge to support appropriate reasonable adjustments. Whilst it is unclear who the participants were within the workshops the findings of this UK based study do appear applicable to all health care professions. An objective of this study was to understand the individual student's perspective of their own experiences of academia and practice and their journey to becoming an Occupational Therapist.

Whilst many recognise that over time improvements have been made to the institutional, organisational and physical environments including improved access to buildings and rooms, IT support, student support services, disability coordinators, the development of local policies and procedures and access to quiet spaces (Betz, 2012; Jung et al, 2008; Jung et al, 2014) some still identify barriers in these areas (Jung et al, 2008; Velde et al, 2005). Others continue to report on the difficulties and bureaucracy and time taken to access technology and equipment (Archer, 1999; Sivanesan, 2003). Students are however aware of the universities responsibilities to support them to be successful and make adjustments to make this possible (Paul, 1999). Understanding the support and barriers that OT students with impairments in one specific UK University experienced whilst training to become an Occupational Therapist was deemed important and was therefore a further objective of this study.

2.5. Practice Educator Experiences.

Whilst it was not the intention of the proposed study to canvas the opinions of practice educators, the research offering an insight into their experiences of working with OT students with a disability provided an interesting perspective and context for the research. Hirneth and Mackenzie (2004) conducted a qualitative pilot study exploring the supervision experiences of OT practice educators when supporting students with a range of disabilities in Australia. A phenomenological approach was adopted. Six participants were interviewed.

Participants reported adopting the role of a 'therapist' when working with students with disabilities and recognised that this was 'less effective than an educator role in developing students' initiative and clinical reasoning skills' (p401). Thus, supporting the experiences of Sivanesan (2003). Students with complex physical difficulties, those who lacked insight and those who had rigidity of thought were identified as the most challenging to support during a practice placement. Participants within the study called for improved preparation for students with disabilities prior to their placement and suggested that 'clear statements also need to be made about the level of support that students can reasonably expect from practice educators' (Hirneth and Mackenzie, 2004; p 401). Practice educators also felt a significant responsibility for their student to be successful and those adopting the role of the therapist were also concerned that they lowered their standards or gave students an inaccurate and higher indication of their skills. Results also indicated that participants required greater education and support from universities.

The need to support educators to develop an understanding of and the skills to facilitate learning within the placement setting for students with disabilities is suggested by many (Hirneth & Mackenzie, 2004; Jung et al, 2014; Sivanesan, 2003; Velde et al, 2005). Understanding the placement experiences of students with additional support requirements, including the perceived role practice educators took when supporting these students was therefore explored within this study.

2.6. Qualified Occupational Therapists Experiences.

Autobiographical narratives presenting the personal journeys of some who have become an Occupational Therapist suggest that an increased number of individuals with disabilities are successfully demonstrating their competence and qualifying (Bennett, 1989; Guitard & Lirette, 2005; Hibberd, 1998; Howard 1999; Murray, 2002). Many of these narratives, however, describe challenging

journeys, with some similarities linked to the attitudes of academics and practice educators and the challenges of accessing reasonable adjustments (Archer, 1999; Bennett, 1989; Murray, 2002).

A number of studies have been completed exploring the experiences of those, who have qualified to become an AHP (French, 1988) and an Occupational Therapist (Bevan, 2014; Chacala et al, 2014; Velde, 2000) and have a disability. Whilst, the focus of these studies was the individual's experiences of clinical practice, all considered the experiences of the participants whilst training and are therefore relevant to the current study.

Almost 30 years ago, French (1988) conducted a study exploring the experiences of 25 disabled health care professionals. Results indicated that most participants had favourable reactions to their disabilities within the workplace from their colleagues and patients alike but some had experienced negative attitudes during their education and training to become a health professional.

It appeared that the participants in the study by French (1988) experienced greater challenges from an attitudinal perspective prior to and / or during their training than once qualified. They outlined challenges in terms of a lack of reasonable adjustment and being prejudged as a result of their disability. However one OT within the study reported positive problem solving from her academics during her training, perhaps indicating that OT educators were more familiar with making adaptations in practice and were able to transfer these skills to the education and practice placement settings. French hypothesised that the differences in attitude whilst training as opposed to once qualified maybe as a result of a lack of 'professional status' (p184).

Four participants within the study reported difficulties in identifying and securing work following completion of the education programme, with all indicating that they had been selective about the jobs and roles they had applied for.

Supporting the findings of others all participants believed that their disability was advantageous in their work, with many identifying empathy and a first-hand understanding of illness and disability to be crucial in this (Bevan, 2014; Chacala et al, 2014; Velde, 2000). Some also identified how patients appeared to have a greater confidence in them and were therefore more likely to take their advice (French, 1988).

More recently and in some contrast Bevan (2014) and Chacala et al (2014) have reported on studies conducted with disabled Occupational Therapists exploring their experiences of becoming and being an Occupational Therapist. Both studies highlighted an incongruence between the underpinning philosophy and 'core assumptions' (Chacala et al, 2014; p107) of the OT profession and the cultural values and beliefs of their disabled participants. As it has been suggested that Occupational Therapists have

...traditionally drawn on the medical model in which disability means impairment, limitation, inferiority, deviance from the norm, warranting discomfort, pity, charity or concern (Chacala et al, 2014; p108).

Disability studies scholars implore Occupational Therapists to reconsider their use of the Medical Model of Disability in favour of the Social Model (Oliver, 1983) or Affirmative Model (Swain and French, 2000) which view disability as a social construct and impairment as

...simply difference, part of the natural range of human diversity, rather than an aberration in need of fixing (Chacala et al, 2014; p108).

Bevan (2014) suggested that it could be assumed that health professionals with disabilities would face minimal barriers to work given their working environments should be accessible and their colleagues should have an understanding of disability. However, the findings of her study and that of others (Chacala et al, 2014) did not support this assumption. Bevan (2014) and Chacala et al (2014) identified that Occupational Therapists with disabilities experience attitudinal, organisational and physical barriers.

Bevan (2014) hypothesised that the negative attitudes which had been endured by the participants in her study could at best be attributed to ignorance but at worst be attributable to indirect or direct discrimination. Similarly, Chacala et al (2014) identified that participants had experienced marginalisation and bullying within the work environment.

Bevan (2014) recommended 'removing disabling barriers in education, practice and research' (p593) and this research sought to identify current barriers within education which could be removed locally through the implementation of the study recommendations.

Velde (2000) suggested that her findings of a study exploring the experiences of disabled qualified Occupational Therapists held relevance for the education of OT students from a university academic and practice educator perspective. She implored academics and educators to understand and support the development of the needs and skills of their students. She also highlighted the importance of reasonable adjustments and the identification of coping strategies and support networks.

Velde (2000) explored the experiences of having a disability from a qualified Occupational Therapists perspective. She interviewed 10 Occupational Therapists with a range of physical disabilities, 7 of whom were diagnosed prior to their OT education. There is no mention of ethical approval reported within the article which is a significant concern.

Participants who had their disabilities prior to training as an OT, described challenges associated with entry to OT, practice placement and securing their first post following qualification but all commented

...that as their resumes grew, employers and peers began to see them as able therapists, not persons with disabilities...and competence was no longer questioned (Velde, 2000; p186).

The findings depicted largely positive experiences of being an OT with a disability for those participants involved in the study. However, this may have been as a result of the sampling strategy used to recruit participants. Participants may have volunteered for the study because of the nature of their success. Those experiencing high levels of difficulties within practice may have been more reticent to volunteer.

The study by Velde (2000), created considerable discussion within the American Journal of Occupational Therapy (AJOT) and the publication of this study resulted in calls for a similar study with Occupational Therapy students. Thus prompting Velde et al (2005) to complete the small scale study previously discussed. This also demonstrated the need for such a study internationally more than 10 years ago and yet still this under investigated research topic remains unexplored within the context of the UK, thus further justifying the need for this study.

2.7. Summary

Research conducted to date has identified a paucity of research exploring the experiences of disabled OT students during their OT education indicating the need to pursue this field further (Jung et al, 2008; Jung, 2014; Sivanesan, 2003; Velde, 2000; Velde et al, 2005). The OT research identified has been found to be specifically related to the experiences of qualified Occupational Therapists with a disability (Bevan, 2014; Chacala et al, 2014; Velde 2000), the practice educator experience (Hirneth & Mackenzie, 2004), was conducted external to the UK (Brown et al, 2006; Jung et al 2014; Velde et al, 2005) or was opinion based and related to personal experiences (Archer, 1999; Bennett, 1989; Murray, 2002; Sivanesan, 2003). With no specific research conducted in the UK, with OT students, with impairments identified, within the last 7 years, since the Equality Act (2010) superseded the Disability Discrimination Act (DDA) (1995).

Current literature suggests that there are a number of areas within the education process that require further consideration. These areas include pre-entry and admissions, teaching learning and assessment, disclosure of disability and support requirements and practice placements (Hirneth and Mackenzie, 2004; Sivanesan, 2003; Storr, Wray and Draper, 2011; Velde et al 2005).

Whilst reviewing the OT literature exploring the experiences of being an OT student with a disability it became apparent that the lens with which I viewed the literature was linked specifically to the dynamic interaction between the person, the environment and the occupation of studying OT. Thus implicitly using the broad context of a model of OT practice to understand the experiences described within the studies.

There is also very limited research exploring the experiences of students with mental health conditions in OT. This may perhaps be as a result of a lack of disclosure associated with perceived stigma, the prevalence of mental health conditions or the currency and location of the previous studies.

Texts and guidance have been written, outlining good practice when working with students with disabilities (Fuller et al, 2009; Haines and Ruebain, 2011; Riddell, Tinklin and Wilson, 2005). These provide instructional guidance for those working with students with disabilities and whilst offering a historical account, they are however, out of date as soon as they are published, as policy, processes and procedures are changed, updated and amended frequently.

The need to explore and understand the views of those experiencing the phenomena of being a student with additional support requirements studying OT in the UK is clear and is supported within the literature (Coffey, 2001; Jung et al, 2008; Murray, 2002; Velde, 2000). Whilst 2 studies have been completed exploring this phenomena they have both been conducted outside of the UK, Velde et al (2005) in USA and Jung et al (2014) in Canada. Thus providing further support for this proposed study.

There are many limitations to the existing literature. To date the studies which have been conducted within OT are all international and have all been small scale studies. It is therefore necessary to explore the UK perspective, in order to identify if the experiences of those internationally compare with those in the UK.

The process of examining my personal experiences of working with students with disabilities, who have studied OT and completing an initial review of the existing literature allowed me to identify a gap in the knowledge base and to determine the research aim and objectives of the study. The introduction and literature review have presented the gap in the existing knowledge and outlined the research problem, the rationale for conducting the study and the context in which the study is set.

2.8. Research Aim and Objectives

2.8.1. Research Aim.

The aim of this research was therefore to:

- Understand, analyse and interpret the individual's experience of being an OT student with additional support requirements / disabilities at one higher education institute within the UK.

The expectation was that each participants experience would be unique and would provide rich detailed descriptions and interpretations of their 'lived world'.

2.8.2. Research Objectives.

The objectives of the research were:

- Understand and interpret the meaning disability has for individuals with additional support requirements who are undertaking a BSc (hons) in OT.
- Understand from the individual student's perspective, the true experience of being an OT student and becoming an OT with a disability from both the academic and practice placement perspectives.
- Explore and understand the individual student journey through their personal narrative.
- Explore and understand through the voice of the individual the factors that hinder and support the successful completion of the programme.
- To propose actions and recommendations for the future.

The principle purpose of the research was to seek to enhance knowledge by understanding the unique experiences and the meanings attributed to these experiences by students with disabilities in the under researched field of OT in the UK.

This research offered the potential to provide an enhanced knowledge base on which to make recommendations, develop policy and guidance and enhance current practice (Pring, 2004; Kielhofner, 2006), whilst recognising the importance of the student voice and their experiences (BIS, 2011) in higher education and 'students as co-creators, not consumers of their education' (Campbell et al, 2009; p1).

3. Methodology.

3.1. Introduction.

This chapter will present the philosophical stance, research design and methodology, including the method of data collection and how this will be analysed and interpreted in this thesis. This research was underpinned by Interpretative Phenomenological Analysis (IPA). IPA is a research approach identified in the late 1990's by Smith (Smith, 2004), a psychologist and whilst primarily used by psychologists, its prevalence and popularity as a qualitative approach to research within other professions is increasing (Clarke, 2009). Initially, the theoretical underpinnings of IPA as a qualitative research approach will be discussed, including that of phenomenology, hermeneutics and idiography. Links will be made between the theory that supports and underpins IPA and the philosophy that underpins the Occupational Therapy profession. The ontological and epistemological position taken within the research will be briefly considered. Justification for the chosen methodology whilst considering its limitations will be provided, along with a brief consideration of other qualitative approaches. Finally the research and analysis of the data will be considered focusing on issues of quality, such as trustworthiness of this research. Some consideration will also be given to the potential effect of being an "insider researcher" and the impact this may have had on the data collected.

3.2. Philosophical Stance and Research Design.

The importance of researcher positioning is widely acknowledged as essential prior to conducting research (Nayar and Stanley, 2015). It was therefore important that I explored my own views of reality and my cultural values, attitudes and beliefs prior to undertaking this research. Consideration of the influence of my professional philosophy, including its values and beliefs were also key to understanding my position in relation to the research.

There are a number of epistemological positions which exist within the literature, with scholars debating if they exist as separate entities or indeed upon a continuum from which research and the search for knowledge is understood (Kielhofner, 2006; Pring, 2004). The epistemology underpinning the positivist stance is that of objectivism (Crotty, 2015). Objectivism is

...the notion that truth and meaning reside in their objects independently of any consciousness (Crotty, 2015; p42).

Adopting a positivist approach would have required the use of objective, quantitative research methods, of the natural sciences such as experiments and the use of surveys to measure, behaviours, actions, interactions and cause and effect relationships, avoiding error or bias (Bryman, 2007). My personal interest was never in quantifying, gathering statistical objective data, testing hypotheses and theories or developing laws. I therefore rejected positivism.

Within this research, I wanted to understand the meaning each student constructed as they interpreted their experiences of being a student with additional support requirements on the BSc (hons) OT programme within one Higher Education Institution (HEI) within the United Kingdom (UK). My intention was to understand their life-world as they constructed it, viewing the individual as a 'sense maker' (Ashworth, 2015; p 15). It was my intention to co-construct the research findings through interaction and interpretation. I was interested to understand the subjective meaning of their disability, their experiences of academic life and practice placement and their motivations for becoming an Occupational Therapist. I wanted to give my participants a voice empowering them to influence change and enhance future practice (Allan, 2010; Gibson, 2015).

Therefore the aim and objectives of this research were more aligned to interpretivism which seeks to understand human behaviour rather than explaining human behaviour, as would be expected from a positivist perspective. The literature recognises the polarized stances of positivism and

interpretativism (Blair and Robertson, 2005; Howell, 2013; Pring, 2004). It was not my intention to reduce the complexities and nature of exploring individual's experiences and environments to component parts or 'discreet variables that can be measured and controlled' (Nayar and Stanley, 2015; p4). Furthermore, I did not wish to generalise the research findings (Willig, 2000) to a larger population, as would be expected if testing a hypothesis using a large sample. My intention was to understand the 'multiple realities' (Cresswell, 2007; p16) of the subjective concept of disability from an individual's perspective in the context of studying OT in one university within the UK.

Remaining emotionally neutral and detached, as would be expected within an objectivist epistemology and positivist approach (Green & Thorogood, 2009; Howell, 2013) would have been impossible, as I am an OT lecturer and practice placement coordinator. I recognised my position in relation to both the research topic and the participants. I acknowledged that my knowledge of the subject would influence my interpretation but that this would also allow me to consider my professional understanding of the research (see section 3.4). I reflected throughout the research process and analysis of the data anticipating the effects of my position, as envisaged within an interpretivist approach (Cohen, Manion and Morrison, 2011).

It could also be argued that, professionally as an Occupational Therapist whose philosophy is grounded in humanism and understanding the complexities and uniqueness of individuals that the 'pursuit of objective evidence' (Blair and Robertson, 2005; p270) is incompatible with the professions philosophy. Conducting research which reflected and was congruent with not only my personal philosophy but that of my profession, from both an OT and educationalist perspectives was important to me (Tight, 2003).

Research within OT began to develop within the 1950's and was predominantly focused on objective scientific methods to gather data emulating our medical and psychology colleagues (Custard, 1998; Yerxa,

1991). At this time scientific research was deemed essential for the growth of the profession (Custard, 1998) and thus OT was driven to establish the value of occupation using experimental quantitative methods 'in an attempt to validate its existence [and] ensure its survival' (Custard, 1998; p676). The focus, therefore, being on pathology, effectiveness of intervention and outcome measurement such as range of movement, strength and endurance rather than that of true occupation (Yerxa, 1991).

Whilst the focus on experimental scientific research supported the development, growth and reputation of the profession, it was 'inconsistent with the holistic philosophy of OT' (Custard, 1998; p679) and in 1991, Yerxa suggested that the OT profession needed 'to seek or invent new ways of knowing' (p200), which were more consistent with the profession's epistemology. She suggested that the epistemology of OT was far from that of the medical profession and argued eloquently for the use of research which is ethically and culturally consistent with the values of the profession.

Qualitative research in OT and Occupational Science (OS) began to emerge as the profession sought more congruent research design and methods to explore the context and meaning of individual's lives, occupations and illness experience, adopting an interpretivist epistemology. As a result, significantly increasing the volume of qualitative research within the profession (Nayar and Stanley, 2015). The current research within OT and OS aims

...to understand the place of occupation within and throughout people's lives (Nayar and Stanley, 2015; p9).

In congruence, it was my desire to explore and understand how studying OT had and was influencing the participant's lives. My intention within this research was specifically to explore and understand the person's experiences of the role of being an OT student with a disability and in participating in the occupation of studying OT, which is suggested, is

...information which can not be enumerated or captured by measurement without losing some of the richness and depth of meaning (Nayar and Stanley, 2015; p9).

OT is built on the premise that there is an inherent link between occupation, health and wellbeing and that engaging in meaningful occupations can lead to a greater fulfillment and quality of life (Wilcock, 2001). The profession is underpinned by humanism and its values. Occupational Therapists recognise the complexity and uniqueness of human beings, whose qualities include

...language, history, culture and the endowment of life experiences with spiritual meaning (Yerxa, 1991; p199).

It is this complexity and uniqueness which I aimed to explore, illuminating the individual's experiences and the meaning attributed to this through their own cultural and historical stories. Occupational Therapists recognise the importance of the lived experiences of the people they work with and my intention here was to seek the individual's 'real world' view (Yerxa, 1991; p201) of being an OT student, with a disability studying a BSc (hons) programme in the UK. I did not seek to reduce this experience to a single cause-effect relationship removing variables, which would have inevitably lost sight of the complexity of both the person and their occupations (Yerxa, 1991). My interest lay in the subjective experience and the environmental and contextual influences of this experience. Occupational Therapists recognise the environment as a barrier or an enabler to engagement and occupational performance and I wanted to understand and interpret the impact of the environment, in its widest context, on the individual's experiences.

From an educational perspective, Cohen et al (2011) also suggest that whilst the traditional scientific objective research approaches remain important, there has been increased interest and a tendency to adopt interpretivist approaches. Miller and Glasser (2016) suggest that

...research can not provide the mirror reflection of the social world that positivists strive for, but it can provide access to the meanings people attribute to their experiences and social worlds (p53).

Interpretivism was required to gain insight into the complex subjective experiences of the students and there are a number of research methodologies outlined within the literature which could have been employed to explore this phenomenon. Whilst qualitative methodologies such as ethnography, grounded theory, narrative research and case studies have similarities to phenomenology, they also have distinct differences. All qualitative research begins with a research problem, which requires exploration (as outlined within the introduction and literature review). Frequently they employ similar methods of data collection, within a natural setting, use inductive data analysis to identify themes, ensure that the voice of participants is evident, within 'thick' descriptions, whilst explicitly demonstrating researcher reflexivity (Cresswell 2007). However, their purpose and aims differ.

Exploring a life [phenomenology] is different from generating a theory [grounded theory] or describing the behavior of a cultural group [ethnography] (Cresswell, 2007 P77)

It was my desire to explore the life experiences of individual's with a disability studying OT. Differences also exist in terms of the 'emphasis' and 'extent of data collection' (Cresswell, 2007; p77) e.g. observations within ethnography and the multiple forms of data collection within case study research to develop a comprehensive view of the case.

However, phenomenology and specifically Interpretative Phenomenological Analysis (IPA) which has its focus on the everyday 'lifeworld' of individuals was indicated to explore a concept which had not been widely researched previously (Maringer and Jensen, 2014; Wright-St Clair, 2015).

Phenomenologists, seek to understand an individual's 'personal lifeworld' (Ashworth, 2015; p4) through understanding, describing and interpreting an individual's perceptions and the meaning they ascribe to experiences they have had. Concepts which resonate well with the philosophy of OT, in which we focus on the participation in meaningful occupation, such as studying OT with a disability (Nayar and Stanley, 2015).

Very little previous primary research has been conducted exploring the experiences of being an OT student with a disability as discussed previously. However, those that have been completed (Brown, et al 2006; Jung, et al 2014; Velde, et al 2005) have all adopted a phenomenological approach. Therefore supporting the use of the approach in this study, however, none of those identified explicitly used Interpretative Phenomenological Analysis (IPA).

3.3. Interpretative Phenomenological Analysis (IPA).

IPA is a qualitative research approach with its foundations in phenomenology (Smith, Flowers and Larkin 2009). IPA was initially developed by Smith, a psychologist, in the 1990's and has 3 underpinning theoretical influences, that of phenomenology, hermeneutics and idiography (Smith, 2004).

3.3.1. Phenomenology.

Within this research I wanted to illuminate the unique experiences of studying OT as an individual with a disability, as described by my participants. The focus of the study was human experience.

Phenomenology was developed originally from Husserl's seminal work (Kaufman and Chemero, 2015). The term phenomenology is derived from the Greek words phenomenon and logos. Phenomenon translated means

...appearance which can have different forms where some are disguised or latent and logos means analytic thinking which helps facilitate or grasp this appearing (Davidsen, 2013; p323).

Thus phenomenology is interested in the analysis of how experiences appear and it was my intention to explore how being an OT student with an impairment was experienced and appeared to the individual. Phenomenology

is concerned with conscious thought, individual's experiences and the rich thick descriptions individuals use to articulate these experiences. I was interested in exploring how my participants described their experiences of living with a disability, whilst studying to become an Occupational Therapist. Phenomenology has been described by Finlay (2011) as bringing

...to life the richness of existence through description of what may appear at first sight to be ordinary and mundane living (Finlay, 2011; p 26).

Finlay (2011) suggests that phenomenology is unlike other research approaches as it

...does not categorise or explain behaviour nor does it generate theory. It seeks solely to do justice to everyday experience, to evoke what it is to be human (p3).

It was not the primary intention of this research to generate theory but to explore the experiences of studying OT, from the perspective of an individual with a disability and therefore a phenomenological approach was deemed most appropriate.

Savin Baden & Howell Major (2013) suggest that phenomenology seeks to uncover the commonalities of an experience or phenomenon from a range of participants and within this research whilst committed to understanding the individual's experiences, I was also interested to see if there were any commonalities and differences within the participant experience.

Phenomenology also differs from other qualitative methods in its stance toward the participant and the researcher. Phenomenological researchers view the person and their environment as a whole. They believe that the person who experiences the phenomena is the 'only reliable source of information' as their experience is unique but Ashworth (2015) suggests that life worlds have some 'universal features' (p13) including

...temporality, spatiality, subjective embodiment, intersubjectivity, selfhood, personal project, moodedness and discursiveness although individuals experiences may differ (Ashworth, 2015; p13).

Phenomenology as a research methodology is philosophically compatible with OT (Finlay, 2011) as well as within health care and education (Lopez and Willis, 2004). Wilding and Whiteford (2005) suggested that phenomenology has become more popular within OT as the approach is congruent with the philosophy of the profession and it's beliefs surrounding the uniqueness of each individual and the meaning they associate with their experiences.

Finlay (2011) also suggests that researchers are

...drawn to phenomenology; its holistic appreciation of every day human experience resonates for them (p ix).

This was certainly the case in this instance, the importance of truly listening and understanding the individual's experiences of disability whilst studying to become an OT resonated not only with my personal philosophy but also with the philosophy of OT and OS. I wanted to use the participant stories to empower and enhance future practice (Gibson, 2015; Vickerman and Blundell, 2010). Finlay (2011) also suggested that phenomenology allows for personal and professional development, deepening the understanding of our practice and this was a key objective within the research.

The use of phenomenology, within this research, allowed me to:

- Focus on the individual's lived experiences of being an OT student with a disability and the meaning this held for them.
- Use rigorous, rich 'thick' descriptions when illustrating the student's stories.
- Consider existential issues arising from the students stories and narratives, by exploring what it was like to 'be' an OT student from the unique perspective of each participant.
- Assume that the individual and their world are entwined.

- Engage in the research which was potentially transformative and illuminating for both the participant and the researcher (Finlay, 2011; p6).

There are many forms of phenomenology, however, theorists who have influenced the development of IPA specifically emanate from descriptive and interpretative or hermeneutic phenomenology. Each of these have influenced the development of IPA as a research method but the primary differences between these approaches to / forms of phenomenology lie in the generation and analysis of the data and how these findings add to the knowledge base of the profession (Lopez and Willis, 2004).

3.3.2. Interpretative Phenomenological Analysis.

Phenomenological philosophy 'provides IPA with a rich source of ideas about how to examine and comprehend lived experience' (Shinebourne, 2011; p17). Husserl, the founder of descriptive phenomenology, recognised that human experience held value and should and could be studied scientifically (Lopez and Willis, 2004). He thus believed that research could scientifically investigate

...essential components of lived experiences specific to a group of people (Lopez and Willis, 2004; p727).

Smith et al (2009) suggested that like Husserl's descriptive phenomenology, IPA is underpinned by a systematic and attentive reflection of human experience. However, Husserl's phenomenology was more aligned with a positivist paradigm (Wright-St Clair, 2015) and his ideas were further developed by Heidegger and others and interpretative / hermeneutic phenomenology was established (Ashworth, 2015; Howell, 2013; Smith, Flowers and Larkin, 2009).

Wright-St Clair (2015) suggests that as

Heideggerian phenomenology is a way of uncovering and interpreting people's situated experiences in this world, thus it fits within the interpretative paradigm (p54).

Furthermore, she believes that interpretative phenomenology is concerned with understanding and interpreting the existential nature of being (ontology) rather than

...seeking to understand how people come to know things in the world (epistemology) (p55).

Heidegger's philosophical aim was to understand existence. He identified the concept of Dasein or 'being there' / 'there being' which relates to the understanding of being. He espoused that the person and their lifeworld are inseparable and that this should 'be the focus of phenomenological inquiry' (Lopez and Willis, 2004; p729). Within this study, I wanted to understand what 'being' an OT student with a disability was like from the individual's unique perspective.

Whilst a separate body of knowledge, hermeneutics, the theory of interpretation was also recognised in the work of Heidegger (Smith, Flowers and Larkin, 2009). Hermeneutics is concerned with the interpretation of text, in order to understand the individuals thoughts and lived experiences (Smith, Flowers and Larkin, 2009; Wright-St Clair, 2015).

Heidegger suggested that

...a phenomenon is something which is not self-evident; it is taken for granted or concealed in some way (Wright-St Clair, 2015).

Through interpretation the phenomenon becomes illuminated. The exploration of the lived experience of disability whilst studying to become an Occupational Therapist, aimed to illuminate and examine the previously under researched and unknown subject within the context of the UK Higher Education.

Heidegger theorised that description involved interpretation and believed that with experience comes meaning and that meaning can be identified via hermeneutics or a process of interpretation (Lopez and Willis, 2004). I wanted to uncover the meaning that individuals attributed to their disability and how they interpreted their experiences of being an OT student.

Schleiermacher, a hermeneutic scholar, suggested that through interpretation the analyst, along with their knowledge and experience of the subject is able to offer a different perspective to the text than that of the author (Smith, Flowers and Larkin, 2009). Thus my interpretation of my individual participant's narratives and the whole data set, would offer a different perspective given my knowledge and experiences.

IPA is a structured hermeneutic phenomenology, which allows rigorous and systematic exploration of subjective experiences (Biggerstaff and Thompson, 2008). It is a dynamic approach in which the researcher plays an active role within the research process (Smith and Osbourne, 2007; Smith, 2009; Clarke, 2009; Cronin-Davis, Butler and Mayers, 2009; Pringle et al 2010). IPA is primarily an interpretative approach which

...aims to capture and explore meanings that participants assign to their experiences (Reid, Flowers and Larkin, 2005; p20).

IPA, following the beliefs of Heidegger,

...is concerned with examining how a phenomenon appears and the analyst is implicated in facilitating and making sense of this appearance (Smith, Flowers and Larkin, 2009; p28).

Thus developing an understanding of an experience within an IPA study is crucially not just about identifying the phenomena but also to

...understand, both in the sense of trying to see what it is like for someone and in the sense of analysing, illuminating and making sense of something (Smith, Flowers and Larkin, 2009; p36).

Thus my intention was to understand what being an OT student with a disability was like from the participant's perspective, whilst also analysing the individual's perspective in the context of my knowledge. This two stage interpretation process, referred to as a 'double hermeneutic' by Smith (2009) acknowledges the researcher's involvement when interpreting the participant's personal experiences thus allowing the researcher to access the individual's 'inner world'.

In order to maintain integrity in interpretation, I endeavoured to understand the experiences of the individual from within (Cohen et al, 2011) whilst acknowledging that it is not entirely possible 'to stand in the shoes of the subject' (Pietkiewicz & Smith, 2012; p8).

My emphasis was on interpretation, which generated a deeper understanding of the experiences of being an OT student with a disability from the individual's perspective through the lens with which I viewed the data (Clarke, 2009) as an Occupational Therapist and an OT educator.

The ability to fully achieve transcendental reduction, as suggested by Husserl, is disputed by phenomenologists such as Heidegger, Sartre, Gadamer and Merleau Ponty. They believed that truly and fully bracketing all knowledge, bias and preconception is impossible given the researcher's 'own embodied position in the world' (Smith, Flowers and Larkin, 2009; p18). Lopez and Willis (2004) also highlighted how knowledge, understanding and interest in a topic are frequently the initiators of research, as was the case here. Smith, Flowers and Larkin (2009) also suggest

...the reader, analyst or listener brings their fore-conceptions (prior experiences, assumptions, pre-conceptions) to the encounter and cannot help but look at any new stimulus in the light of their own prior experiences (p25).

Recognising my 'fore-conceptions' and 'fore-structures' allowed me to consider the 'likely consequences of [my] preconceptions and structure of

[my] knowledge' may have on the research, thus improving the credibility and transparency (Finlay, 2011; Smith, Flowers and Larkin, 2009). My subjectivity and any preconceptions which may have impeded the research also 'enabled insight' which others would potentially not have had (Finlay, 2011). I, therefore embraced my subjectivity and potential biases but engaged actively in reflection and reflexivity, throughout the research process, as implied in Dasein (Smith, Flowers and Larkin, 2009).

Reflecting on my personal and professional beliefs, I recognised that I am influenced by my culture and history. I am an Occupational Therapist, who believes that everyone is unique and has the right to engage and participate in occupations which hold meaning and value to them. Therefore, I believed that my participants would be unique and that studying OT would be meaningful to each of them. I accept that engagement in meaningful occupation can positively influence health and wellbeing. I believe that everyone has an equal right to education. My experience of education has changed; I have been actively engaged in the education of OT students for more than 20 years from both a practice educator and lecturer perspective. A positive outcome of the widening participation agenda with HE and anti-discriminatory legislation is the increased numbers of individuals with disabilities accessing HE and OT specifically. The greater diversity within the student cohort is welcomed and refreshing but can also pose challenges. During the last 20 years the complexity of the adjustments some students with disabilities require appears to have increased. Whilst it also appears that systems within the university have improved enabling students to access and utilise reasonable adjustments, these adjustments are not always so readily available within the practice setting. As a practice placement coordinator, I have been exposed to potentially discriminatory attitudes towards students with additional support requirements, which would not be expected from a profession whose core skills include activity analysis, grading and adaption.

The work of Heidegger and interpretative or hermeneutic phenomenology proved most influential when considering the aims of this research, given the desire not only to describe the experiences of individuals with additional

support requirements but also to make sense of and interpret the meaning of those experiences. Wilding and Whiteford (2005) also contend that

Heideggerian phenomenology is consistent with OT's philosophical beliefs about the importance of everyday life and everyday doing (Wilding and Whiteford, 2005; p99).

My intention was to explore the individuals every day experiences of being an OT student with an impairment, considering their academic life and their experience of practice placement.

Smith, Flowers and Larkin (2009) suggest that an underpinning belief of IPA is that

People are physical and psychological entities. They do things in the world, they reflect on what they do and those actions have meaningful, existential consequences (p34).

This too resonates with the underpinning beliefs of OT and OS reflecting the holistic nature of the profession and our beliefs linking participation in meaningful occupation to doing, being and becoming (Wilcock, 1999; See Section 4.3.1.1).

Merleau-Ponty and Sartre, further added to Heidegger's perspective on phenomenology and their beliefs have also influenced the development of IPA specifically but also appear to link directly with the philosophy of OT. Merleau-Ponty believed that:

The lived experience of being a body in the world can never be entirely captured or absorbed, but equally, must not be ignored or overlooked (Smith, Flowers and Larkin, 2009; p19).

His belief that the individual's cognitive and physical aspects of the body in the world were influential within an experience link well to the holistic beliefs within OT, that the body and mind can not be separated. Sartre believed that

we are always becoming ourselves, and that the self is not a pre-existing unity to be discovered rather an ongoing project to be unfurled (Smith, Flowers and Larkin, 2009; p19).

His suggestion that we become who we are through engagement in 'projects', frequently with others, is also reflected in OT philosophy and our beliefs that engagement in occupations (such as studying to become an Occupational Therapist) are linked to the development of one's identity. This study sought to explore if and how studying OT was linked to the development of the individual's identity. Typically, within an IPA study, I wanted to explore the embodied, existential factors, thoughts and feelings (Smith, Flowers and Larkin, 2009) which impacted upon my participants as they experienced a new 'project' studying to become an Occupational Therapist, being an OT student with a disability.

IPA differs from other hermeneutic approaches, in that, it focuses on the individual and prioritises exploration of the individual's sense making (Maringer and Jensen, 2014). IPA is committed to idiography. Idiography opposes nomothetics in its approach to knowledge. Nomothetics considers how the behaviour of an individual is

...the outcome of laws that apply to all and the aim of science is to reveal these general laws (Ashworth, 2015; p14).

Idiography focuses upon the particular. IPA is concerned with depth and understanding the detail of particular experiences 'from the perspectives of particular people in a particular context' (Smith, Flowers and Larkin, 2009; p29). Thus data analysis is detailed and thorough.

Idiography can also refer to the commitment to the single case in its own right, or to a process which moves from the examination of the single case to more general claims. Thus idiography does not eschew generalisations (Smith, Flowers and Larkin, 2009; p29).

The commitment to idiography and the particular was a further reason for undertaking an IPA study, the idiographic element was important to me and my professional beliefs. I believed it was important to recognise the distinct

voice of the individual and to understand their unique experiences and the meaning they ascribed to their lifeworld before considering if there were convergences and divergences across cases. I was committed to the idiographic sensibility as I wanted to understand the experiences of the students with additional support requirements whilst studying OT at one university within the UK.

As an interpretative phenomenologist, I explored the experience of disability as it was reflected upon by my participants, as it emerged and became visible to them initially, as they made sense of their experiences and to me as I interpreted their sense making (Smith, Flowers and Larkin, 2009).

My primary rationale for choosing IPA rather than any other qualitative approach was related to its 'fit' with the epistemological position of the research question (Smith, Flowers and Larkin, 2009). IPA was chosen for a number of reasons:

- In congruence with OT, IPA offered a detailed exploration of how the participants make 'sense of their personal and social world' through the exploration of the meaning of their experiences' (Smith and Osbourne, 2007; p55). Using IPA offered the potential to interpret how the occupation of being an OT student was experienced and how the meanings of participating in the occupation was ascribed by each individual participating in the occupation.
- IPA allowed me to explore the 'rich, multifaceted, intangible and dynamic phenomena' (Wilding and Whiteford, 2005; p103), of being a student with a disability, studying OT. I wanted to understand, imagine and interpret 'insider accounts' via participants (Smith et al, 2009), which is not a requirement of all qualitative research.
- IPA is idiographic and as such client / person centred and focused on the detailed exploration of each individual's lived experience of

studying OT before making comparisons with others (Smith, Flowers and Larkin, 2009).

- IPA allowed me as an OT researcher to develop a deeper understanding of each participant individually and the meaning studying to become an Occupational Therapist held for each of them. The use of IPA facilitated a deep and thorough personal reflection on existing practice, leading to a potentially enhanced service for OT students with disabilities (Clarke, 2009; p37).
- IPA has also recently increased in popularity not just within psychology but within other healthcare disciplines, including OT and education (Clarke, 2009; Finlay, 2011; Smith 2011).

3.3.3. Limitations of IPA.

Despite its growth, IPA remains a 'relatively new methodology' (Wagstaff et al, 2014; p4) and its use within Occupational Therapy has not been fully evaluated. However, its use and application within OT is increasing. The reported limitations of IPA include the variations of its application, the lack of understanding and support (Wagstaff et al, 2014) and the amount of time and commitment required to undertake in depth data analysis (Clarke, 2009).

Brocki and Wearden (2006) suggest that there is limited information about the level of researcher interaction and interpretation within the interview which can lead to variations in the quality and quantity of data gathered. This was evident upon review of the interviews undertaken within this study, where I believed I was offering an interpretation but felt the need to prefix my question / comment with 'I am not putting words into your mouth'.

A further limitation of IPA, described in the literature is 'an uncomfortable dualism or opposition between theme and idiography' (Wagstaff et al, 2014;

p12) and this was something that I struggled with during my analysis of the data, reflecting my values and beliefs as an Occupational Therapist.

3.4. Insider Research.

As a researcher, a lecturer and the practice placement coordinator investigating the experiences of having a disability, illness or condition whilst studying OT, I was an insider researcher (Helawell, 2006). I was part of the organisation and culture to which the participants belonged. However, I was not a direct member of the 'community' that was being researched. I held prior knowledge of the 'community' under investigation but I was neither a student nor an individual with a disability and therefore a 'partial insider' (Chavez, 2008; p475). I did however, have a long history of working with students including some of the participants with additional support requirements. Although I would not consider the relationship with any potential participants to be that of an 'intimate insider' (Taylor, 2011; p15) as none of the participants were known from a personal perspective.

I also had significant experience of the OT programme and as such felt I had some understanding and a significant interest in learning more about the value and experiences of this group of which I was not a part. Being an insider researcher, allowed me the opportunity to explore the student's experiences from a position of some shared understanding. I was aware of processes and procedures within the institution and beyond and potentially understood the decision making processes which appeared illogical to some participants. I was also conscious of the potential to misinterpret the individual's story based on my prior knowledge and possible assumptions related to their experiences within the University, such as the barriers individuals encounter (Mercer, 2007). Recognising this unique position allowed me to employ strategies, where possible, to limit bias and enhance quality and trustworthiness.

As an insider researcher I was conscious of the potential benefits and challenges this brings to the research process and the research findings.

Ethical and moral considerations were required to ensure that participants were protected and boundaries adhered to.

The need for research which explores the experiences of those we work with, particularly those who are marginalised, so that we are better able to understand and enhance future practice is encouraged within our institutions (Mercer, 2007; Gibson, 2015). An obvious benefit to conducting research within this environment is the access to participants. This does however raise concerns regarding the potential power imbalance, possible change in relationship between the researcher and the student and the perception of trust (Mercer, 2007). Interestingly only half (6) of the participants who volunteered and participated within this study (n=12) were known to the researcher and 3 of those who were known to the researcher had successfully completed the programme and were awaiting graduation. Thus perhaps empowered to be completely honest, fearing no reprisal. For those who had successfully completed the programme, participation within the research offered the opportunity to reflect, provide feedback and gain closure, all of which appeared to be important. My position may have been influential in recruitment, despite my vigilance to 'minimise the power differential' (Greene, 2014; p6) by attempting to become an advocate and present the views and opinions of the participants. Maintenance of confidentiality and no repercussions on withdrawal from the study were assured along with outlining the potential for enhancements in practice in the future within the participant information leaflet (see appendix 10.1).

Recognising the familiarity, I had with the subject area, allowed for the implementation of strategies such as remaining reflexive throughout the research process to reduce bias and complacency which could have led to a superficial analysis of the data or indeed a 'loss of objectivity' (Greene, 2014; p4). The need for reflexivity is further complicated within IPA, as there is a recognition through the double hermeneutic that the researcher becomes part of the research and is required to interpret the participants stories (as discussed previously). The importance, therefore, of utilising strategies such as a reflexive diary, supervision and the use of research networks and support

groups to reflect upon my position and experiences and remain vigilant to the potential for over familiarity and complacency, was essential. Discussions with other colleagues and the research supervisor allowed for further 'deconstruction of the familiar world' (Greene, 2014; p9). These also allowed for regular scrutiny of my methods, analysis and interpretation. Whilst it was never my intention for the research to be objective, scientifically valid or reliable, I have attempted through peer review, attendance at data analysis workshops and supervisor support to enhance the objectivity of data analysis. However, it is recognised that:

The stories our participants tell us and how we choose to represent and share them are inevitably shaped by our own understandings and where we stand with regards to their (or our!) social world (Greene, 2014; p11).

Given that the data collected within this research was of a personal and at times sensitive nature, it was essential to ensure the anonymity of participants within the thesis and for this reason some potentially identifiable information and data (e.g. specific diagnoses, ages, routes of study) have been withheld. Pseudonyms have also been used to protect the identity of the participants. The continued anonymity remains important given that most of the participants have now qualified and graduated.

The anonymity of participants was further maintained as the research supervisor was not a member of staff within the institution where the research was undertaken and therefore she would not have been able to inadvertently identify participants when reviewing data etc.

3.5. Research Method.

Methods in qualitative research are not clearly defined recipes or protocols. Davidsen (2013) suggests that they are flexible, responsive and 'there is always a demand for creativity and reflexivity' (p333). However, others warn of the need to ensure that the appropriate qualitative approach underpins and

provides a robust justification to answer the research question and to ensure the credibility of the research (Griffin 2004, Holloway and Todres 2003).

3.5.1. Inclusion / Exclusion Criteria.

In order to answer the research question and fulfil the aim and objectives of this research participants were required to be OT students or recent OT graduates with self-disclosed disabilities who were available for interview. Those excluded from participation were students who were not studying OT or had not recently graduated from the OT programme and those who did not have any self-disclosed additional support requirements.

3.5.2. Participants and Recruitment.

The sample of participants within this study was affected by issues of convenience and the willingness of students to participate. The choice of who participated within the research was governed by those who responded to the advert (see appendix 10.2) and then who chose to consent to participate within the study. Whilst I hoped to recruit participants with a variety of disabilities the importance of autonomy and participant choice was vital to the credibility of the research. Therefore participants self-selected and as such they were not individually targeted to participate within the research. There was no financial reimbursement offered for participation in the study.

Participants were recruited via an advert which was uploaded to the online OT student platform, at the University where the study was undertaken. In total seventeen undergraduate and very recently qualified graduate Occupational Therapists responded to the advert. The newly qualified graduate Occupational Therapists had completed their OT training within the previous 3 months, which allowed them to reflect on their experiences of the programme as a whole. None of these participants were employed as qualified Occupational Therapists at the time of the interviews. All 17 participants who

responded were invited to interview. However, 5 of those who originally responded either failed to respond to the invitation to interview, cancelled the interview or were unable to arrange a mutually convenient date and time for the interview with the interviewer and thus deselected themselves from the study.

Twelve participants were therefore recruited and interviewed. Smith, Flowers and Larkin (2009) warn against being over ambitious within IPA studies and recommend up to 10 participants within professional doctorate studies, whilst Reid, Flowers and Larkin (2005) suggested a mean number of 15 participants following a review of studies conducted until 2005. Smaller numbers of participants are suggested to enable greater depth and commitment to idiography rather than broader and more descriptive analysis seen within thematic analysis (Hefferon and Gil-Rodriguez, 2011).

3.5.3. Interviews.

Given the sensitive and personal nature of the subject, data was collected using semi – structured in-depth interviews, which allowed for rich data collection and they are a congruent tool for data collection within IPA (Smith, Flowers and Larkin, 2009; Finlay, 2011). My aim and objectives and therefore my questions were focused on developing an understanding from my participants perspectives of their view of the world of studying to become an Occupational Therapist and how they made sense of this world. I wanted to understand what had motivated them to undertake the OT programme, what had challenged or supported them whilst studying. Exploring how their disability impacted upon them within the context of their studies. Interviews provided an opportunity to understand my individual participant's perceptions of their realities of being a student with a disability in the context of studying OT. Interviews are a data collection tool which 'enable description, interrogation, evaluation and consideration of personal accounts or biographical and historical data' (Howell, 2013; p.198). A semi structured interview schedule (see appendix 10.3) was developed guided by my

experiences of working with OT students with disabilities, the literature reviewed and the research question, aim and objectives (Smith, Flowers and Larkin, 2009). The interview topics and questions offered the opportunity to develop a 'loose agenda' (Smith, Flowers and Larkin, 2009; p58) for the interview and included consideration of topics for discussion as well as the structure and some consideration that the questions posed were in an open format to allow participants to provide their stories, uninterrupted. My questions were exploratory and focused on the meaning of the experience e.g. how does your disability impact upon you? Could you tell me about your experiences of studying the OT programme? Could you tell me about your practice placement experiences? Through the questions I posed I aimed to examine and elicit the individual's experiences of being an OT student with a disability. Consideration was given to the planning, ordering and phrasing of questions. However, I was guided by the interviewee as the expert of their experiences, thus enabling flexibility, collaboration and co-creation as emergent areas were explored. Participants were empowered to focus on topics and areas that were most important and had value and meaning to them as individuals (Smith, Flowers and Larkin, 2009; Finlay, 2011).

The existing literature that explores the experiences of student with disabilities within HE was also drawn upon when developing the interview schedule (Jacklin et al, 2007; Hirneth & Mackenzie, 2004; Maheady, 1999; Storr et al 2011). I was able to consider and integrate topics, such as barriers and enablers and disclosure which had been previously explored with other groups of students, in order to identify any similarities and differences when compared with OT students within the UK.

Focussed in depth semi structured interviews allowed me to explore complex, sensitive issues within a relaxed atmosphere, whilst enabling rapport and relationships to be established (David & Sutton, 2004; Green & Thorogood, 2009; Cronin-Davis, Butler and Mayers, 2009).

Miller and Glasser (2016) heed caution of the impact the interviewer can have within the interview interaction and warn of how individual participant

responses can differ based on interviewer characteristics. This was an area of concern within this research, as a member of staff potentially working with participants. I therefore aimed to cultivate an environment, in which the participant felt at ease to engage in a two way conversation, having some familiarity with the subject area was of benefit (Miller and Glasser, 2016) as I was able to imagine what having a disability whilst studying the OT programme 'might entail' (Smith, Flowers and Larkin, 2009; p42). It would be unwise, however, to assume that I understood the 'culture' of disability or of studying OT as a student with a disability, as a non-disabled individual.

Establishing an effective relationship with each participant and using my interview skills was essential in eliciting the individual's story and ensuring the quality of the study (Smith, Flowers and Larkin, 2009). I felt that my experiences and skills as a therapist were advantageous within the interviews as I believe they allowed me to establish a rapport quickly within the interview and interpret more than 'just the words' (p228) the student said when collecting the data (Finlay, 2011). I frequently reflected my understanding and interpretation of the 'words' back to my participants.

Miller and Glasser (2016) suggest that whilst 'being a good listener' (p55) is an important factor during interviews, recognising the researcher position also requires attention to ensure the quality of the data collected. It was important, when requested during the interviews, to offer advice and information to the participants, about processes and services in order to maintain and enhance the trust and rapport established which in turn can impact upon the depth and richness of data collected (Miller and Glasser, 2016). Howell (2013) suggests that whilst little training is required to conduct interviews, they are not purely a

...technical matter. Interviews incorporate relationships between interviewer and interviewee and reflects this dynamic as well as the more technical accounts. Interviews involve social dynamics and these will determine and mould the knowledge and understanding accrued – further capability for interpretation (Howell, 2013; p198).

The interview began with the least intrusive questions e.g. what year of study the student was in, whether they were studying part-time, full time or part-time in-service thus enabling rapport to be established and for the participant to feel comfortable, prior to asking more sensitive questions about the nature of their disability or additional support requirements and the impact and meaning this has for them. The inductive nature of the interview allowed for a process of reflection and probing by the researcher. Questions such as can you tell me a little more about that, can you expand any further were used to probe and elicit greater depth.

Twelve semi- structured interviews with OT students from all levels of the programme, including some very recent graduates, were completed. Interviews were completed and data collected between September – December 2013 during a 3 month period. The interviews lasted between 45 minutes and 1.5 hours. Each interview was arranged at convenient time and place for the participant to ensure comfort and familiarity with the setting encouraging honesty, openness and privacy (Bryman, 2008) for storytelling (Howell, 2013). Most interviews were undertaken within a private office set within the naturalistic context of the University setting. Although 1 student requested the interview was conducted within her home environment and 2 students requested that their interviews be completed within their workplace for convenience. The local lone working policy was adhered to when completing these interviews. Following each interview field notes and reflexive diary entries were made analyzing the behaviours and language used by participants.

Interviews were audiotaped and transcribed verbatim (Finlay, 2011; Smith, Flowers and Larkin, 2009). All non-verbal behaviours e.g. becoming upset, humour, laughter, sarcasm and pauses were recorded (Finlay, 2011).

All students who volunteered were able to articulate their experiences well, thus enabling the researcher to explore their expertise of being an OT student with a disability (Reid, Flowers and Larkin, 2005).

There are many benefits and limitations of using interviews to collect data, articulated within the literature and these include enabling the researcher to explore complex and sensitive issues (Smith, Flowers & Larkin, 2009) which was essential within this research. The collection of rich in-depth data (Finlay, 2011; Smith, Flowers & Larkin, 2009) which considered the meaning and complexities of the individual's experiences was a further essential facet of this research supporting the use of interviews as an appropriate method of data collection. Some limitations of interviews as a means of data collection include the impact memory can have on the participants engagement in the interview and the power imbalance within the interview situation which had the potential to impact upon the data gathered in this research, given the position of the researcher as an OT lecturer and the practice placement coordinator. The benefits and limitations of using interviews are outlined below in table 4.

Table 4 - Benefits and Limitations of Interviews

Interviews	
Benefits	Limitations
In-depth data considering the meaning and complexities of individuals experiences, attitudes and behaviours (Finlay, 2009)	Costly and time consuming (Savin Baden and Major Howell, 2013)
Sensitive data can be collected (Smith et al, 2009)	Data is difficult to collect and analyse (Green & Thorogood, 2009)
Complex issues can be explored (Smith et al, 2009)	Interviewer skill and bias (Bryman, 2008)
Opportunity for clarification of responses and answers	Memory bias (Cohen et al, 2011)
Opportunity for relaxed research atmosphere	Hawthorne effect (Savin Baden and Major Howell, 2013)
Relevance of questions (Cohen et al, 2011)	Small samples only – issues with representativeness of data
Comprehensive (Cohen et al, 2011)	Power imbalance – interviewer / interviewee (Green & Thorogood 2009)
Individual experiences gathered (Cohen et al, 2011)	Not all respondents will be articulate (Cresswell 2003)

Phenomenologists are required to explore the meaning individuals ascribe to their experiences through dynamic interactive dialogue and I wished to explore these experiences whilst interviewing the individual participants. The meaning of the experience needed to be imparted to me, prior to any description or interpretation within the findings.

3.5.4. Pilot Interview.

A pilot interview was conducted in the initial stages of the research. The pilot interview was undertaken in-order to enhance credibility and consider the feasibility of the study to answer the research question, aims and objectives (Bryman, 2008). It also offered the opportunity to 'test' the interview schedule and the depth of response which was deemed crucial within the study (Cohen et al, 2011). Feedback following the pilot interview was requested and provided. Thus allowing me to ascertain if the questions and structure made sense and to enhance or further develop the interview schedule accordingly, therefore enhancing the data collected (Carpenter & Suto, 2008). Feedback and personal reflection on the content on the interview topics and questions identified that no alterations were necessary. The pilot interview also allowed for 'testing' of the recording equipment and enabled me to practice completing interviews (Bryman, 2008).

As no amendments were made to the interview schedule consent was sought from the pilot participant for inclusion of data within the main study. Consent was given by the pilot participant to include data within the final project.

3.5.5. Ethics.

Cohen et al (2011) identified greater ethical challenges when completing interpretive or qualitative research. They suggest that there are three main issues for ethical consideration when utilising interviews as a means of

collecting data and within the subsequent analysis and reporting. They identify these issues as informed consent, confidentiality and will participating in the interview have consequences for the participant.

It was essential within the research that it was clear to participants that involvement within the research was completely voluntary and that any information provided within the interview would be confidential and withdrawal from the study would be without consequence.

Prior to commencing the study the research process was widely and rigorously reviewed. Ethical approval was granted from the HEI where the EdD is being undertaken on the 15th May 2013 and from the HEI where the researcher is employed and where the research was undertaken on the 27th September 2013 (see appendix 10.4). This was following a request for further information and amendments to the ethics application. Unfortunately as a result of this delay it was difficult to access level 3 students as they were on practice placement from September until December, when data collection took place and were frequently at a distance from the University. Gate keeper approval was sought and given from the course director. Legislative processes such as the management and storage of data (Data Protection Act, 1998) and Professional Codes of Ethics for research (UKRIO, 2009; BERA, 2011) were adhered throughout the research.

3.5.6. Informed Consent

Informed consent is believed to be the 'cornerstone' of ethical research as it forms the contract between the researcher and the participant (Green & Thorogood, 2009). Written informed consent (see appendix 10.5) was gained from those who agreed to participate, demonstrating respect and protecting the individual, whilst giving them some responsibility for participating in the research (Cohen et al, 2011). As the participants of this research were OT students, it was assumed that they were able to make an informed decision regarding their participation in the study. The information provided (see

appendix 10.1) to the potential participants clearly articulated the reasons for the research and therefore how and why their views, opinions and experiences were of value.

3.5.7. Confidentiality

The participant information leaflet outlined how data protection, confidentiality and the storage of data were to be managed. Anonymity could not be assured within an interview setting (Cohen et al, 2011) and as such may have impacted upon participant response rates. Pseudonyms have been used to protect the identity of participants throughout this thesis. All data collected was also anonymised with no names or identifying features appearing on data transcripts or other documentation, all data was stored on an encrypted memory stick and password protected computer and any 'hard' data was stored in a locked cupboard in a locked office (Data Protection Act 1998). Consent forms were stored in a locked draw separate from any transcripts.

Recognising that qualitative research can positively impact upon the participant and enhance the knowledge base is important. However, caution and sensitivity is required when disseminating findings (Nayar and Stanley, 2015). Thus, where specific information about a participant e.g. diagnosis or programme route may have reduced the individual's anonymity, the information has not been utilized within the thesis. Some data has therefore been omitted from the Participant Information Summary (table 5) within the results, analysis and discussion section.

All raw data will be destroyed following successful completion of the study.

3.5.8. Consequences of Participating in the Interview.

Consideration was given to the emotional consequences of participating in the interview (Green & Thorogood 2009) and two students did become upset

during the interview. These participants were reflecting upon the challenges they had and were still facing as a result of their disability. Both students were offered the opportunity to stop the interview and withdraw from the study. However, following a short break within the interview both felt able and wanted to continue with the interview. All participants were guided to the support offered by student support services within the participant information leaflet and I guided these participants to seek further support following their interviews should they feel that it was appropriate. Neither student required further support following the interview from student support services.

Students were informed of their right to withdraw from the study until the transcript was approved, without any consequence within the information leaflet and prior to commencing the interview. They were also reminded of this when the transcripts were sent for review. No participants withdrew from the study following consent.

3.5.9. Quality, Rigour and Trustworthiness.

The credibility and integrity of qualitative research and its findings and conclusions are essential. Trustworthiness comprises issues such as credibility, transferability, dependability and confirmability (Denzin & Lincoln, 2003; Bryman, 2008; Cohen et al, 2011).

The methods used to enhance the credibility and integrity within this research included returning the transcripts to participants for their review and amendment to ensure that the data gathered was accurate. Member checking is reported to enhance quality, credibility and rigour of the study (Carpenter and Suto, 2008). It is however recognised that this allowed participants to check accuracy but not the interpretation of the data collected (Bryman, 2008; Cresswell, 2013). Some researchers advocate participant involvement following data analysis, interpretation and potential theme development 'to ensure that the research account is faithful to their meaning' (Ashworth in Smith, 2015; p19). Others, however are cautionary about this, as within IPA,

the double hermeneutic is recognised and therefore interpretation offers the researchers view of the participants lifeworld (Finlay, 2011). I, therefore chose not to involve participants following my interpretation and data analysis. One participant made very minor amendments to the transcript as a result of the review and this was to anonymise organisations which he had referred to within the interview. No other amendments were made by any other participants.

Supervision and peer support through research groups and networks were also utilised as a means of auditing and debriefing but also to support greater interpretation of emergent themes thus enhancing the credibility of the findings and rigour of the process (Nayar and Stanley, 2015; Smith, Flowers and Larkin, 2009). The findings of the research were also triangulated with data from other identified studies. The use of field notes and a research journal, as discussed previously also enhanced the quality of the research.

The significance of truly understanding each individual's experience is recognised within IPA and therefore the aim is not to generalise findings, as Pring (2004) argues that 'significant generalisation is impossible' (p32). However, shared experiences and multiple realities have evolved and therefore some transferability from group to group may be possible. Smith, Flowers and Larkin (2009) propose 'theoretical transferability' (p38) where the research consumer is able to consider the findings in light of their own 'personal and professional experiences' (Wagstaff et al, 2014), knowledge and situation.

3.6. Data Analysis.

No universal method of data analysis is agreed within IPA (Smith, Flowers and Larkin, 2009). It is however,

...characterised by a healthy flexibility in matters of analytic development (Smith, Flowers & Larkin, 2009; p79).

In contrast to other qualitative approaches, the researcher does not impose a structure or framework on the data, within interpretative phenomenology (Nayar and Stanley, 2015). The researcher identifies the data and describes and interprets experiences as they were expressed.

An idiopathic approach to data analysis was undertaken, where the transcript of each interview was examined in detail, exploring how each individual made sense of studying OT with a disability (Wagstaff et al, 2014), before considering the next. Thus allowing me to identify particular individual ideas and themes before general categorisation and consideration of similarities and differences (Clarke, 2009; Cronin-Davis, Butler and Mayers, 2009; Pringle et al, 2010; Smith and Osbourne, 2007; Smith, 2009). Only considering convergence and divergence once

...the potential of the case had been realised (Smith et al, 2009; p78).

As this was the first time I had used IPA, I attempted to follow a systematic rigorous and robust approach to the data analysis as suggested by Smith et al (2009) in order to ensure that the findings 'contribute with more confidence to the evidence base' (Finlay, 2011; p22).

My aim was to ensure that the analysis was an 'iterative and inductive' (Smith et al, 2009; p79) and therefore I engaged in a cyclic process of reviewing, analysing and interpreting data 'from the particular to the shared and from the descriptive to the interpretative' (Smith et al, 2009; p79). I moved to and fro, thinking about my data from different perspectives. Smith, Flowers and Larkin (2009) describe the importance of the hermeneutic circle. The hermeneutic circle describes this cyclic nature of the interpretation process and the consideration that is given to the whole and the part of many levels (Smith et al, 2009). Whilst attempting to logically follow the steps outlined by Smith Flowers and Larkin (2009) the need to move from 'the part to the whole' in many different ways was essential. Initially, I reviewed each individual

transcript, line by line, examining word by word the text. Setting the individual's words within the context of the sentence and the paragraph and within the whole interview and the individual's life but constantly returning to review these analyses and interpretations over and over again. Then in light of these findings making comparisons with the whole data set (Smith et al, 2009).

My analysis was initially descriptive and superficial and led to theme development which reflected the responses to and the structure of the interview rather than a deeper more interpretive analysis (see appendix 10.6). However, aware of the potential pitfalls such as treating data analysis mechanistically to identify themes and becoming process driven I focused my attention on approaching data from a truly phenomenological perspective (Larkin and Thompson, 2011). I read, re-read and repeatedly replayed the audio recording of each interview allowing for full immersion in the data. I was interested to relive the experience of each interview, listening intently for intonation, pauses, tone of voice, the use of humour to support my interpretations and provide a greater depth to my understanding. Moving to the transcripts, I initially explored the content, making preliminary interpretations, summarizing and attempting to make associations whilst further exploring the semantic content. This occurred through making notes in the left hand margin of the transcript (see appendix 10.7). Emergent themes were developed, using key words, which focused on parts of the transcript and the researcher's interpretations which were noted in the right hand margins of the transcripts (see appendix 10.7). Searching for connections across emergent themes and integrating themes which involved listing and clustering into super-ordinate and subordinate themes. Post- it notes and mind maps were used to group and regroup these emergent themes (see appendix 10.8). For each transcript a narrative summary was produced which included themes supported by verbatim quotations along with my analytical interpretations before moving on to the next transcript (see appendix 10.9). I returned to the transcripts reviewing the interview experience and taking the interpretations to a deeper level, deepening the analysis by considering metaphors and the temporal contexts and by relating other theory,

subsequently restructuring and redeveloping emergent themes (see appendix 10.10 and 10.11). Care was taken to ensure that the themes were not biased by the researcher and that interpretations were plausible, logical and reflected the 'realities' of the each individual. The transcripts of the first 2 participants were reviewed by the researcher and a critical friend. The process of coding and theme identification was completed separately before comparing findings. The findings identified close similarities with initial theme identification and therefore I analysed and interpreted all further transcripts alone. Supervision, the use of peer review and a critical friend allowed for the theme development to be audited, participation in reflexivity and the development of 'coherence and plausibility of interpretation' (Larkin and Thompson, 2011; p105). Diagrams were developed recording initial thoughts, emergent themes by case (see appendix 10.12) and then emergent themes across cases (Gee, 2011; Smith, Flowers and Larkin, 2009). Individual participant synopsis documents were developed (see appendix 10.13).

Care was taken to see each participant's transcript with an open mind in order to do justice to the individuality of each case. Finally I began to look for patterns across cases, clustering themes whilst noting their mutual relationships (convergence) and their differences (divergence). Again using mind maps and post-it-notes for clustering and regrouping of themes (see appendix 10.8). Some similarities and differences in experience emerged thus promoting the idiographic perspective whilst considering some convergence and divergence of the data collected. I found the identification of super-ordinate common themes challenging. I experienced the 'reluctance to abandon the focus of the individual' (p6) as described by Wagstaff et al (2104) in favour of what I saw to be reducing the uniqueness of the individual to a 'commonality of experience' (Wagstaff et al, 2014; p6). My challenge was moving from the individual to the shared experience, strongly aligned to idiographic concerns of IPA and reflective of my beliefs as an Occupational Therapist. I did, however, identify superordinate and sub-ordinate themes and applied these to each of the participants (see appendix 10.12). Drawing themes into a structure which demonstrates the relationship between these themes (see Figure 1) as described by Larkin and Thompson (2011).

I wanted to be open with my values and preconceptions when analysing data. I recognised the interactive process in which I had become involved and used a reflexive journal throughout the research process to assist in recognising and acknowledging my unique position within the research. The diary allowed me to record events, note ideas and develop thinking throughout the research process (see appendix 10.14). Reflexivity was an essential strategy integral to the whole research process, recognising that I was an integral part of the research and thus maintaining integrity of research was essential (Clarke, 2009; Maringer and Jensen, 2014).

3.7. Summary

Within this chapter, my decision to use IPA to explore the lived experiences of students, who have disabilities and are, studying to become an Occupational Therapist, has been justified. IPA is a hermeneutic phenomenology, committed to idiography and as such allowed me to understand and interpret the experiences and the meaning associated with studying OT from the perspective of the individual with a disability. IPA allowed the participants voices to be heard (Larkin and Thompson, 2011) and I aimed to empower those who experience marginalisation to influence and enhance future practice (Bulk et al, 2017; Gibson, 2015). IPA allowed me to gain an insider perspective of each participant's experience of disability whilst engaged in the occupation of studying OT.

Positioning and reflexivity were crucial throughout the research process, not only to enhance the credibility of the research but also to demonstrate the personal journey that I have experienced, thus allowing the reader to review and judge the findings in light of my values, beliefs and position as an insider researcher (Nayar and Stanley, 2015).

This chapter has considered and justified the approach used within the research. The research method has been discussed and justified and

consideration has been given to being an insider researcher. The strengths and limitations of this role have been identified.

4. Results, Analysis and Discussion.

4.1. Introduction.

This chapter will present the findings and analysis of this study and discuss them in the context of existing OT literature, also encompassing literature and theory from wider disciplines. This study is the first UK based study of its kind, the small scale studies, involving OT students with disabilities, which have been undertaken, thus far, have been conducted in Australia, Canada and USA (Brown et al, 2006; Jung et al, 2014; Velde et al, 2005). When compared the studies have some similarities but exploration within the context of the UK was essential in order to further explore the experiences of OT students with disabilities across the nations. Studies conducted internationally will not be directly comparable given the differences in the Education systems and possibly in the attitude to ill-health and disability within these countries. Differences exist both in terms of funding and the educational level of programmes undertaken in USA, Canada and Australia. It is interesting to note that all of the previous studies included participants with a range of diagnoses including physical, mental health and SpLDs. However, most of the participants within the study by Velde et al (2005) had a SpLD (3) and most of the participants within the Jung et al (2014) study reported mental health conditions and this may have affected these findings of the studies. The participants within Brown et al (2006) study included nursing and OT students and therefore it is impossible to identify the OT participants and provide a direct comparison with these students. The only published work in OT from the UK, which specifically considers the experiences of an OT student with disabilities is a personal account written by an individual with a visual impairment (Sivanesan, 2003). This chapter explores the new findings that this study has illuminated within the context of students with disabilities in HE studying Occupational Therapy and addresses the aim and objectives of the research.

Whilst, undertaking the analysis and interpretation of the data, it became evident to me as an Occupational Therapist that the stories that the

participants presented, were akin to that of an occupational being describing their engagement in the occupation of studying Occupational Therapy. The participant's narratives explored their experiences in light of their own personal characteristics, strengths and support from others. They also considered the challenges they had faced as a result of the environment and / or their disability. Viewing the participant's narratives from this perspective allowed me to see the emergent relationship between the person, the environmental context and the occupation of studying to become an Occupational Therapist and therefore interpret the findings in the context of an OT model of practice. The structure of the chapter reflects the themes and sub themes identified from the data.

When initiating this study, I looked to recruit students with a range of additional support requirements, from a variety of OT programmes (FT, PT and PTIS) and at various stages of their training at one university. I expected to be able to group and compare participant's experiences in order to be able to identify themes as others had previously (Brown et al, 2006; Jung et al, 2014; Velde et al, 2005). I should, however, have paid heed to French (1989) who warned of the need for caution when considering individuals with disabilities as a homogenous group. The comparison proved challenging, as each person's story was unique and in keeping with the idiographic nature of IPA. I also struggled to view my participants as anything other than individuals, reflecting my personal and professional beliefs and philosophy (Wilcock, 1999). Some convergence and divergence within themes was however present and represented throughout the chapter, as the participant's personal stories uncovered a collective journey, along with variations of that collective.

Each participant presented their journey of self-development and discovery, from both a personal and professional perspective and for some it appeared their journey had proven far more challenging than for others. The journeys described included elements of the individuals past, present and future. All participants described their journey to becoming an OT student and their journey through the programme, with some describing their hopes, aspirations

and fears for their future as an Occupational Therapist. Many factors influenced the journey including their personal adjustment to disability / illness / diagnosis and the identification and utilisation of internal coping mechanisms; their personal identity and resilience; their desire to achieve and be successful; their engagement with the programme and environmental factors such as access to support, support systems and the attitudes of others.

The themes identified will be presented and supported using verbatim quotes from interview transcripts. The quotations selected represent those I view to portray the theme most appropriately, demonstrating convergence and divergence, the shared views and that of the individuals. The use of verbatim quotes allows the reader to assess the quality and transparency of the researcher's interpretations (Smith, Flowers & Larkin, 2009), whilst also reflecting the true voice of the participant.. The themes are reflective of my interpretations of the participant's experiences and significance of theme development lies within my interpretation of the data, as would be expected within IPA research (Smith, Flowers and Larkin, 2009). Each superordinate theme title is however, presented in the words of the participants and is frequently metaphorical, again a distinctive feature of IPA research (Shinebourne and Smith, 2010), providing a greater richness to the participant experience.

4.2. Participant Information.

Twelve participants were recruited and were interviewed within the study (see appendix 10.13). The students, who participated in this research, were from a variety of backgrounds. Half of the participants (6) had studied to degree level previously and the majority (10) had a previous career prior to training to be an OT, with some continuing to work (5) whilst training. Participants who were or had studied on the full time, part time and part – time in-service of the programme were recruited. Most (10) participants were over 25, with 7 being between 35 and 55 years of age.

The majority of the participants had non evident or invisible disabilities e.g. Specific Learning Difficulties (SpLD), seizures, long term physical condition, mental ill health. Most of the participants, (7), had a diagnosis of a SpLD, either dyslexia or dyspraxia or both. Table 5 provides some demographic information about the participants. To protect the identity of participants pseudonyms have been used. Some participant information has been generalised to ensure that the participants can not be recognised.

Table 5 - Participant Information Summary

Name	Age Range	Gender	Level of Student	Diagnosis	Diagnosed when	Qualification
Valerie	40+	Female	3	Mental Ill Health	During studies	Completed university module to access OT programme
Tracy	20-25	Female	2	SpLD	Prior to entry to programme	Completed A levels to access OT Programme
Natasha	26-39	Female	2	Long term physical condition which impacted upon her mental health	Prior to entry to programme	Previous degree
Tina	40+	Female	New graduate	Physical disability resulting in seizures and fatigue	Prior to entry to programme	Unknown
Hannah	20-25	Female	3	Mental Ill Health	Prior to entry to programme	Completed A levels to access OT programme
Carmel	40+	Female	1	SpLD and Musculoskeletal injury	Prior to entry to programme	Previous studies to Masters level

Robert	20-25	Male	1	SpLD	Formally diagnosed during first term at university	Previous degree
Amanda	26-39	Female	2	SpLD	Formally diagnosed during first term at university	Previous degree
Andrew	40+	Male	New graduate	SpLD	During level 2 studies	Previous degree
Cathy	26-39	Female	New graduate	Sensory impairment	Prior to entry to programme	Previous degree
Vicky	40+	Female	1	SpLD	Prior to entry to programme	Initiated 2 previous degree programmes.
David	40+	Male	2	Physical injury resulting in some cognitive impairment and SpLD	Prior to entry to programme – non-specific brain injury. Dyslexia diagnosed during first term at university	Previous degree, studied access course to access OT programme

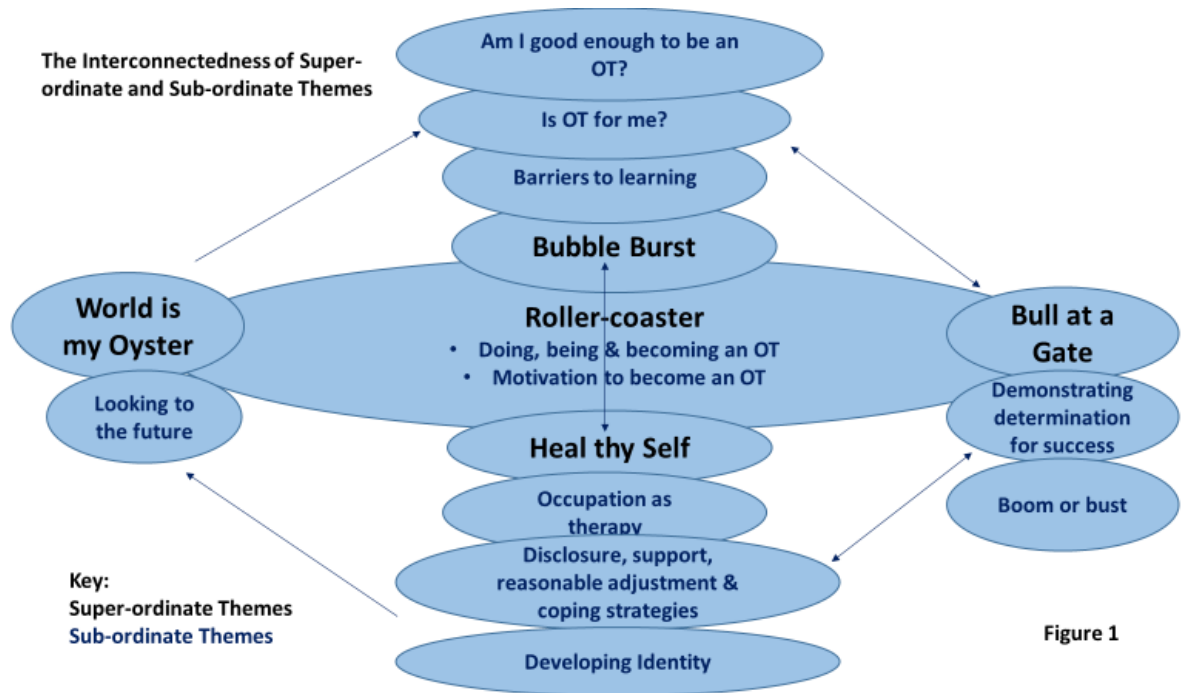
Most participants (8) had, had their primary diagnosis prior to enrolling on the OT programme and had declared their disability within their application, enabling them the opportunity to be assessed by the central disability support team. Most of these students (7) therefore had their equipment, software and support systems in place, prior to commencing the programme.

Velde et al (2005) and Jung et al (2014) identified individual and environmental factors which influenced the occupational performance of the participants within their studies. Both studies, however, appeared to focus greater attention on the influence of the environment as either an enabler or a barrier to success for the student with a disability studying OT. Perhaps indicative of the influence of the Social Model of Disability (Oliver, 1983), although this was not explicitly considered by the authors of the studies. The current study also identified the environment as an important factor. However, the significance of the individual and their personal journey was also paramount in the participant's narratives, perhaps, as a result of considering the findings in the context of an OT model of practice.

Through data analysis, it became apparent that each individual had experienced a journey of highs and lows, described by Natasha and Valerie as a 'rollercoaster'. This therefore formed the overarching theme, which is inextricably linked to all other themes. During this developmental journey, all participants demonstrated their determination for success, often signifying the potential climb to the pinnacle of the 'rollercoaster', which led to the development of the 'like a bull at a gate' theme. The majority also appeared to experience pivotal events, signifying the ultimate lows of their journeys, which is depicted in the theme 'that was when the bubble burst'. For many however, the journey was one of hope and optimism, with some describing a therapeutic journey of recovery and healing, resulting in the identification of the 'heal thy self' theme. It appeared that as their OT identity developed and they learnt more about themselves and through experiential and in some cases transformational learning some participants experienced the therapeutic benefit of participation in the meaningful occupation of studying

OT. The final theme describes the hopes and optimism felt by some (Valerie, Natasha, Andrew, Robert) when considering their future, 'the world is my oyster'. This theme was not applicable to all participants. For some (Carmel, Vicky), it was perhaps too early in their studies to consider their future as a qualified Occupational Therapist, for others (Tina, Cathy) they were pre-occupied by not being able to secure a job and David was contemplating his future on the programme. 'The world is my oyster' reflected the significant impact and opportunity that those who viewed the future favourably believed that becoming an Occupational Therapist would offer them. Many themes are interwoven and were difficult to separate. Figure 1 shows the interconnectedness of themes.

Figure 1 – The Interconnectedness of Super-ordinate and Sub-ordinate Themes



4.3. Themes.

The **super ordinate** and sub ordinate themes identified within the data were:

Theme 1 – ‘It’s a bit of a Rollercoaster’

- Doing, Being and Becoming an Occupational Therapist
- Motivation to be become an OT

Theme 2 – ‘Like a Bull at a Gate’

- Demonstrating Determination for Success.
- ‘Boom or Bust’

Theme 3 – ‘That was when the Bubble Burst’

- Barriers to Learning
- Is Occupational Therapy for Me?
- Am I Good Enough to be an OT?

Theme 4 – ‘Heal thy Self’

- Occupation as Therapy
- Disclosure, Support Systems, Reasonable Adjustment and Coping Strategies
- Developing Identity

Theme 5 – ‘The World is my Oyster’

- Looking to the future

4.3.1. Theme 1 – ‘It’s a bit of a Rollercoaster’.

Both Valerie and Natasha described studying OT like being on a rollercoaster and this metaphor similarly appeared to apply to all the other participants. The metaphor denotes each individual’s journey representing the highs and lows that each participant described. The rollercoaster appears to symbolize times of apprehension, anxiety and fear as well as times of relief, joy, excitement, achievement and accomplishment for all. As indicated previously each individual’s journey was unique and for some their journey to becoming an OT was just beginning (Carmel, Robert, Vicky), whilst for others their ‘rollercoaster’ ride appeared longer and far more arduous / challenging (Cathy, David, Natasha, Tina). The journey that each individual described included a past, their present and for some a consideration of their future as a qualified OT. The end goal of the collective journey was becoming an Occupational Therapist and throughout this journey all participants were

developing their professional identity but this was very much influenced by their personal identity. The 'rollercoaster' ride also appeared to depict how individuals had adjusted and accepted their illness or disability.

4.3.1.1. Sub –Theme 1: Doing, Being and Becoming an Occupational Therapist.

Each individual's journey encompassed aspects of both personal and professional development and had frequently begun before they enrolled on the OT programme. Their professional journey appeared to be leading them all through the stages of doing, being and becoming an Occupational Therapist.

Occupational Therapists believe that

Participation in the everyday occupations of life is a vital part of human development and lived experience. Through participation, we acquire skills and competencies, connect with others and our communities and find meaning and purpose in life (Law, 2002; p640).

OT enables individuals to participate and engage in meaningful occupations that are fulfilling and have a positive impact on health and wellbeing. A significant occupation of interest for all OT students is that of studying to become an Occupational Therapist and as an Occupational Therapist I recognised that the participants in this study were occupational beings engaging in a meaningful occupation.

Occupation is defined as

An activity or group of activities that engages a person in everyday life, has personal meaning and provides structure to time. Occupations are seen by the individual as part of his or her identity and maybe categorized as self-care, productivity and / or leisure (Creek, 2006; p205).

Participation in occupation is influenced by external demands and the individual's internal motivation (Jonsson et al, 2000). Participants were motivated to study OT thus the occupation was purposeful but also held individual meaning for each of the participants. Taylor (2008) suggests that

The word meaning has a relationship with sense-making and coherence and for some spirituality, in the individuals overall life (p19).

Extrapolating that occupations 'can have meaning', 'can make meaning', 'can give meaning to life' and can help individuals to 'find meaning' (Taylor, 2008; p19). For participants within this study it appeared studying OT created meaning for them in many different ways.

Wilcock (1999) suggests that 'occupation is a synthesis of doing, being and becoming' (p1) and that becoming is dependent upon a 'dynamic balance between doing and being' (p1) which is crucial for health and wellbeing. In this case, 'doing' relates to engaging in all aspects of studying OT, academically and within practice placement. Being is more contemplatory and existential and is concerned with the 'nature and essence' of self and therefore 'being' relates to who the individual is including their personal characteristics. Becoming an Occupational Therapist is a transformational process during which the individual may experience self-actualization (Maslow, 1954). Therefore, the transformation of becoming an OT is dependent upon the individual's participation and engagement with studying OT and 'being' an OT student, with a disability and the impact this has on health and wellbeing.

4.3.1.2. Sub theme 2: Motivation to become an Occupational Therapist.

No specific research was previously identified which focused on why people with disabilities are motivated to become an Occupational Therapist. A desire to help others was strong motivating factor for striving to become an OT for all who participated in this study.

I just thought it's such a good job to be able to help people to do things by themselves (Tracy).

When you have a disability you always think how am I going to help other people. Well I certainly do (Cathy).

...a profession...where I could help people (David).

The motivation of participants, in this study, to become an OT is reflective of the wider OT student population and is also reflected within the personal narratives of students and qualified Occupational Therapists with disabilities which are presented within the literature (Bennett, 1989; Guitard and Lirette, 2005). Craik and colleagues completed a number of studies (Craik & Napthine, 2001; Craik and Wyatt-Rollason, 2002) in the UK and whilst dated these studies identified that the reasons individuals chose to study Occupational Therapy included a desire to help people including those with disabilities. Therefore suggesting that this is not a significant finding which is linked to those with a disability.

Whilst it is recognised that participants were attracted to OT for a variety of reasons, many (9) participants were primarily motivated to become an Occupational Therapist as a result of their personal or professional experiences of OT. Some (5) attributed their desire to become an Occupational Therapist to their own personal experiences of working with an Occupational Therapist or knowing an Occupational Therapist whilst others (2) attributed it to a professional encounter with an OT. This is perhaps somewhat unsurprising given that OT is a little known profession.

For Natasha, Tina, Hannah and David, their journey to becoming an OT was initiated as a direct result of their disability, condition or illness. Their personal experiences of illness and disability led them to choose OT as a career.

In a more recent study conducted by Byrne (2015) it was identified that more than 70% of participants who responded to a survey of 139 OT students had

been exposed to OT and it had been an influencing factor when deciding to train to become an OT. However, only 5.8% (n=8) of respondents reported that their exposure to OT was as a result of being in receipt of OT personally. Of these, 6 reported this to be the most influential factor in their decision making. Similarly one participant within the current study had been in direct receipt of OT and this had significantly impacted upon her decision to become an Occupational Therapist. Anecdotally, these numbers appear quite low as in practice many more students with disabilities report previously having OT intervention as a factor which influenced their decision to become an Occupational Therapist. However, the findings of this study and that of the work by Byrne (2015) may have been affected by recruitment bias.

Tina was inspired by an Occupational Therapist, who she described as

The person who understood me even though I don't think at that point I even knew what an Occupational Therapist was (Tina).

The importance of being 'listened to', 'understood' and given 'permission to not focus on the stuff that wasn't important' was crucial to Tina during her recovery and it was this philosophy that resonated with Tina's needs at that time.

Natasha did not talk of having personal experience of OT but her illness experience had also had a significant impact on her decision to become an Allied Health Professional (AHP). She talked of wanting to make a difference in health care. She viewed her own experiences of the National Health Service (NHS) as challenging at times and felt an incongruence with the medical philosophy she had been subjected to. Her personal values and those of the medical profession were in conflict. For Natasha, her personal identity was almost disregarded by her Consultants; their interest lay in what they saw as the cause of the 'problem'. Natasha was however striving to be understood by her Consultants and felt their authoritarian approach was inconsistent with her personal philosophy which had driven her to seek a career which empowered and collaborated with service users to achieve their goals. She felt that her medical interventions had been excellent but that

psychological support was lacking and she felt a desire to correct this injustice.

I wanted to do something health related. I wanted to do something which made a difference to other people, having been through all this health stuff, I wanted to give back in a way and help other people. I love the fact that with OT it's about the person and not the condition as I felt a lot of the time with the consultants and things, they treat me as an illness, ... and even my consultants who were incredible and I trust them completely with my physical health, have never offered me psychological support ... When I got depressed it was time for happy pills; no sort of wow, she has been through so much, we need to look at the psychological impact ..., so that is why I love OT, it treats the person as a whole and it looks at how the illness impacts on the life, ...with a long term illness you have to live with it for the rest of your life. So you have to balance managing the condition, but also having a good quality of life and that's what I love about OT (Natasha)

Natasha demonstrated empathy and understanding and a strong desire to change and improve health services in the future. She had personal experience of the Medical Model and its intention to 'fix' the problem medically and personally rejected this model in favour of the Social Model of Disability (Oliver 1983). Natasha demonstrated what Kamilowicz (2011) described as an 'attempt at maintaining an established identity and social roles over the control of the symptoms' (p280) as she described the need to live her life and to experience quality of life despite her illness. Natasha was striving for psychological ownership of her illness (Kamilowicz, 2011).

Her obvious enthusiasm for OT appeared to be born from the client centred, collaborative and holistic philosophy of the profession, which appeared to resonate with her own personal philosophy and values, as a result of her illness journey. Her determination to be an advocate for others was clear. Recognising the importance of occupational balance and its impact on health and wellbeing and applying this to her own situation, had led Natasha to believe OT was her career of choice.

Similarly, Robert was attracted to OT because of its humanistic and holistic philosophy. Robert had completed a previous degree and subsequently had a

financially successful but unfulfilling career. As a result of this he had a complete career change, a few years prior to the interview. Prior to returning to university to study OT he worked as a support worker and he sought a professional career, which offered similar job satisfaction. Robert recognised the perceived need for status within his community and the impact his perceived previous lack of status had had upon him and his relationships and social networks.

I found out about OT through the job, it was the best level up for me, because I compared all the others, I literally looked at everything else...with occupational therapy... it has got the human touch to it you know, it's got the holistic approach which I like...because everybody is so complicated ..., you look at it as a whole and to me, it is very rewarding for me, when I got into some gatherings and all that and people ask me what I do I will say Occupational Therapy and some of them don't even admit to know what it is. I don't care anymore, but most people don't know what it is, but it is a shame because it is actually really good, it's good for me, so I don't really mind that people don't know about it (Robert)

Robert was concerned about how he was viewed by others within the communities in which he engaged. He appeared unconcerned that OT is not a well-recognised profession, however in contradiction admitted that this 'is a shame', perhaps recognising his disappointment given the importance he places on becoming a professional, being qualified and the recognition this offers. Robert believed that working with people altruistically had been of personal benefit to him. He saw similarities in the personal rewards he had felt whilst working as a support worker and in becoming an Occupational Therapist.

...getting to work with people who need help and everything, that just led me directly into OT because it is very similar, it's just more OT I think, it is a better title, because with *** support work and everything; it is also to do at the beginning with image. I guess, a lot of people in my community didn't like the fact that I was a support worker or a carer or anything, I lost a few friends out of that, because of that, because I didn't mind because I just stuck with my thing, but I didn't really have much of a social life during those years, at first I didn't mind, but sometimes it would get to me sometimes (Robert).

The importance of his position within the community and how he is perceived within his community is of great importance to Robert and it appeared to be a significant factor influencing his decision to become an OT.

When contemplating the move to the OT programme from her previous degree programme, Vicky too described her personal need for a career 'with a professional ring to it'.

I am a people person and I am very good at talking with people, and I am very good at listening to people and I don't tell you, you need to do that, but I will get you to think about things that you need to do to try and help yourself and I listen very keenly, that's one thing I have always prided myself on (Vicky).

Vicky believed that she had the personal qualities to become an OT.

I am good at helping others, that's why I would make an excellent OT (Vicky).

She exhibits pride in giving people time and encouraging them. She suggests that she has used her communication, listening skills and powers of persuasion to influence people to be more independent and implicitly suggests this is why she would be a good Occupational Therapist, recognising these as key skills in OT. Vicky describes how she is able to use herself therapeutically to facilitate independence. She believed that OT was her perfect job and that all her previous jobs in care had similarities and had supported her personal development and now she requires the theoretical underpinning to support her desire.

I want the outcome very much, if I am really honest with you, I think everything I have ever done, I really do believe, I have been doing it and it has been building to this (Vicky).

Vicky's desire to become an OT, a professional who commands respect, is in a position of authority and responsibility, was evident. She appeared desperate for the recognition she was so clearly searching for, having attempted two previous degrees; she appeared to be pinning her hopes on

OT, both in terms of achieving success by gaining the award of a degree but also the professional recognition.

Tracy too, recognised that she possessed skills that are of benefit in OT, such as creativity and was drawn by the philosophical underpinning of facilitating independence.

I thought it was a really great job; I had no idea what it was and then I looked, thinking I want to do something in healthcare ... I just thought it's such a good job to be able to help people to do things by themselves because a lot of jobs out there are just kind of caring for people...but not everyone needs to be cared for when they can do it themselves (Tracy).

Much of the existing literature which considers the factors which influence OT student's decisions to train to become an Occupational Therapist is dated (Craik et al, 2001; Rozier et al, 1992) and investigates the influencing factors superficially using questionnaires. The literature does identify some consistency in that the predominant factors which appear influential are the variety offered within the profession, a desire to help people, the altruistic nature of the individual and an interest in the course content (Craik et al, 2001; Roney et al, 2004; Rozier et al, 1992). In a US study, Rozier et al (1992) also suggested that prestige and job availability were important, as reflected by Robert and Vicky. However, these factors were least important in the study conducted by Craik et al (2001) within the UK. The availability of jobs within the UK has been varied in more recent years and thus may have been influential at the time Craik et al (2001) conducted their study but also since.

The existing literature does not appear to identify if OT students consider their pre-existing skills when deciding on OT as a future career as was indicated within this study. The qualitative nature of this study allowed for a greater depth of exploration and identified that the participants within this study were attracted to study OT predominantly as they believed they had skills which would be of benefit in their future careers. They also reflected on the professions underpinning philosophy and how this compared with their own

personal values and philosophy. The findings highlighted within this sub theme have distinct similarities and overlap with findings highlighted in the sub theme developing identity discussed later within this chapter.

4.3.2. Theme 2 – ‘Like a Bull at a Gate’: Demonstrating Determination for Success.

Whilst all of the participants demonstrated a determination in their desire to become an Occupational Therapist as is reflected within the literature (Brown, et al 2006; Velde et al, 2005), the levels of determination did appear to vary. Most participants demonstrated high levels of motivation and commitment. However, this was not overt within Carmel’s narrative. Carmel appeared unsure as to why she wanted to be an OT suggesting:

I probably researched and things like that, you know, just reading about it and I also weighed it up, like with social work and OT, I know there is a big difference between them, but they are both supporting roles (Carmel).

Carmel was interviewed during her first term and was perhaps still unsure about her career decision. This could possibly provide an explanation for why her motivation and determination were less evident in her narrative than for other participants.

Cathy, David, Tracy, Andrew, Robert and Vicky all sacrificed an income to train to become an Occupational Therapist in the hope of a new future. Robert and Vicky were desperate for professional recognition and this acted as a significant motivator. Like those in previous studies (Velde et al, 2005) Tracy, Andrew, Robert, David, Vicky, Amanda, Cathy and Tina described the additional time and effort they were required to invest in-order to keep up, manage the workload and achieve success.

It’s not like my disability is paralyzing, because I have found ways to cope and get through it...but just what should have, for other

people is quite easy, it is quite challenging for me...it takes me a lot more work or has taken a lot more work (David)

I did an awful lot of work because I have a work ethic, because I know that I struggle more than other people (Tracy)

Hannah's motivation was implicit within her journey; she battled mental ill-health following her GCSE's. She attributed her illness to the stress and anxiety caused by the examinations. Hannah's illness was serious and her recovery was lengthy but she bravely returned to the school in which she undertook her GCSE's to complete her 'A' Levels determined to continue her education and become a health professional.

4.3.2.1. Sub theme 1 – 'Boom or Bust'.

For some (Tracy, Natasha, Tina, Valerie) however, the intensity with which they were driven to achieve had a negative impact on their health and wellbeing.

Valerie and Tina used the programme as a distraction and a focus to avoid dealing with the psychological impact of the consequences of their illness and disability. Their dogged determination to focus on the programme was evident. They were both actively avoiding addressing their psychological wellbeing in favour of their commitment to their studies. Tina was 18 months post injury, when she commenced her OT studies and clearly wanted to actively avoid thinking and processing her thoughts and feelings about the impact of her injury.

...it did give me something else to focus on and it enabled me to deliberately go well I can't think about that because I have my course to do and I just shut off a whole pile of other stuff to focus on getting my degree (Tina)

Valerie's illness was diagnosed following the threat of redundancy at work. This led to Valerie feeling overwhelmed and stressed. Work provided the

stability, which once threatened, triggered an episode of mental ill health. Valerie's desperation was evident within her narrative, fearing for her own and her children's security and stability. Her attendance at University was also dependent upon her work further adding to the pressure she felt. It was evident from her story that she was extremely capable, balancing work, children and studying. However, she recognised that she needed to seek support and that she was not well.

I had to go and get seen (Valerie).

Valerie appears to imply here that she needed to be seen to be believed and implies some of level of weakness in seeking support. She appears to rationalize her reactions disclosing an earlier history of abuse. The primary reason for seeking support appeared to be her inability to focus on her studies, a distraction technique she had used for some years to avoid addressing her own psychological distress.

...it all came to a head, where I just couldn't cope anymore, well that's how I felt, and I didn't want it to affect my studies, but I do remember sitting there looking at a screen and you know, for 2 or 3 days and without typing a word, ...it was like, something is not right here, so yeah, I had to go and get seen, but I had got, you know, there was stuff that went on before the course, ..., some *** abuse, and so I sort of hadn't attended to my emotional needs there and just sort of carried on with study, study, study, study, filled in my time and just gone at it like a bull at a gate really (Valerie).

The potential threat of redundancy and the fears associated with losing her job led to an inability to study. Applying Maslow's Hierarchy of Need could explain how Valerie's basic needs (as the threat is at the security and safety level) were required to be addressed before she was able to attend to her cognitive needs.

Valerie and Tina used the occupation of studying to completely distract them from processing and attending to their psychological needs. They avoided addressing their psychological wellbeing, perhaps experiencing 'flow'

(Csikszentmihalyi & Csikszentmihalyi, 1988) during their intense engagement with the programme. Flow is associated with feelings of happiness and satisfaction in life and is described as

A positive feeling that occurs when there is a balance between perceived challenges and one's skills and may include enjoyment, intense or total involvement, deep concentration or the loss of one's sense of time (Jacobs, 1994; p989).

Both Valerie and Tina continually pushed to improve themselves and their abilities (Csikszentmihalyi & Csikszentmihalyi, 1988) through participation in the meaningful occupation of studying OT. They were task focused and striving for 'a sense of challenge from the activity and a sense of mastery' (Law, 2002; p642). However, at times meeting the 'just right' challenge proved difficult impacting on their health and wellbeing. The use of studying OT as a means of distraction or avoidance has not been previously considered within the literature.

Eight participants (Tracy, Natasha, Tina, Hannah, Andrew, Cathy, Valerie, David) had all completed at least one placement at the point of interview. Very little is written regarding the experiences of OT students with additional support requirements whilst on placement (Hill and Roger, 2016). Individuals have written of their personal experiences of education including practice placements (Archer, 1999; Bennett, 1989; Sivanesan, 2003) and Brown et al (2006) completed a small scale study with 5 students (3 OTs and 2 nurses) exploring their specific experiences of practice placement.

Tracy was meticulous in her approach to her level 1 placement, she was motivated to achieve the best grade possible and ensured that she was fully versed with the placement expectations and the marking criteria. Tracy, an academic high achiever, pushed herself 'to the limit' demonstrating determination and her negotiation skills during her formative collaborative assessment within her level 1 placement.

When it came to my actual assessment I made sure I had written down everything that I had done to get the mark that I wanted because of what it said in the marking strategy and in one of the things it actually came in quite handy because she had given me 85%. I know it was really cheeky but I thought I should get 95% because I did all of these things and then she said no, you are right you should get 95% so I was quite happy I did that (Tracy)

During the placement, Tracy had however, recognised that she was experiencing occupational disruption and imbalance and therefore adapted her behaviour in order to maintain her health and wellbeing

...and then I was like I can't do this anymore, I need to like watch telly or just think or something (Tracy).

While most participants who had experienced a placement indicated mainly positive experiences, both Natasha and Tina described the significant impact that completing a placement had had on their health and wellbeing. Both Natasha and Tina had significant, long term health conditions / disabilities and they described the impact the placements had on their occupational balance, causing significant occupational disruption.

Natasha and Tina demonstrated perfectionist traits. Both were academic high achievers and were striving hard for success and to prove to both themselves and others that they were capable, competent and worthy of achievement. Which compares favourably with the findings of Brown et al (2006) who identified that participants within their study were highly motivated to succeed during their practice placement experiences. They also identified the potential need to 'prove' their worth to themselves and others. Natasha, applied significant pressures to herself throughout her first year placement. The placement was six weeks long and the shortest of three placements. Some adjustments were made to her weekly placement hours in an attempt to reduce fatigue, which was significant symptom of her condition.

My health wasn't great on placement, I think it was quite a lot for me to manage and it was quite a lot to do after..., it has been a full on year after being ill for so long, being probably a bit optimistic about managing it all really, maybe it was too soon to come back,

but then I thought things would be better health wise than they have been (Natasha)

Describing her disappointment and almost wistfully considering how her hopes for greater health improvement had not materialized, led Natasha to debate the timing of her return to education. Following her level 1 placement at the end of her first year studies, Natasha, had a significant relapse in both her physical and mental health. Natasha had a chronic illness which was characterized by significant fluctuations in symptoms and as such it was difficult for her to feel a sense of control or mastery (Kamilowicz, 2011). She was forced to face her current limitations and recognised her dependence on others and her concerns for the future leading her to question if she would be able to complete the course and to become an OT.

I felt my mood slipping; it was becoming quite low again and I was getting really anxious and being on placement, it was very hard and then I was having those thoughts, thinking well am I ever going to be able to do this? Am I ever going to be able to have a job? Am I ever going to be able to support myself and my family?...I was finding it so hard to deal with, just the placement ... my mom was looking after me, she was cooking all of my food, doing my washing and she was driving me in ... So all I was doing was the work and I found it exhausting and I got those anxious thoughts about the future ... and people say to me then, you know you wouldn't be able to have a fulltime job, you will have to do it part-time and I have accepted that, but it is really hard as well, because I don't want to have to work part-time but I know if my health stays the same, then that is never to be (Natasha)

It appeared that the first placement had been a time of great angst for Natasha and that this had led to a significant increase in mental health symptoms leading her to fear returning to a 'dark place' that she had seen previously. Her use of language is interesting within this quote. Her use of terms such as quite low, really anxious, very hard, and ever are inconsistent but indicate the depth of despair and concern she had begun to feel. The pressure of the first academic year, concluding with a highly demanding placement left Natasha mentally and physically drained with significant concerns about her ability to do the job she loved and was passionate about.

Natasha acknowledged an acceptance of the need to work part-time but recognised this with a heavy heart and appeared resentful of the need for this. The support of her family was crucial to her successful completion of the level 1 placement, her reliance and dependence upon them is evident.

Passion and commitment to OT were evident throughout Natasha's interview. She described how the condition had taken so much from her during her teenage years and that there was still a risk it would take more. She spoke openly and articulately about the impact the condition had had on her life for nearly 20 years since her diagnosis. She described how the illness had already removed her chances of becoming a performer, something 'she trained to do from a young age'. She discussed her fears that the illness may now also take away the opportunity to do OT too.

I also knew this was what I really wanted to do, so it was really hard wanting to do something but not knowing if you would ever be able to do it and that has already happened with my ***, I knew that wasn't a career I would ever be able to pursue and I had found something else which I really wanted to do and I was really worried about that as well, but the *** really helped with that, sort of helped challenge my anxious thoughts around it (Natasha)

Natasha recognised the return of her mental health symptoms and in fear of losing a career that she desperately wanted, she sought and engaged strategies and support to gain 'psychological ownership' (Kamilowicz, 2011).

The significance of the illness was apparent throughout Natasha's interview as she described the war and battles that she had fought as the illness 'attacked' her body and the frequency with which she was hospitalised as a result of her condition. For Natasha the stakes were high, she desperately wanted to become an OT and was extremely successful academically but feared that whilst the 'mind was strong, the body may fail her'.

Natasha described her own internal conflict with being a perfectionist and the notion of reasonable adjustment and how this led her to potentially applying greater pressure to herself to evidence her study during her placement.

I was very worried about the placements; I was worried about how I was going to cope. I was also worried because we had put things in place to have the day off and I am a perfectionist and the sort of person who likes to do their best and because I had the day off, I felt I had to compensate in a way actually and so I was often doing the studying things on the day off because I thought I had more to prove because these allowances had been made for me. I felt I had to prove myself, that I was good and it was worth making allowances for... So it involved quite a lot of work outside the placement hours as well so that was quite hard because you came home tired, but pushed myself to do extra work because I didn't want to not do it and I didn't want to let people down (Natasha)

Natasha felt indebted to her educator and the University for making reasonable adjustments, but for her the placement almost became a vicious circle. Reasonable adjustments had been negotiated to enable Natasha to have sufficient rest periods to manage her workload effectively during her placement. However, the guilt she felt about these adjustments led her to spend her rest time studying in an attempt to prove her worth to her educator. This behaviour led to a significant imbalance in her occupations, with an increased dependency on her family, in terms of supporting her activities for daily living whilst Natasha gave all of her energy to the placement.

As this was Natasha's first placement experience she lacked awareness of the placement expectations and this may have impacted upon how she felt about her placement. Recognising the demands of the placement experience and her own her expectations led to increased anxiety and fear about future placements.

It is just trying to get through the placements and because of my last placement I was thinking I don't think I will finish this degree. I don't think I will be able to because I don't think I will manage it. So it is trying to sort of think about how to manage it. I think it is going to be hard to manage the next 2 (Natasha)

Similarly, Tina described the impact that her placements had on her occupational balance identifying that her life revolved around either placement

or sleep and rest. She used emotive language to describe her feelings of being deprived of basic activities of daily living, particularly pleasurable activities such as leisure, whilst suggesting that she was holding on almost by her fingertips to complete the placement. Tina experienced seizures as a result of her condition and as such there was a significant unpredictability in her condition, which also resulted in a lack of control and mastery.

I was hanging on for the end to the complete detriment, work life balance, there wasn't one, I was on placement or I was asleep and not very much else happened (Tina)

No studies have been identified which specifically consider the impact that practice placement has on student's health and wellbeing but it is recognised that the practice placement experience provokes stress and anxiety for all students (Mitchell and Kampfe, 1990; 1993) and that students with disabilities perceive the need to work harder and for longer (as tasks take longer) during their placements (Velde et al, 2005). The work completed by Mitchell and Kampfe (1990, 1993) is now dated and was not completed within the UK and therefore further research exploring the impact of practice placement on health and wellbeing and specifically with those with a disability would be advantageous.

As can be seen from both Natasha's and Tina's narrative, the importance of the placement experience is evident. Whilst the participants perceived level of control over their transition from the university setting into practice placement was not directly explored within this study. Neither Natasha nor Tina appeared to feel in control of the transition and when considering future placements Natasha believed that regardless of pacing strategies the workload would be out of her 'control'. Feeling in control of the transition from university into placement has been shown to have a positive impact on health and wellbeing (Mitchell & Kampfe, 1990; 1993) and therefore the lack of control felt by Tina and Natasha could also have had a negative impact upon their health and wellbeing. Problem focused strategies were employed by both Natasha and Tina and these included disclosure, preparation for placement and pre-placement visits and the use of problem focused

strategies rather than emotion focused strategies have also been identified as important in terms of indicating a sense of control which can potentially have a positive impact on psychosocial wellbeing (Mitchell and Kampfe 1990, 1993).

Tina and Natasha were driven to be successful during their placements, they both had very high standards and were striving to do the best they could in challenging circumstances. Whilst they both pushed themselves to extremes, Tina felt that the impact this had on her could have been avoided if reasonable adjustments had been considered and implemented. In comparison Natasha, felt that she needed to work harder as a result of the reasonable adjustments which had been agreed and implemented. This reaction is supported by some of the participants in Velde et al's (2005) study who also found the idea of support was paradoxical. Overcompensation as a technique is identified within the literature (Velde, 2000) and applies to both Natasha and Tina as they were motivated by a need to prove themselves and to be the best they could be.

During the process of data analysis, I became interested in how motivation and determination for success appeared synonymous with the concept of volition. Volition was initially described by Kielhofner (1985) as a crucial aspect of the person component of The Model of Human Occupation (MOHO). This again led me to consider how the use of a conceptual practice model could be further applied to the findings of this research. As it was becoming clear that there was a dynamic relationship between the person, their environment and the occupation of studying to become an Occupational Therapist. The specific relevance and application of MOHO to the findings of this research will be discussed in chapter 5.

4.3.3. Theme 3 – ‘That was When the Bubble Burst’ – Pivotal events which had negative consequences for participants

The findings of this research identified pivotal or critical events within most participants journey’s which led to a feeling of the ‘bubble [being] burst’.

These events included:

1. Natasha and Tina’s placement experiences and Valerie’s threatened redundancy as previously discussed in **‘Boom or Bust’**
2. Potential discriminatory experiences and attitudinal barriers which can exist as **barriers to learning** in the education of OT students with disabilities.
3. Experiences which led participants to question **Is OT for Me?** and **Am I good enough to be an OT?**

These events and barriers frequently hindered the participants’ abilities to participate fully in the occupation of studying OT (Kielhofner 2008, Law 2002).

4.3.3.1.Sub Theme 1: Barriers to Learning.

Some of the pivotal events which led participants to experience feelings of disappointment and frustration, in systems, processes and people included those described by others as environmental barriers to learning (Jung et al, 2014; Sivanesan, 2003).

Historically, it is reported that prior to the introduction of the DDA-SENDA (2001) and the Equality Act (2010) there was little or no support for students with disabilities in Higher Education (Vickerman and Blundell, 2010). This was reflected in the experiences of participants who had previously studied within HE (Cathy, Andrew, Amanda).

The introduction of the DDA- SENDA (2001) and the Equality Act (2010) prompted a call for resource investment by universities (Sivanesan, 2003; Harrison and Swee Hong, 2003). It has been argued more recently that whilst

investment and subsequent improvements have occurred more work is still required in order to achieve equity for all (Jung et al, 2008; Vickerman and Blundell, 2010).

Whilst some participants within this study experienced barriers to learning during their University education which were similar to those described in previous studies (Jung et al, 2008; Jung et al, 2014; Sivanesan, 2003; Velde et al, 2005), these barriers were not present for all participants. Thus, supporting the suggestion that improvements and enhancements to university wide processes and procedures have been made nationally and internationally (Jung et al, 2008).

Whilst in the minority, both Cathy and Tina experienced cultural and attitudinal barriers, viewed by many, to be the most challenging barriers in education to overcome (Bennett, 1988; Maheady, 1999; Sivanesan, 2003). The barriers were exhibited by both teaching and practice placement staff. Cathy had faced attitudinal barriers both within the University setting and in practice. A pivotal event for Cathy was the moment an OT manager, a person in authority, who she believed should have an understanding of equality and anti-discriminatory practices, indicated to her that they had experienced concerns prior to offering her a placement as a result of her disability. This was the moment that for Cathy 'the bubble burst' and she realized that potential discriminatory practices can and still do occur. Cathy had expectations that because she was working with Occupational Therapists, they would practice in a non-discriminatory way. She envisaged that their practice would be underpinned by OT principles and philosophy not only in their work with service users but also when working with students. Previous literature would suggest that other OT students with disabilities have also questioned the integration or lack of underpinning OT philosophy within educational and practice settings (Archer, 1999; Jung et al, 2014). Velde (2001) supported the need for Occupational Therapists to extend their philosophy, values and beliefs about their clients and patients with disabilities to those with whom they work, their peers and students practicing to become Occupational Therapists.

I think what brought it home to me was actually when the lead of that department said, we weren't sure about having a *** person and I think at that point I realised that how actually people's attitudes were and being an Occupational Therapist is not as easy as I thought it might be in terms of attitudes. I know Occupational Therapists are supposed to be very non-discriminatory and we have a code of ethics and standards of proficiency to abide by, the reality of that is not the same and I think at that particular point in my third year, that was when that bubble was burst and I didn't say anything and I think I probably did, but I can't remember what it was, and I think 'it didn't turn out to be too bad then', was it? So I probably made some sarcastic comments, but I think in that particular instance, they had already had a *** student, so they were comparing me with the previous *** student (Cathy)

Cathy was also disappointed to have been compared with a previous student with a similar disability. Again, from Cathy's perspective this was incongruent with OT as a client centred profession, who respect and understand people as individuals, each with their own strengths and areas for development.

Her use of sarcasm in this instance was, potentially used to deflect from the situation but also to demonstrate her dissatisfaction, hurt and pain.

Throughout her placement she had demonstrated her skills, adaptability and her knowledge. She was also an expert in understanding how her condition impacted on her and had a clear well utilized strategy to support her learning. She, therefore, believed that the placement had not 'turn[ed] out to be too bad'. Cathy's recognition that despite governing policies the potential for discrimination still exists was hugely disappointing and frustrating. A point underpinned by Vickerman and Blundell (2010), who recognised that there was a requirement for more than legislative change in order for significant improvement in attitude and culture change suggesting greater consultation and involvement of disabled people in HE was required.

Cathy's experience of the 'bubble being burst' reflects the continued difficulties of being pre-judged and potentially discriminated against prior to or during a practice placement for students with disabilities. Bennett (1989), almost 30 years ago, was confronted by similar attitudinal barriers, when one

of her placements was cancelled as a result of her disability. Bennett's personal experiences led her to question the attitudes and beliefs of some within the profession. Disappointingly, despite legislation, increased education, policy and procedures these similar attitudes were highlighted again within this study.

In 2005, Awang and Taylor wrote an editorial paper as a result of challenges identifying placements for students with disabilities and a perception that these students were pre-judged and potentially discriminated against, a perception which is well supported within the literature (Archer, 1999; Sivanesan, 2003; Velde, 2001; Velde 2002) and supported by Cathy's experience. They posed questions to practice educators in the UK and asked them to consider if their philosophy differed for their patients and students with disabilities. They also asked educators to consider if their approach differed between that of a therapist or educator and Taylor (2007) suggested that as Occupational Therapists we view patients with disabilities more favourably than students with disabilities. Taylor (2007) argued that despite our philosophical underpinnings of being holistic and client centred, empowering and embracing the Social Model of Disability (Oliver, 1983)

We are still working from a position of professional power and stereotypical medical model view of people with disabilities...needing help to function successfully (Taylor, 2007; p280).

Whilst the potential for discrimination was not evident in any other participant's narrative perhaps suggestive of improvements in practice over the last 10 years, it remains concerning that such an attitude does still exist.

Cathy and Tina also believed that academics within the University had been unsupportive. A further but similar pivotal event for Cathy occurred within the University setting. Following difficulties encountered with reoccurring tasks within her seminar group as a result of her disability, Cathy approached her seminar tutor to discuss reasonable adjustments. Cathy's disappointment is again understandably evident as she describes the frustration she feels that

staff, who she felt should be more understanding and accepting of disability, had been unsupportive and unhelpful in providing reasonable adjustments within the classroom.

Like I said I feel like I did everything proactively, I let people know, which you are encouraged to do so, but that is the way staff members are, not what you would expect with being on a health and social care course, but what do you do, ... So you complain about them, what is going to be the end result, they are not going to get kicked off because that is not what I want them to do, ... I want them to actually take action, a positive action, to feel that you are actually listened to and things are happening (Cathy)

Whilst her disappointment and distress were evident, it was also clear that she wanted to influence change, to ensure that staff were educated, understood and were actively supporting students with disabilities ensuring equity and avoiding discriminatory practices. Her language was emotive; she did not want staff to lose their jobs but did want to see attitudinal and behavioural change. Thus, demonstrating her determination to advocate for herself but also the continued need for staff development (Jung et al, 2014).

Similarly, a pivotal event for Tina occurred when she felt that her needs had not been considered nor appropriate adjustments negotiated or made when allocated her final practice placement. Tina described how she felt that the OT Practice Placement Team's attitude was also incongruent with the philosophy of the Occupational Therapy profession.

There is no personalising placements at ***; this is how we do them and it's just get on with it and it was made clear from the beginning (Tina)

Tina was angry and frustrated particularly around the length and timing of her placements. She felt unsupported by the team and that her personal health situation was not considered. Her belief was that simple compromises, which would have led to 'a better, more realistic, more achievable experience / placement' could have been made but were not. Tina felt that it was ironic that

the job 'we' do within the workplace is about adaptation and adjustment but that this strategy is not employed for students on the OT programme.

It's quite funny really that we go out into the work place discussing reasonable adjustments, but we don't have any of our own (Tina)

Flexibility within the curricula is advocated by many for students with disabilities (Jung et al, 2014; Vickerman and Blundell, 2010) and whilst this may promote equity for all, this can also pose significant issues for programme teams. The curriculum is designed to offer a 'wrap around' of the development of theoretical knowledge and opportunities to apply this knowledge in practice settings encouraging the development of professional identity and competence in practice. Placements are positioned within the academic year but with little space to extend as students are required to return to the University for continued study, thus limiting the flexibility of the placement period. That said as indicated by Tina the level 3 placement was preceded by the summer holidays which allowed her to 'prepare' completing work which she was able to 'drip feed' throughout the placement, reducing the level of work required during the placement. Thus, she adapted the placement experience as much as she was personally able to ensure success.

I spread the work load out in advance and basically fibbed to practice educators that I had been doing research while I was there and I hadn't; I had done it before I had gone, but fed it in slowly, but I know roughly what I am going to need to know ... I had done it all in advance, because it helped me to manage it and it meant that I could go home and just write up my blog for the day, deal with any important points that I had to, but the background reading had already been done (Tina).

As placements progressed Tina had developed strategies for managing, what she identified as the pre-identified workload for the placement. She was able to demonstrate her organizational skills and abilities to pre-plan her placement time and ensure success.

There were many instances within Tina's narrative which highlighted her dissatisfaction with the support offered by the university. Tina was angry; she

had to contend with many new situations during her training to be an OT which created lots of anxiety, fear and stress. Her disability had had a significant impact on her identity and she was struggling at times to adjust to these changes. Her anger was projected during the interview at the University and the lack of perceived support she had received and it was evident that she needed to ensure that her voice had been heard.

It is evident from both Tina's and Cathy's narratives, concern continues to be expressed within this study and by others regarding 'overt stigmatisation and a lack of sensitivity' (Jung et al, 2014; p150) by those 'in a profession that adheres to a philosophy of inclusion and acceptance regardless of ability' (Jung et al, 2014; p150). For both Cathy and Tina, the attitudes of these Occupational Therapists concerned them, with both believing that Occupational Therapists should be better informed, more empathetic and more willing and open to supporting students with disability. Vickerman and Blundell (2010) felt that inadequate staff attitude and behaviour was frequently linked to a combination of a lack of training regarding diversity in teaching, learning and assessment and lack of knowledge and awareness regarding legal obligations. Thus, providing support for the need for continued education and training for new and existing academic and practice placement staff.

In complete contrast to the experiences of Tina and Cathy, most of the participants described their experiences of support by staff both in practice and within the University positively acknowledging it as invaluable. This finding is supported by Brown et al (2006) and Velde et al (2005). Velde et al (2005) surmised that the largely positive response from her participants was reflective of the departments and institutions attitude to disability and whilst possible, a possible counterargument could implicate recruitment bias. Perhaps those who chose not to participate had a different experience and with such a small sample, it is impossible to make firm or generalisable conclusions.

A pivotal event for Vicky was identified as the prolonged wait for 1:1 support despite being diagnosed with dyslexia prior to commencing the programme.

This led Vicky to believe that she had been disadvantaged from the very beginning of her training

She has come back and said to me that they have got a waiting list. I have never heard this before, never, they have got a waiting list and they have got 20 people on the list at the moment who are still waiting to get, I call them dyslexia tutors, so they are still waiting to get a dyslexia tutor, so I am now 21 (Vicky).

Frustration was evident within Vicky's narrative; she had previous experience of education and was outraged that there was a waiting list for 1:1 support she knew she desperately required. The fact that she was twenty first on the list added to the frustration and appeared to indicate to her that there was little or no chance of receiving the support she knew she required.

Delayed access to assessment, equipment and resources such as laptops, software, lecture / seminar materials etc. (Cathy, David, Vicky, Carmel, Tina) were also identified as challenging events which participants were required to overcome. Accessing equipment and support early is essential as this enables students to familiarise themselves with equipment and software to support their studies. Thus, preventing them from becoming disadvantaged. Early diagnosis, preparation and the provision of equipment and support is also of benefit to the academic team and the wider University, as this enables early collaboration with students facilitating achievement of their academic potential.

For Cathy a further pivotal event and one of the greatest barriers she felt she had faced was not being able to have a communication support worker with her during her placements.

I never had any support in terms of communication support workers on any of them, purely because of the money situation, I can't afford to, which is quite galling, when you have had support from access to work in a previous working capacity and you know they are available there all day (Cathy).

Communication whilst on placements provoked anxiety for Cathy and whilst she had worked previously and accessed Access to Work funding, her Disabled Students Allowance (DSA) budget was not sufficient to pay for a support worker whilst on placement. Thus, leading to feelings of anger and frustration at the inequity of the situation.

Historical and more recent literature related to students in HE with disabilities still frequently discuss the barriers to learning which exist. The findings of this study and that of others (Jung et al, 2014; Maheady, 1999; Storr et al, 2011) suggest that students are still at times required to battle with processes and procedures (Vicky, David, Cathy, Tina, Carmel) and cultural and attitudinal barriers (Cathy, Tina). Unfortunately, as a result of recent cuts to DSA (Willetts 2014) and support services within the University it is likely that the frustration and dissatisfaction experienced by Cathy, David and Vicky will be felt more widely in future. The need for participants to be assertive, know their rights and strongly advocate for themselves and others was required by Cathy, Tina, Andrew, David when dealing with challenges and barriers to learning. The development of these skills is advocated by Paul (1999) and Brown et al (2006) as would be expected within the Social Model of Disability (Oliver 1983). The continued need to empower students within the potentially challenging times ahead will be essential.

4.3.3.2. Sub-Theme 2: Is Occupational Therapy for me?

David experienced a number of key pivotal events which led him to experience an identity crisis and question if OT was the profession for him. The events began during his level 1 placement where he acknowledged finding the assessment process challenging and believed this had led to difficulties with his communication and interpersonal skills

There were a few problems with the way I came across and expressed myself but I think part of that was because I was being stared at and watched (David).

David was uncomfortable with the style of assessment, used during the placement, perhaps as a result of feeling judged. David acknowledged that he had listened to the feedback he had been given during the placement and adapted his approach resulting in a 'glowing reference' and 'improved marks'. Thus, indicating that in his opinion he had demonstrated his abilities to reflect upon, learn from and adapt his behaviours (all skills required of an OT student) based on the feedback he received and this learning resulted in success at the end of the placement.

A further incident occurred with a seminar tutor, who David claimed had stated he had 'no interpersonal skills whatsoever'. In explaining the comment and defending himself he stated

I am aware that I can be a bit direct,..., but the level it came at, I was quite surprised if I am being honest and I have had a chat with the tutor about it and I did acknowledge that I can be a little abrupt but I have worked tremendously hard, ..., if I came across in a manner which was disrespectful – I apologised unreservedly as I understand it can't be good to be stood there and perceive you are being undermined, which I wasn't and wouldn't do but I feel sometimes people misinterpret what I am saying or doing (David).

David was clearly concerned that he may have appeared disrespectful or undermining to a member of staff he perceived to be in a position of authority. He clearly wanted to rectify the situation and wanted the tutor to understand his efforts to adapt his approach.

David believed that the comments from the seminar tutor and from his practice educator were not congruent with feedback he had received from others, in both a professional and non-professional context. He explained that he had completed voluntary work and shadowing experiences and had received good feedback about his interpersonal skills and therefore this feedback was very disappointing. However, this had clearly impacted significantly on how he perceived his future in OT stating

I'm thinking if I can't communicate with people, or if people are thinking that, what they were thinking about my communication and

interpersonal skills, maybe I am wasting my time because there is an argument that I don't fit in with the whole OT thing. It's been pointed out to me, also, that I know it is a largely female dominated industry and the way I sometimes talk to people and put myself across is not always effective communication with ladies, which again surprises me somewhat I get on with everyone that I am aware of anyway and it's like am I going to be a fish out of water and upset everybody (David).

David recognised that OT is a predominantly female profession and highlighted the fact that he believes he is able 'get on with everyone'. He perhaps, however recognised the distinct differences between his past careers and that of a health professional. The perceptions and opinions of others are important to David. His use of the metaphor 'like a fish out of water' describes how he feels about himself and his perceived incompatibility with the OT profession. Also highlighting perhaps his feelings of being surrounded by people who are different to him.

His feelings of confusion and frustration were compounded by the fact that he no longer felt he 'belonged' as part of his group of male friends.

I went away and spent time with my mates, had a good laugh ... but I actually feel I don't belong there anymore. So, I understand a lot of my mates, for instance are not like what you would class as being an Occupational Therapist's mate. I am a bloke's bloke... I can't be this OT student all the time, when I am with them, the same as I can't be like them when I am surrounded by all of these Occupational Therapists – if you get my meaning – it is like 2 worlds. I know people have separate lives but I actually felt like I didn't belong there anymore and this was the same time, ... when I didn't feel like I belonged here anymore either and I was just really confused and I thought like you are kidding yourself, can you work in this environment? can people in this environment actually work with you? (David)

David appears to be struggling with his past identity as a 'bloke's bloke' and his current identity of an OT student and future health care professional. There appears to be incongruence between the 'really hard lads' he previously associated with and the caring profession he is currently associated with. The methods of communication used previously within his formal working career and more informally with friends also appear disharmonious with current professional expectations. The personal and

financial sacrifices David had made and the commitment he was showing was obvious. However, it appeared that he was experiencing an identity crisis, as he transitioned from his past careers and roles to becoming a health care professional. The complexity of this transition was even more challenging as a result of David's injury, as it was difficult to ascertain if the 'personality' change and associated behaviours were as a result of his injury thus adding to his confusion and frustrations. David had experienced a number of significant life events prior to his entry on to the programme, he had sustained a potentially life changing injury, been made redundant, decided to retrain all of which had a significant impact on who he saw himself to be and who he was becoming. The reconstruction of David's identity following multiple life changing events was complex. The impact of the cultural shifts proved a significant challenge for David. His battle appeared to be in transitioning and reconciling his past identity with that of his new identity. Constructing a new identity perhaps proved difficult whilst 'grieving' for the loss and changes to his previous self (Unruh, 2004). David's ability to actively reflect upon and control his identity reconstruction (Taylor, 2008) also appeared impaired perhaps as a result of his condition which further added to the complexity.

In congruence, Tina also questioned if OT was the profession for her as a result of her final placement. She expressed anger and frustration with her final placement allocation. She was concerned that her needs had not been assessed and that she had been potentially placed at risk in a community setting. She felt her experiences had impacted upon her confidence at a crucial time within her training. Her anger was evident and potentially aimed at me as a member of the team who had allocated the placement. She demonstrated a belief that little or no thought was given to her placement allocation. She also indicated a dichotomy in that she liked the placement but felt it was irrelevant to her future career.

I suspect in my case I should never have had a community placement, end of...The last placement there were some challenges which affected my self-esteem fairly largely actually; it was a bit of a battle because when you are a third year you want to be seen to be independent, to be functioning as an OT and

because of the type of the placement I had, I couldn't do that and it left me wondering quite seriously whether I was on the right career path. Whether I was going to actually finish my degree. Whether I could manage to do it all...I liked the placement a lot, but I knew there was no way that I could apply for a job in that position, so it made it a slightly irrelevant placement. So I could argue, that perhaps a little more sympathetic managing of placements might have been in my best interest (Tina)

Tina's final placement significantly impacted on her self-esteem. Her perception was that she was required to be independent during this placement but as a result of being placed in the community and unable to drive, she felt she was unable to demonstrate this level of independence. This led to an internal 'battle' which impacted upon how she viewed herself and potentially served to reduce her confidence to 'do the job'.

...it is difficult, maybe I am going for the wrong profession, I still don't know quite, I think it could be managed with certain adjustments, but there weren't too many in placement (Tina).

Tina continued to debate her future as a result of her placement experience and lack of self-confidence.

Whilst it is possible that all students studying OT question if they have made the right career choice during their education, no evidence was identified to support this.

4.3.3.3. Sub theme 3: Am I Good Enough to be an OT?

Cathy had successfully completed her OT training, had HCPC registration and had applied for numerous jobs but had not secured a post at the time of interview. She exhibited uncertainty and fear which were linked to feelings of self-worth and value. Despite 'doing very well on all assessments' and successfully qualifying Cathy described a 'nagging doubt' about being 'good enough' to be an OT. This seemed to be reinforced by her inability to secure a

job at the time of interview. However, this was at a time when newly qualified band 5 posts were scarce.

I was so looking forward to getting a job at the end of it and thought that I would have no trouble in getting a job ... So yeah that's how I now feel. So I think I was in this very hazy yes, nearly there, going to get a job, can't wait, but now I feel quite deflated after having the amount of interviews that I have had and almost getting there, but not quite getting there and it's almost like the carrot has been dangled, you know, you still try to grab it, but as a disabled person I can't help thinking, yeah, you have the policy, but there is always a way round it, you can always use an excuse not to employ me and say because I said something or I didn't add something, but that is me being cynical (Cathy).

Cathy was frustrated at not being able to secure a job and expressed her concerns about discrimination. She remained cynical about why she has not been employed, recognising that policy and legislation count for little (Vickerman and Blundell, 2010). Cathys use of a metaphor, 'the carrot has been dangled' indicates that she is desperately looking to be rewarded for her hard work and get a job. However, she currently feels she is being punished as she has not been able to secure one.

Similarly, Tina had successfully completed her OT training and was awaiting graduation when interviewed. She had not applied for Health Care and Professions Council (HCPC) registration or secured a job.

Tina's fears as a newly qualified graduate were multifactorial. She questioned her ability to cope within a working environment as a result of her final placement experience which had a significant impact upon her self-confidence and self-esteem. She was also afraid to apply for HCPC registration fearing rejection based on her diagnosis and had therefore not completed the application. She lacked knowledge and understanding about HCPC registration and acknowledged that she had avoided investigating it for fear of their response. Tina feared that despite her hard work and reward that she still may face rejection based on her diagnosis. Tina recognised the decision was out of her control, which increased her anxiety. Tina also appeared to

doubt her own clinical abilities and appeared to be resistant to taking responsibility for herself and others.

I haven't applied for my HCPC, there is still a bit of me that is scared to apply in case someone says no. That was never discussed before I started the course at all. I didn't know about it. So it wouldn't have really occurred to me and my health has improved considerably over the last * years anyway and might still continue to improve, but I definitely don't want to hear someone say you can never be an Occupational Therapist because that would make the whole last * years have a rather different connotation. It hasn't happened, bit scared it might and don't know, because obviously I will have to declare it ...I don't know really how to handle that and it is definitely partly the reason why I haven't applied for my HCPC; that's cowardly isn't it (Tina).

Tina's narrative highlights the need to ensure that all students are familiar with the HCPC registration process and should therefore be integrated into routine Academic Personal Tutor (APT) meetings with final year students.

Tina recognised that she was anxious about attending graduation and acknowledging that she had not secured a job as an Occupational Therapist. She identified the skills she had developed throughout her training but worried about becoming an Occupational Therapist. Tina also expressed concerns about the potential for stigmatisation and discrimination linked to her disabilities within the job market.

I think the job market is particularly difficult, you are at a bit of a disadvantage to start with, which doesn't help, maybe that is just a great excuse at being bad at interviews. So, it is going to be hard with a declared disability there is no doubt about it; it is going to be harder and I have got to be more selective about what I apply for, if I can get my registration, which again limits the availability of jobs... Everybody is struggling for jobs, you know, being a disabled student looking for a job ..., just means you get the cursory interview, doesn't necessarily mean you get the job, or anymore help getting the job and as an employer, if I had the choice between employing someone that I didn't have to make reasonable adjustments for rather than having to go through a whole process of making reasonable adjustments, I can see why, even employers such as the NHS would take the easy route. (Tina)

Tina attempted to review the interview process through the eyes of the employer believing that employers pay lip service to the process 'even within the NHS'.

Whilst, it is likely that most students would at some point experience a crisis of confidence during their training, it is interesting that the participants who expressed their anxieties about being good enough to be an Occupational Therapist in this study had both already qualified. Thus, perhaps indicative of the impact that their disability had had on their self-confidence.

Velde (2000) also suggested that, as students, her participants (qualified Occupational Therapists) had faced greater challenges in education, practice placement and securing their first post which is reflective of the findings of others (French, 1988) and concurs with the experiences of Tina and Cathy. At the time French (1988) conducted her study within the UK however, the job market was more prosperous than at the time Tina and Cathy qualified. Despite the struggles to secure their first post the participants in Velde's (2000) study had a wealth of experience and had had a number of roles including those within advanced practice and management and leadership. Thus, demonstrating the value added and respect commanded as a qualified therapist with a disability and this is confirmed within other studies (French, 1988).

As can be seen from this research the search for employment can be daunting and frustrating as well as instilling fear of discrimination as outlined by both Cathy and Tina. Vickerman and Blundell (2010) advocate the incorporation of opportunities to explore employability and career options with students with disabilities in order to 'confront barriers to employment' (p29). Opportunities for greater support at this time may reduce the fears and anxieties associated with identifying employment whilst empowering individuals with disability. It is therefore proposed that further formal professional development opportunities are offered within the programme to support employability and career development.

4.3.4. Theme 4 – ‘Heal Thy Self’

The theme, ‘heal thy self’, was a reflection by Tina on her journey through the OT programme, or her engagement in the occupation of studying to become an Occupational Therapist. For Tina, engaging in the occupation of becoming an Occupational Therapist appeared to provide her with ‘therapy’. However perhaps unsurprisingly, it also appeared that either implicitly or explicitly engaging in the meaningful occupation of studying OT was therapeutic for many. Engagement in meaningful occupation for health and wellbeing is the premise on which OT is based. It is to be expected that the occupation of studying OT holds meaning for all participants and therefore would have therapeutic benefits, potentially not just for these participants but all students studying OT. The programme provided participants with a purpose, a structure for their time and offered opportunities for personal and professional development. No evidence was identified to suggest that the therapeutic benefits of studying OT have been previously researched.

4.3.4.1. Sub Theme 1: Occupation as Therapy.

Tina, Cathy and Andrew had all successfully completed the OT programme and were awaiting graduation and they all explicitly described the OT programme as providing a therapeutic benefit.

Tina believed that the OT programme had offered her direction. Her personal therapeutic gain from studying OT was significant. She appeared to suggest that participating in the occupation of studying OT was a life-line. It provided structure, a new identity and role as a student, deadlines and goals to focus on and provided a potential distraction. The occupation of studying to become an Occupation Therapist provided Tina with a meaning for her life but also appeared to be supporting her to find meaning in her life following the onset of her condition.

I mean the condition necessitated the career change, I was floundering around not knowing what I was doing and the OT course provided some direction that, ... I don't know where I would be without that course over the last * years, because I really got myself into a state that I was struggling to find a way out of it and it gave me something to focus on and it gave me, you know your smart goals, you know, get this assignment in on time, ... I have been back to ***, waving my piece of paper and their reaction was fairly amazing too because it is good for them to see what they created out of a basically blubbering wreck in **** to someone that can go on and not only get a degree, I was so proud of my 1st, I was close to it all the way through and I was determined I wasn't going to let it go ... but the trouble is at the end of the course, I am a little bit scared to be heading back, to I don't know, what to do with myself. I signed straight up for a post-grad cert, knowing that it was going to be a bit floundering to give me some direction (Tina)

Not for the first time, within her narrative Tina appeared to compare herself to that of a patient. Here in terms of setting 'smart goals' and previously when she referred to her seizure management plan as a 'care plan'. She appeared to have become dependent and thrived on structure, routine and all that was familiar, fearing change and this was demonstrated when she immediately enrolled on a further education course post qualification and appeared to avoid or delay applying for HCPC registration and working as an Occupational Therapist. Implicit within, Tina's story, was how she appeared able to apply the principles of OT and the teaching within the course and in her words to 'heal thy self'. For example, she appeared to apply the OT process to herself throughout the programme. She used opportunities to goal set, assessed situations (e.g. her placement allocations), analysed activities (e.g. attendance at classes, preparation of assignment), graded and adapted interventions (e.g. actively preparing for placement, in-order to reduce workload during the placement and focus purely on the practical aspect of the placement) and evaluated her progress and achievements. Tina appeared to consider herself still to be a patient within the context of the University. The use of the word heal is important here, almost as if she felt broken and in need of becoming 'healthy', well or fixed again post her illness and prior to studying OT. Using language such as 'floundering' on multiple occasions also perhaps indicating that she 'was out of her depth' and needed guidance,

support and therapy to be 'healed'. Murray (2002) in recalling her own personal experiences recognised the positive impact studying OT had on her. She wrote of her personal experiences of becoming an OT who had never practiced as a result of her 'lack of confidence and conscientious attitude about my own professionalism' (p354). Murray (2002) outlined articulately her battles with severe and enduring mental ill health and supported the idea that OT education had been of benefit to her 'personal growth' (p355), health and wellbeing.

Tina described the elation she felt when she returned to revisit the OT department where she had been inspired to become an Occupational Therapist. She demonstrated an overwhelming pride in her achievements and a desire for recognition from those who had initially inspired her to become an Occupational Therapist. Tina demonstrated a fear of returning to a phase in her life where she had little or no direction or control. Throughout her narrative Tina appeared to have an innate need to be in control. At times where she was unable to be in or take control she appeared defensive and blaming of situations, circumstances and people and perceived a lack of support from the University systems and staff. This appears to be directly linked to her understandable fear of new situations.

Tina recognised the impact the programme had had on her own self-perception.

...but I have taken a lot away from the course apart from an OT degree and hopefully a job...I genuinely don't think that if I had gone and got a job or anything else, I don't think I would have had the sense of self-worth the course has given me (Tina)

Here, Tina links the benefits of, not only, the participation in the occupation of studying OT but also the outcome of studying, recognising the therapeutic benefits in terms of both process and product, as also seen by Paul (1999) and recognised by Occupational Therapists as of equal importance within the therapeutic process (Hinojosa and Kramer, 1997).

Whilst, Cathy had previously worked within health care, she also recognised the therapeutic benefits of studying OT. She viewed her position on the course as offering an opportunity for her peers to work with someone with a disability on a day to day basis. The positive impact of which was also exposed by French (1988). She identified that the impact of the presence of students with a disability within the classroom environment was significant for their non-disabled peers. As, the experience enabled first hand exploration of disability within the classroom, as French willing became a tool for learning. Interestingly and in contrast, the participants in Jung et al (2014) expressed concern that their experiences of personal disability were not discussed within the context of the classroom and that this resulted in some conflict and incongruence between the taught and lived experiences of these individuals.

Cathy also felt that she had opportunities to widen her own experiences of working with people with a range of disabilities in practice.

It has been quite therapeutic for myself being on the course... It kind of opened me up to other disabilities and that was one of the reasons why I chose Occupational Therapy because it didn't hold me into dealing with people who are ***, so it opened up a whole different variety of people that I could hopefully help (Cathy).

Cathy felt that through her studies, she had been exposed to working with many individuals and that this would continue through her working career.

Andrew also described how undertaking the OT programme and being diagnosed with a SpLD during the programme had been of personal therapeutic value and had helped to alleviate his previous suffering.

It's definitely something I didn't think I would get out of that degree, out of the OT degree, that would be a healing process for me, that's something I didn't imagine at the beginning, that there was going to be something in it for me that was going to be intrinsic to how I go forward within the next 25 years of my life (Andrew).

He acknowledged the 'pain' he had felt throughout his education whilst he was undiagnosed and the relief he had felt as a result of his diagnosis which had provided an explanation for his previous struggles. He had not expected to benefit intrinsically nor therapeutically from studying OT following his diagnosis with a SpLD. Andrew believed that his diagnosis was a 'gift'. He felt that the 'gift' had offered him an answer and an opportunity for self-reflection, apply his learning and problem solve in order to 'heal' his pain and suffering, improving his health and wellbeing.

I did not anticipate uncovering the therapeutic benefits of studying OT, nor has it been a topic which has been considered within the existing literature. It is however understandable and perhaps unsurprising given the nature of the programme, the teaching styles employed and the learning that is facilitated. The Royal College of Occupational Therapists (RCOT) suggest that:

Occupational Therapists promote activity, quality of life and the realisation of potential in people who are experiencing occupational disruption, deprivation, imbalance or isolation. We believe that activity can be an effective medium for remediation, facilitating adaptation and re-creating identity (COT, 2014; p2).

It appears that some of the participants who were perhaps experiencing occupational disruption, deprivation, imbalance or isolation; as a result of their learning difficulty, chronic illness or disability; used the training and education whilst becoming an Occupational Therapist as an effective medium to facilitate occupational adaptation and adjustment to disability whilst re-creating their identity. The RCOT further suggests that students studying OT need to 'experience the transformative potential of occupation' (COT, 2014) through and within the curriculum. It was evident from some participants narratives (e.g. Andrew) that 'being' a student, 'doing' Occupational Therapy had been a 'transformative' experience resulting in Andrew, Tina and Cathy 'becoming' an Occupational Therapist.

The World Federation of Occupational Therapists (WFOT) further describes OT as 'a client-centred health profession concerned with promoting health

and well-being through occupation' (WFOT, 2012) and again the participants were able to use engaging in the occupation of becoming an Occupational Therapist as a focus and possible distraction (Valerie, Tina) to enhance their own health and wellbeing.

The education and training to become an OT is demanding for all students (Velde, 2002). The teaching within the programme lends itself to the development of skills such as critical thinking, reflection and self-awareness, which are a requirement of the professional body. It is anticipated that students will critically consider who they are and examine their strengths and areas for development. Velde et al (2005) shared this vision and was 'encouraged' (p87) to identify that students with a disability demonstrated self-acceptance and self-awareness. The programme was not however designed as a therapeutic tool it is designed for education and this is an area for potential conflict.

I believe that there is a fundamental challenge for academics within OT education and that this relates to the differing philosophies and roles that we undertake as Occupational Therapists and as an academic, lecturer and educator. I feel the variation in roles causes challenges for practice educators, academics and the students we work with and can cause a blurring of professional boundaries. Whilst the academics and practice educators are therapists they are not working in this capacity when working with OT students and therefore should not be offering 'therapy' to those who require active intervention. The position of the OT educator, when working with students with disabilities, has been debated in the past. Questions have been posed with regards to the approach to working with these students either from a therapeutic or educational perspective (Velde, 2002). Conclusions have been drawn that indicate the need for collaboration and a client centred approach (Bennett, 1998; Salvatori 1999; Velde, 2002). McFarlane (2016) identified that professional experience contributed to an academic's confidence when dealing with students who were distressed. However, she also highlighted how this could also impact on the establishment of boundaries and suggested that further research was required to determine the

impact of this paradox. It is therefore suggested that the position of the academic should remain one of 'supporter' and academic guide who is able to signpost to appropriate others for intervention, thus avoiding role blurring.

The joint aim of the professional body and the local OT programme, therefore, is to produce Occupational Therapists who have excellent interpersonal skills, are able to use themselves therapeutically, are reflective, self-aware and able to respond to the needs of the patients and service users they work with.

These individuals also need to be able to identify their own learning and development needs and address these. Through their narratives participants gave examples of how they were able to do this. Robert was actively seeking interpersonal skill development through the programme. He recognised this as a personal area for development and believed that the programme would provide opportunities to further develop and enhance his skills.

It is about personal development, it's about improving the way I communicate, that's another thing because I have always had problems...sometimes I just struggle when I start to think about what I am going to say...and I thought being here, it would be nice just to learn about how to get through things like communication (Robert)

Robert recognised how the course had the potential to support his personal development.

4.3.4.2. Sub Theme 2: Disclosure, Reasonable Adjustments, Support Systems / Mechanisms and Coping Strategies.

The complexities and concerns regarding disclosure are well articulated within the literature as has been previously highlighted (Archer, 1999; Bevan, 2014; Chacala et al, 2104; Hill and Tinklin, 1998; Maheady, 1999; Jung et al, 2014; Sivanesan, 2003; Velde et al, 2005). Disclosure was associated with negative emotions such as fear, distress and worry within Brown et al's (2006) small scale study. It has been argued that the fear of disclosure stems from the potential consequence of rejection based on an individual's diagnosis and a

potential concern about being 'devalued and stigmatised' (Vickerman and Blundell, 2010; p26). Disclosure is however, essential for the provision of reasonable adjustment and the provision of reasonable adjustment is frequently crucial to an individual's success. Whilst findings from this study do offer some support to previous studies, in terms of the fears surrounding disclosure, this was not a significant issue identified by many of the participants within the study. With some (Andrew, Robert, Tracy) appearing empowered to disclose. Sheridan et al (2016) suggested that disclosure is:

An adaptive strategy enacted to both manage their condition and to attain more meaningful participation (Sheridan et al, 2016; p489).

Thus, suggesting that those who feel a greater sense of ease with disclosure would be more engaged and this would positively impact on their health and wellbeing. It is however, important to recognise that all of the participants in this study, volunteered to participate thus perhaps reflecting a greater ease with disclosure but possibly not representative of those who chose not to volunteer to participate in the study.

Participants within this study had all disclosed their conditions within the University setting and within their interviews they discussed the equipment and support they had been or were to be provided with. Within this study, it was evident that some participants (Hannah, Valerie, Vicky, David and Cathy) were discerning with whom they chose to disclose and this was dependent upon their perceptions of need.

I don't think it is anybody's business, it's my business and if I feel that I need to tell people, depending on the situation that I am in, then I will share that information with people, if I think they are going to do something productive and positive with it, otherwise what is the point (Cathy)

The choice by all to disclose to the University Support Services was perhaps viewed as safer more objective choice for disclosure, given that is removed from the OT department and the interface with the placement setting. It was also the department in which participants were assessed for and gained

access to their support plans, assistive technology and other reasonable adjustments to support and enhance their learning.

The complexities of disclosure to practice placement providers appears more complex for a number of reasons. This includes the fears of inequity, discrimination and being judged based on disability and / or health but also relates to the understanding of reasonable adjustments both from the student and educator perspectives (Brown et al, 2006; Hirneth and Mackenzie, 2004; Jung et al, 2014).

For some students within this study, the choice to disclose to practice was not a 'real choice' due to the nature of their condition or disability. Natasha, Tina and Cathy all required significant adjustments to their placements and risk management, which necessitated discussions and negotiations from the University's perspective to identify and secure appropriate placements. These participants gave consent for the University to disclose, on their behalf, to potential placement providers in order for appropriate placements to be sourced. In hindsight, I could perhaps have asked these students specifically how they felt about the need for disclosure, particularly as Cathy was adamant that disclosure should only be on a need to know basis and when it was clear how it would benefit her. It does however appear that Cathy did feel it was the practice placements 'business' and having reasonable adjustments was 'productive and positive'. She, along with Natasha welcomed the support offered by the university in planning and preparing for placement

...so, planning it with the placement team was a good starting point in figuring out what would be a best placement for me to get the most out of and also be able to do effectively and having the pre-placement visit, that was invaluable.... from a disabled student point of view, it was very important from any reasonable adjustments that needed to be made...., that was a big aspect (Cathy)

Coming with me, the first time, to meet my practice educator was helpful, we sat down and just told her what the issues were and what would be good to help me and I think that was really handy having the Uni support (Natasha)

Both Cathy and Natasha had complex needs, they welcomed the support offered as suggested in previous studies (Jung et al, 2014; Velde et al, 2005). Being supported by a member of University staff, who attended meetings pre-placement and during the placement was perhaps seen to offer validation for their support requirements.

Of those who had experienced a placement, where disclosure had occurred either by choice or consent (Tracy, Natasha, Tina, Andrew, Cathy, David) all were positive about their experiences recognising that disclosure was potentially a means to support achievement within the placement, for example when Tracy was asked how she felt about disclosure, she described her openness to disclosure

...I don't really shy away in telling people that I am dyslexic because I think a lot of people assume that people who are dyslexic aren't bright and I think that is difficult because it means that when you tell someone that, they might instantly think that you are not bright, but if you are going to spend some time with them, then hopefully they will realise you are bright, but then I was warned by a few people that maybe I shouldn't say that because it might seem like I was saying that I don't want to do work or that I was lazy (Tracy)

Recognising a potential wider societal view of individuals with dyslexia, Tracy, felt empowered to change people's initial opinions and views through her behaviours, actions and the demonstration of her strengths and abilities. In doing this, she was perhaps beginning to address the barriers and stigma faced by those with dyslexia and disability and in turn advocate to legitimise disability (Easterbrook et al, 2015). Tracy was proud of who she was and her SpLD was a significant part of her identity. Tracy also demonstrated her ability to listen to the views of others but to make her own informed decisions about disclosure.

Tracy was keen to suggest how she could demonstrate her proactivity, determination and enthusiasm to succeed by considering and discussing

strategies for managing her dyslexia during her placement with her educator. Such strategies were also highlighted by participants within the study by Velde (2000).

I thought that if I had a plan of my own then I could be like clearly not lazy and I thought about these are my difficulties; this is the stuff I can feasibly do and it will be good quality what are your opinions and take these on board (Tracy).

Similarly, Amanda, who had not experienced a placement was also happy to disclose her SpLD in practice because of the coping strategies she has developed.

I think so, I think because I am quite lucky really because I don't really think that my *** is that bad and because I have coped with it for such a long time I have probably got more, more adaptive, I have got more strategies in place because I have been already in the work place before, so I don't think that would really bother me (Amanda).

Both Amanda and Tracy demonstrated confidence in the strategies they had developed which had proven successful for them previously and both appeared prepared to take the 'risk' in disclosing as these strategies reduced their fear and anxiety.

Conversely, Valerie and Hannah actively chose not to disclose their disabilities / conditions to the placement provider. Both had a mental health diagnosis and chose not to disclose this information to their practice educators or the University Practice Placement Team perhaps fearing stigmatisation, marginalisation and / or discrimination. When Valerie and Hannah were diagnosed with their mental health conditions, both would have already developed their own preconceptions and attitudes to mental ill health. It is therefore, likely that these, along with wider societal attitudes and beliefs also impacted upon their decisions regarding disclosure. It is also possible that they both feared how others would view them and the impact this may have had on their ability to legitimise themselves as an OT student and future health care professional (Easterbrook et al, 2015). Both Valerie and Hannah felt that they were managing their condition and coping well and therefore

neither felt that disclosure was necessary. Thus, appearing to have attempted to rationalise their decisions. Both claimed that they would have disclosed if necessary during their placements but neither felt it necessary prior to their placements and this attitude to disclosure is supported within the literature (Brown et al, 2006).

I don't want to be telling a complete stranger, I didn't say that I had been diagnosed with ***** or that I was on meds or anything because I hoped that it wouldn't be obvious.....No I didn't feel there was a need, if I had started the placement and I was breaking down and unable to do be professional, you know, get on with whatever was needed, then I would have had to (Valerie)

Here, Valerie links her diagnosis to 'breaking down' and as this was not an overt consequence during the placement, she felt in control and rationalised that she therefore did not need to disclose. Valerie appeared to want to hide her diagnosis, hoping 'that it wouldn't be obvious' perhaps because of her own perceptions about mental ill-health as well as her fears about the opinions of others. Valerie felt skilled at being professional and equates this to leaving issues 'at home' and an ability to 'get on with whatever was needed'.

Valerie did however, disclose information about her work circumstances which were causing her considerable stress and may have been the trigger for her mental ill health. Disclosure on this level appeared more acceptable to Valerie. Perhaps as this was linked external factors and circumstances which were beyond her control and her perception may therefore have been that it would have been viewed more positively by her practice educator.

Whilst Valerie felt that if her ability to be professional had been compromised she would have disclosed, Hannah argued that her decision not to disclose was to maintain her professional boundaries.

...even though I haven't disclosed that, there hasn't been really any situations that have made me want to, keeping professional boundaries of the educators and you know, I don't go into my whole life story and say oh do you know what's wrong with me, do

you know what's happened and because I have been coping fine, I felt like they didn't really need to know (Hannah)

Hannah was currently completing her final practice placement, when interviewed and so her strategy of non-disclosure had been successful for her.

I haven't at any time felt like it was necessary to tell them everything because I was coping so well, but at any time that I did feel unwell I think I would definitely be able to say to them, tell them my situations, say I need some support from Uni, I am going to get in touch, but no they have all gone really well (Hannah)

Participants within Jung et al (2014), the majority of whom had also been diagnosed with a mental health condition, similarly found it more challenging to disclose within the placement setting. The reluctance to disclose could be explained by the potential threat disclosure has to their OT student status and future within the profession (Brown et al, 2006).

Neither Valerie nor Hannah had disclosed their condition to the university practice placement team again perhaps fearing the implications of doing this.

I didn't specifically disclose and talk to say the placement team in particular because again I thought I will give it a go by myself and see how I get on and I have been absolutely fine, so I have just kind of gone for it, but I always know that if I did struggle that I could contact someone (Hannah)

Fear and reluctance to disclose was also demonstrated by Vicky, who had not yet experienced a placement. Her fears appeared to be rooted in her previous working history and the attitudes of others. She compared her experiences within education and at work and felt a greater stigma and lack of understanding within the working environment. She appeared to be reluctant to disclose to employers feeling that it was pointless as they had not responded to her needs nor offered the support required but she appeared to recognise a responsibility and feel duty bound to inform them. Vicky seems to experience a dilemma here, it appears that by informing the employer of her diagnosis, she has an expectation that support and reasonable adjustment

would naturally follow. She does not however appear to request any help or reasonable adjustment but experiences disappointment when support is not provided. She also demonstrated the significance of her fears of being judged and of stigmatisation but also perhaps a sense of shame, as she describes her non-disclosure to even her closest family.

I have to tell them by law anyway, but because they never understand, they never say nothing to me, I always put it in my letter ...I say I am required to inform you that I am dyslexic, that's all I say, that's it done. No one comes back to you and says how do you want us to help you, because they don't understand, yeah, but I just leave it at that, but education bang on, but nobody else, so I don't say nothing, my mom don't know, my brother don't know.... they put you into a different box, and they see you in a different way (Vicky)

Vicky appears to have difficulties with the concept of trust and support. She fears being seen differently by her family, which may be related to her place within the family, as someone who is capable and independent which is in direct conflict with her own negative self-perception of being 'thick'.

When asked if she planned to disclose within the placement setting, she again demonstrated the same reluctance and fear but believed that she had to disclose. She does; however, appear to almost internally debate the merits of disclosure, with her main reason for disclosure relating to her perceived responsibility to disclose to her superior. She also lacks the belief that support and understanding will follow disclosure perhaps as a result of her previous experiences in the work place.

'Yes, I have to, no I have to:

1, because I have to, if she is going to be the person over me, she is needs to be aware; she's my boss really and then
2, hopefully because not everybody understands it, but hopefully there would be an understanding, but I don't know, I don't know if the understanding will be there, but yes I will disclose... so I will disclose because I feel, but I am required to, but whether or not there will be an understanding is another story.' (Vicky)

The importance of support systems and coping strategies are well documented within the literature (Brown et al, 2006; Maheady, 1999; Velde, 2005). Prior to application and interview, participants proactively researched and appraised the teaching, learning and assessment strategies and the merits of the support mechanisms offered by the University (Hall and Tinklin, 1998; Paul 1999). Thus, enabling them to make an informed decision prior to entry.

...but one of the reasons that did influence my decision to do OT was that it was all course work and placements and no exams because that was definitely a big trigger to kind of bad periods of anxiety (Hannah).

One of the reasons I really wanted to come here, is when you have lectures, you have the slides up beforehand, which is the best thing because you don't have to spend the whole time writing while someone is talking (Tracy).

Participants recognised the value of the support which was offered within the University. Many participants had 1:1 support from a SpLD tutor, coach, mentor or non-medical support worker. The importance of working with the same support worker was highlighted as this offered familiarity (Cathy, Tracy, Tina) and 'a safety blanket' (Tina). The benefits of the support worker were professed by Tina, Cathy and Tracy. Tina relied heavily on her support worker and was not prepared to risk losing her even when acknowledging that her need had diminished throughout the programme.

I mean, by the end of the course I didn't need ** nowhere near as much as I did at the beginning; I kept her because she was a safety blanket, and I could pretty much guarantee that the minute that I said oh no I could probably manage without you, I knew what was going to happen, so that wasn't the gamble I was prepared to take (Tina)

For Tina the stakes were too high and the risk too great. Tina demonstrated a perhaps understandable aversion to risk within her narrative as a result of her experiences. She experienced difficulties with change and sought familiarity. She does however fail to recognise the

implications that this has on resources for other students as highlighted previously by Vicky.

Tina also recognised the initial challenges facing those who have a support worker in seminars and the 'visibility' of this support leading to forced disclosure within the group. Tina reflected that this may have impacted upon her integration within the group. She also highlighted the challenges in identifying a replacement support worker, in the event of sickness, in a lecture theatre with over 100 people in it. Again, raising the issue of forced disclosure within this situation.

... the note taker was really useful, but in some ways a bit of a hurdle as well into integrating with the peer group, because you are never quite sure how to explain, particularly,... in a seminar group, you have 25 in the seminar group, which means you kind of got to, as it happens I didn't have a problem letting everybody know, that that this is *** and she comes with me! But it does force you into a position of saying you have a note taker... It is very much in your face, so I felt from the beginning it was easier for people to know and so we just covered that (Tina).

Here there seems to be some conflict in the language Tina uses perhaps suggestive of the dilemma she faced when she initially began the programme compared with her feelings upon completion of the programme, when more familiar with her seminar group. Cathy, however, felt that as someone with a sensory disability her support worker supported her integration into her seminar group.

...keep me up to date with gossip if you like, and what's going on in people's lives because you do miss that...and that helped to build rapport up with people and you can, I think, appear to be quite standoffish and I am quite sure that there are some students that probably think that, but once they get talking to me they realise that's not the case (Cathy).

Participant opinions varied in relation to the support offered within the OT department specifically. A number of roles exist within the department which aim to support students with additional support requirements from an academic and practice placement perspective. These roles included the

personal tutor, disability support tutor and the practice placement team. The distinction between roles appeared to some to be vague and undefined leading to some confusion (Cathy, Natasha). Tina, however, identified that she had found the pre-course information and the opportunity to meet with other students with disabilities, offered by the OT department prior to starting the programme positive. These sessions provided opportunities for the students with disabilities to increase their confidence and knowledge about the institution (Taylor, 2007). They also support the anticipatory requirement that HEIs should, if disclosure is made prior to entry to the programme, be proactive to work with students to ensure smooth transition into the University environment. In contrast to Tina's positive reaction, the findings of a study by Vickerman and Blundell (2010) identified that supported transition occurs infrequently and when it does it is not always found to be a helpful process. This study was not completed with OT students. Tina valued the opportunity for peer support and recognised that continuing to meet with other students who had a disability during her education and training would have been beneficial. The development of community of practices (Wenger, 1998); peer support groups or peer mentoring (Sheridan et al, 2016) to share experiences, develop and learn from each other and in the development of identity are suggested within the literature.

Peer support, as highlighted by Sivanesan (2003), was a crucial factor in Tina's successful completion of the programme. Tina's condition had resulted in her experiencing seizures, an invisible disability which limits participation in HE (Sheridan et al, 2016). She therefore relied heavily on the support of her peers, who she felt knew her well and were able to distinguish the severity of her seizures.

... my peer support was really strong and was the one thing that kept me on the degree course, definitely, that was really important for me... There may not be that person there that you feel would support you, would know you better, know how to deal with things, know when things are more serious, less serious (Tina).

Tina described a number of incidents where following a seizure, an ambulance had been called and she had spent hours in A&E before being discharged home.

So, avoiding that helps and that comes down with peer knowledge and peer support, rather than to be fair, anything that Uni did... So, I know it has impacted on other people and that's quite hard..., it is bad enough that it is impacting you, but you don't want to spread the love; that's a bad idea, so yeah, that's been crucial to me finishing the degree, is the peer support (Tina).

In Tina's opinion the University was frequently at fault for calling for an ambulance following a seizure. She did not seem to recognise the 'Duty of Care' that the seminar tutor / lecturer had and the potential lack of familiarity they had with her specific condition as a result of a large cohort of students. Tina did however feel a greater level of support from her peers who spent significant periods of time with her and often recognised signs that preceded a seizure. This level of support from neophyte Occupational Therapists would potentially be anticipated as it demonstrates their application of OT principles and the development of their own therapeutic skills. This was however disputed by Bennett (1989) who indicated that she 'encountered covert prejudice and in some cases overt ableism' (p264) within her peer group. When she 'naively' believed that OT students would be more accommodating of those with a disability. She concluded that attention needed be focused on peer attitude to disability within OT as a result of her own experiences and the increased numbers of students with disabilities entering OT education.

Sheridan et al (2016) conducted a qualitative study exploring the experiences of peer disclosure for 8, eighteen to twenty-five-year-old students with epilepsy. Whilst, Tina was older and therefore not transitioning into adulthood in the same way as participants within the study, she was adapting to her condition whilst transitioning into HE. Tina did not have a diagnosis of epilepsy but was experiencing seizures and therefore there are some similarities within the cases. Sheridan et al (2016) indicated that the decision-making process, considering who and when to disclose to peers served to restore a sense of control which was lost as a result of the epilepsy. Peers

were seen as trusted allies who supported and maintained the safety of participants. They were experienced in understanding the seriousness of a seizure and when an ambulance was required. Developing trust with peers was also recognised as beneficial to the participant's mental health and safety and this is reflective of Tina's story.

Tina recognised the impact her condition had on others including her peers, lecturers and other students and described the guilt she felt because of this. The language she uses 'you don't want to spread the love' demonstrates her personal distaste for the seizures and the impact these have and her potential view of spreading the impact almost like a disease. Tina described her doubts about completing the programme on a number of occasions within the interview and she recognises the part her peers played in encouraging her to remain on the programme. It appears however that she experienced difficulty in recognising and reflecting on her own capabilities, perhaps as a result of a recurrent lack of confidence and therefore needed to rely on 'external supporters' and peers to provide this perspective.

I wouldn't have done it without the other ... girls, I know I wouldn't, you know you have the big wobble about, which everybody does, you know, I can't do this; they were the ones to say, you know, don't you remember how you dealt with; and without that continuity it is quite hard to reflect back on that and say well, yeah ok maybe I can (Tina).

In contrast, David and Vicky, exhibited signs of embarrassment about their diagnoses particularly within their peer groups. They were both clear that they 'did not wear it [their diagnosis] as a banner' (David). Both reported the value of coloured overlays and recording devices but neither were prepared to make their diagnoses visible to their peer group. Both appeared to fear being judged by their peers.

No, it's hard, I want to put my Dictaphone down, nobody else was doing it and I am feeling embarrassed (Vicky)

David had disclosed to a few close friends and 'trust[ed] them not to tell others'.

so sometimes it can be a little difficult – I can be a little disingenuous because my colleagues don't know that I have difficulties and maybe they think that I am just a little off hand or I'm a bit abrupt ... but the reason I have to keep it to myself is that I mentioned it when I was on my access course and you would have been amazed by the reaction of some people and they are going into a caring profession ... I didn't enjoy that at all on my access course I don't want to be questioned all of the time, forget it – I don't want to be dissected by 20 OT students each time (David)

Based on his previous experiences David had made the decision to disclose to very few people but he felt that this may make him appear less genuine. He recognised, how disclosing previously had made him feel and behave and this was something he did not wish to repeat.

Natasha, Valerie and Hannah all actively sought external support from counselling and psychological services whilst studying OT. They all considered these services to have been of benefit in addressing issues of mental wellbeing and providing strategies for success during the programme, with Natasha suggesting that psychological therapy had done her 'the world of good'. Valerie felt that the counselling had offered an opportunity to reflect, she felt that her self-awareness had been enhanced as a result of the intervention but recognised that the process was challenging and not curative.

...it's not cured anything, but it has given me a few more, sort of skills and tools to deal with things and to recognise when things aren't so good and what to do about it, so yeah, they have been really good (Valerie).

Following Hannah's initial diagnosis, she received intervention from a community mental health team. Hannah believed that this intervention and support was crucial in her recovery. Hannah had developed many adaptive, problem solving coping strategies previously and continued to use these throughout her OT training.

Hannah appeared to have an internalised Wellbeing Recovery Action Plan (WRAP). Whilst WRAPs were not discussed within the interview, Hannah may have been familiar with the concept given her history of intervention. Hamilton et al (2015) proposed the implementation of WRAPs for all nursing students in Ireland. They suggested that given the challenges and demands of current nursing education and working within the NHS that staff including nurses would benefit from developing and implementing, as necessary, personal WRAPs. WRAPs were initially utilised within mental health services but have more recently been implemented with a wider range of individuals with and without health conditions e.g. addiction, diabetes, epilepsy but also transitioning to retirement. It is suggested that the plan allows the student an opportunity to develop greater insight into their own 'early warning signs' and 'triggers' but also the 'tools' that may prevent ill health or crisis. They theorised that use of the WRAP would reduce an individual's vulnerability and increase their resilience (Hamilton et al, 2015) and therefore impact upon health and wellbeing. Also suggesting that as the individual had been proactively involved in the development of the WRAP that it would be more meaningful to them and therefore they would be more likely utilise / engage with it, leading potentially to behaviour change. Valerie, too appeared to have either informally or possibly formally with the support of her counsellor developed her own WRAP and is perhaps suggestive of the success both Hannah and Valerie had academically and whilst on placement. The findings of this study would suggest that developing and implementing a personal WRAP would have been of benefit to many of the participants. It would have offered an opportunity for proactivity in problem solving and possible aversion of some of the crises which did occur e.g. Natasha, Tina. It is envisaged that the development of a personal WRAP could be discussed and initiated with all students within the placement preparation module at level 1 for further individual discussion with personal tutors for students with disclosed disabilities.

David, however, rejected the idea of counselling hoping that his situation would change resulting in an improvement in his mood.

I'm not in a happy place and I don't think that the way I interpret things post-accident is helping to be honest. I don't want to use university counselling or anything like that – I know why and what's bugging me and so I am going to play it by ear carry on for the minute and hope things change (David).

David appears to be against counselling and perhaps this links to his past identity as a 'bloke's bloke'. He appears to find it difficult to ask for help and support. David also appears here to rely on 'wishful thinking' and 'avoidance' strategies (Mitchell and Kampfe 1990) which are negatively related to mental health rather than the problem-solving strategies employed by Natasha, Hannah and Valerie which have been seen to have a positive impact on mental health.

Support systems offered to all students within the university, such as the Centre for Academic Writing were also accessed by some of those interviewed (Tina, Tracy, Cathy). However, at times it was recognised that access to these services was limited by demand. The introduction of technology, which has enhanced learning for all students e.g. recording of lectures and web-based module resources was also welcomed by all.

Whilst many participants described the importance and value of the reasonable adjustments and support offered within the University. There was what seemed to be a largely 'one size fits all' approach to the provision of reasonable adjustments from University Support Services which perhaps adds to the pressure and cost of provision but is also a reflection of disenfranchising the individual by support staff who mean well.

I felt I knew what I needed so I told her and I told her the reason why, she agreed with me and she also actually said do you think this might help so she was very helpful in that sense and did suggest other things including the information software like mind mapping ... and I have to say I think I have used that twice, I found it a little bit complicated... I don't really need, like a laptop stand,... it almost feels like you are supposed to be grateful for being given something, you don't need or want (Cathy).

The implementation of coping strategies is a mechanism to reduce stress and enhance learning. Whilst it is recognised that some stress can be beneficial in promoting learning and in personal and professional development (Mitchell and Kampfe, 1993), stress, becomes counter-productive when experienced in high levels or over a prolonged period of time. Increased levels of stress and anxiety have been reported in students studying OT (Govender et al, 2015). Many of the participants in this study identified internal coping strategies to reduce stress and anxiety experienced during their studies.

Like participants in previous studies, many of the participants in this study, were able to identify problems and challenges and use problem solving skills to identify coping strategies to support their personal success. They exhibited skills and attributes of an expert in their own condition. Amanda did this prior to her diagnosis. She had completed a previous degree and recognising her challenges with learning had sought support from her family for proof reading and editing purposes

...I have done a whole degree without anybody knowing I was dyslexic...but I did have a lot of support from my boyfriend. He helped me loads and loads and I wouldn't have got through my other degree if I hadn't have had that support (Amanda)

For others the problem solving occurred following diagnosis. Andrew's diagnosis provided him with the opportunity to seek support and implement strategies such as going 'paperless'. Andrew had conformed during his previous degree and within this degree prior to his diagnosis in his attempts to be successful. He had taken notes within his lectures but had never been able to make use of them as a result of his poor hand writing and the legibility of his work. Once diagnosed and with support he made the decision to go 'paperless' thus radicalising his academic experiences and significantly increasing his success. Andrew recognised he was still identifying coping strategies but felt better equipped to manage his learning and placement experiences following diagnosis. Likewise, Sivanesan (2003) believed that her abilities to develop coping strategies to overcome barriers that she experienced during her training to become an Occupational Therapist would

enable her to similarly overcome anticipated barriers within her practice now qualified.

Becoming a strategic learner was an important coping strategy for many participants within this study. It was recognised that many tasks took additional time to complete. Therefore, it was essential that each participant understood how they learnt and had strategies in place to prepare, plan and organise their thinking, learning and assessment.

Other coping strategies employed by participants included being adaptive (Amanda, Tracy, Hannah), the effective use of time (Amanda, Valerie, Carmel, Cathy, Andrew, Natasha, Tina), meditation (Robert), the use of technology including voice recognition software (Amanda, Andrew, Carmel, Tracy, Hannah, Cathy, David) and getting adequate rest and sleep (Cathy, Tina, Natasha). These strategies were developed by the individuals to manage personal challenges with fatigue, memory, frustration, writing, organisation and capturing ideas. Good time management skills were also crucial to success with participants (Natasha, Tina) theoretically adjusting deadlines to ensure completion of assignments and others admitting to being 'lastminute.com' (David). Similar coping strategies were identified by Velde et al (2005).

Similarly, to some participants within Velde et al (2005) study, Andrew, Amanda, Robert, David, Valerie all received their diagnosis whilst on the programme and Andrew, Amanda, Robert and David were all diagnosed with SpLDs. For these 4 participants the identification of the SpLD provided an explanation for some of the challenges they had faced previously. It also provided the opportunity to access support and implement coping strategies to support success. Andrew saw his diagnosis as a revelation (as previously discussed) and similarly to participants in Velde et al's (2005) study it allowed him to better understand his previous academic struggles.

Vicky and Andrew described the experience of having a SpLD as 'debilitating' and 'painful'. Their stories and their utilisation of reasonable adjustments

however were distinctly different, polarised in-fact. Andrew was diagnosed during his second year at University and since embracing his diagnosis he has implemented many strategies which have 'liberated' his learning experiences. The implementation of the strategies had resulted in significant improvements in his academic outputs and achievements 'literally overnight'. The transformation of self is almost viewed as incredible, the provision of support, IT equipment and increased understanding and knowledge of the condition and how it impacts on individuals made an unbelievable difference.

Absolutely I wasn't going to make it if I am honest, I wasn't going to make it without the assisted technology, without the support I would not have made it because there were too many challenges... so it made it feasible, it made it possible, it made it a much better experience. The main thing that it's taken away, is it's taken away the pain, the physical pain of writing...it was just a really really painful process for me to write and then you know, I got the assisted technology ...and the experience would be totally different, to being tired and painful and exhausting to ease of use, very productive, quite light and positive (Andrew)

Andrew recognised that the academic work was becoming more difficult as a result of the increased expectations and the increased time it was taking to complete activities and assignments. He believed that without the diagnosis, support and strategies he would not have completed the course. Andrew, was 18 months post diagnosis, he had been proactive in seeking support, accessing equipment and technology and developing strategies which significantly enhanced his learning, skills and abilities to write academically.

In stark contrast, Vicky, who was diagnosed a few years before starting the OT programme had very few personal strategies for managing the demands of higher education and had been unable to access 1:1 support as a result of high demand. Vicky had had two previous attempts at Higher Education and chose OT, because she had a perception that it had a greater practical element to it. Thus, demonstrating a determination but perhaps also a desperation for recognition, professional qualification and 'proof' that she was not 'thick'. Vicky had previously experienced academic success with 1:1 support but not at degree level. Throughout her narrative Vicky repeatedly

stated what her SpLD reports and her previous tutors had indicated, that her intelligence was above average. However, she appeared to dispute this claiming she was 'thick' throughout. Her perception of HE was that she had been repeatedly let down by a lack of support, understanding and interpretation of her 'support plans'.

Every single solitary course I ever do I cry, why? Because I don't understand what you are asking me to do. I don't understand what I am reading. I don't understand what is expected of me. I don't understand, it is as simple as that. I would be like it for this one. I haven't started crying through it yet, but I will because I don't understand it and even though they have told me off so many times for doing it, I can't help it. I still see myself as thick because everybody else is listening and going off and writing. I am sitting. I want to start writing. I want to start doing it, but I don't know what to do, and I feel too embarrassed to go and say, I don't understand it yeah? But if I could get people to do exactly what they have put in my assessment, break it down in to stages for me, I would be able to do it yeah (Vicky).

Vicky demonstrates her frustration and high levels of emotion in what she perceives is a lack of support. She recognises her lack of success and sees that history had repeated itself and appeared to be waiting for the same to happen again. Vicky was interviewed in her first term studying OT prior to completing any assignments. It also appears throughout Vicky's narrative that she was embarrassed and feels a sense of shame about her diagnosis and as such she fails to access and use support which is available. Vicky had however attempted to arrange peer support / study sessions in an attempt to establish networks and implement strategies, she felt comfortable with. Unfortunately, her attempts to do this had been unsuccessful and this was likely to result in reduced participation (Law, 2002), social isolation and increased anxiety and concern (Sheridan et al, 2016). Thus, potentially impacting upon her success on this programme too.

Conversely, Carmel, who had previously completed a degree and worked in learning support, understood her learning support requirements well and had significant strategies for managing her learning, experienced significant difficulties integrating into her seminar group and working with others. Carmel

confessed to be 'set in her ways' but this resulted in significant inflexibility and adaptability within the classroom environment, particularly when required to work in groups with others. Having structure and being prepared and organised was crucial for success for Carmel.

I am struggling with certain aspects and it's not about working with people, it's about how people work for me, because they work in such a different way to the way how I work and that's why I am really really struggling ... I seem to have got into a little clique where people, only in my opinion, work in a very very unstructured way compared to me and I can use the term 'winging it', which I am finding very very difficult, to the point ... I can't work in a situation like this. It is very very difficult... It is difficult because I have got 2 little know it all's, 2 young little know it all's, ... I don't want to be in the group... and I won't be working with them; ... there is no doubt about it, I won't do, because I just won't (Carmel).

Carmel emphasizes how challenging she is finding working within groups as a result of how others work. The language that she uses here is interesting, whilst she was working with a group of younger students, who she possibly felt she had authority over, the group was collaborative and therefore no one person was 'working for' another. The level of difficulty and struggle she is experiencing when working with others, who she views to be unorganized and unstructured and prepared to 'wing it' is evident. The language she uses when describing her peers appears quite derogatory and lacking in respect. She appears to suggest that because they are young they lack her level of commitment to learning and assessment. It is obvious that the group work experience is causing stress and anxiety, as she wants to present work which demonstrates her knowledge and she fears 'it is going to be a bit of a mess', which she does not want to be associated with. Carmel also demonstrates her own strategic approaches to learning and how her learning styles and coping strategies are incongruent with others in her group. She demonstrated an absolute determination of no compromise in her approach to this challenge.

There appeared to be a distinct difference between those participants, who despite their challenges had identified and utilised external support and internal coping strategies which appeared to be an indicator of success and

mastery within the learning environment (Tracy, Andrew, Amanda, Cathy, Hannah) and successful completion of the OT programme (Andrew, Tina and Cathy). This is also reflected in the findings of Velde et al (2005). However, it appeared that this may be more challenging for Carmel, Vicky and David.

4.3.4.3. Sub- theme 3: Identity Development.

All participants within this study, were attempting to 'become' an Occupational Therapist and in doing so were being shaped by the philosophy of OT, their professional identities were developing but yet for some this was also a significant period of identity change as a result of their disability, illness and / or condition. The development of identity appeared important throughout the study and aspects of this have already been previously discussed within other sub themes e.g. Motivation to become an OT and Is OT for me?

Occupational Therapists believe that participation in meaningful occupation shapes an individual's identity. Christiansen (2004) suggests that individuals are defined by what they do within a social world. Occupational Therapists collaborate with 'service users' to facilitate occupational engagement, aiming to positively impact on health, wellbeing and adaptation to disability or chronic illness. Wellbeing is defined as:

A subjective assessment of health which is less concerned with biological function than with feelings such as self-esteem and a sense of belonging through social integration (Wilcock, 1998; p98).

A positive balance of occupations is understood to contribute to an individual's health and wellbeing, including aspects 'such as life satisfaction, adaptation, self-esteem and the construction of identity' (Taylor, 2008; p20). The social and personal meaning attributed to the occupation will influence the construction of identity. Participants within this study were engaging in the occupation of studying OT. They were being socialised into the profession through their studies, academically and within their practice placements. The

development and construction of identity occurs over time with a past, present and a future evident (Christiansen, 1999).

The experience of illness, disability and impairment can have a significant impact on the individual's perception of themselves and how they believe they are perceived by others. Thus, illness and disability can impact on the individual's identity, which in turn can subsequently impact upon their feelings of self-worth and self-esteem. It can also impact upon an individual's ability to perform valued roles and a loss of valued role can further influence an individual's identity. Life roles help to define who we are and shape our identity. Our identity is also linked to our personal attributes, values and qualities. Participation in the OT programme and studying to become an Occupational Therapist provided participants with an opportunity to seek to identify a new self, new roles, a sense of achievement, competence and mastery of their environment. This again seemed to link directly to the dynamic relationship between the person, the environment and the occupation of studying OT but most specifically to the language and concepts within MOHO (Kielhofner, 1985). The relevance and application of MOHO to the findings of this research will be further explored in chapter 5.

The RCOT (2014) considers the crucial aspects which underpin successful competence to enable OT students to be fit for practice and eligible for registration. This includes demonstrating a strong professional identity, demonstrating beliefs, values and attitudes which are cognisant with those of the profession, having a knowledge and understanding of the philosophy and complexity of OT and having the skills required to demonstrate competence in practice.

Professional identity is developed over time and involves becoming educated into the world of OT including the shared knowledge, attributes, beliefs, value and skills that are inherent and synonymous with the profession (Whitcombe, 2013). Adams (2006) and Turpin et al (2012) suggest that the development of professional identity may begin prior to students entering education programmes and may be based on their perception of OT from the public's

perspective (Turpin et al, 2012). Whilst, to some extent this may be true, in a profession which lacks a strong public awareness, it must also be argued that, as with the participants in this study, that their personal experiences and the knowledge they held of the profession influenced their decision to become an Occupational Therapist.

Supporting previous findings (Jung et al, 2014; Velde et al, 2005), many participants recognised that their illness and / or disability experience was an integral part of who they were. Hannah, Valerie, Natasha, Cathy, Andrew and Tracy highlighted how they felt that their personal characteristics, attributes and skills (e.g. empathy, proactivity, reflection and determination to succeed) had developed or had been enhanced as a result of their diagnosis and subsequent experiences. They also believed that these attributes would benefit them in their future careers as an Occupational Therapist.

...it's nice to hear, especially on placement other people's stories and kind of relate without saying specifically to them; you know I have been through similar. You know you definitely feel a lot of empathy and ... I think it would definitely influence my way of working, my outlook on OT in the profession (Hannah)

Here, Hannah recognises her ability to empathise with clients as a result of her own experiences. She also demonstrates how she believes her experiences have had a positive impact on her ability to establish a therapeutic relationship with the clients she works with now and in the future. Thus, recognising how her experiences have influenced her identity development. In congruence Natasha, also recognised how her experiences had influenced her personal and professional development.

I do believe that its helped me as an OT because I think I have that understanding which a lot of people don't and won't be able to. So, I try and look at it that way, that it has been horrible but hopefully it will help me to help other people....so as a child who has suffered... I kind of understand some of the things they might be feeling. So hopefully I can empathise and use that and I think also as well, of the parents because I have seen how much my parents have suffered...I know how much it has impacted on them and so I try to use that... so hopefully it will make me a better OT (Natasha).

Natasha appeared to recognise that her own experiences of pain and suffering as a child would enable her to have empathy and greater understanding for those she worked with. She recognised her own personal challenges but believed that she would be better situated to help others because of her own suffering. Recognising the challenges from a very personal perspective, for both children and their families, she demonstrated a desire to improve this for others. She talked on multiple occasions within her narrative of wanting to ease the suffering of children and expressed her own understanding of how this felt. She appeared to want to protect future children and their families from experiences similar to hers. Natasha's experience of suffering had become part of who she was, but this had also influenced who she wanted to become. Her suffering had served to motivate her to change the experiences others have in the future.

Cathy identified how she had chosen a previous role within health and social care as a means of 'consolidating my identity' appearing to indicate an affiliation with a culture. However, there was conflict within Cathy's narrative. At times she appeared to reject the label and identity of a person with a disability, frequently referring to people with disabilities as 'they' rather than 'we' e.g. 'they should be seen, they should be heard and their views are important'. Cathy did however highlight that in order to access reasonable adjustments during the course she was required to conform to being 'labelled' as an individual with a disability.

Cathy described how she had been able to establish rapport and a therapeutic relationship when working with others in practice as a result of who she was and her disability particularly with individuals who faced similar challenges. Bennett (1989) concurred; she too believed that her disabilities had enhanced her practice, describing how others had suggested she was inspirational and motivational, much like Cathy within this study. However, both appeared somewhat uncomfortable with these descriptions appearing to reject societal views that those with disabilities who achieve are exceptional or

super human. Preferring to simply recognise their skills and attributes as a therapist.

...all throughout university people say to me you will make a great OT, you are an inspiration and that's coming from people who are disabled themselves and so it made me think more and more about being this role model. I am not very comfortable with the title of role model. I don't feel very comfortable with that title at all because I don't think I am doing anything special (Cathy).

When reflecting on her own experiences of disability and practice Cathy 'hopes to be a better OT' as a result of her experiences. She also highlighted the importance of empathy but recognised that there is a uniqueness to each individual's experience of disability, echoing the overall findings of this study.

It helps me, I think, to empathise definitely, I can't pretend to know what it feels like to have a different disability, but I can say I have walked in those shoes as a disabled person (Cathy).

Cathy demonstrated a constant dedication and dogged determination to battle for and defend the rights of those with disabilities. She was a disability activist. She did however also demonstrate a sense of weariness, recognising the isolation she felt in this role, in what seemed like a lonely battle for equity, her rights and the rights of others.

...as a disabled person you do have to be proactive because nobody else is going to do it for you ... you do have to almost campaign for yourself and that again is tiring. It really is tiring, just to keep carrying that baton going for yourself and it can get quite lonely if you are the only... person with a disability, but at the same time it keeps you going because there is going to be more after me; so there have been some before me, and I am here, then there will be more after me...and I can forget about it once I finished the course, so let somebody else deal with it, it sounds horrible, but I just didn't have any fight in me at the end (Cathy)

Concluding that it was now someone else's fight, as she had completed the programme appeared difficult for Cathy, as she had demonstrated a long history of striving for equity and determination to change attitudes within the classroom and beyond. Being a disability activist was part of Cathy's identity

and would be a strength in her future career as an Occupational Therapist advocating on behalf of the patients she works with.

Valerie described how her own experiences of mental ill health and counselling had led her to develop enhanced reflective skills and a greater self-awareness, essential skills required by an Occupational Therapist. Thus, demonstrating how her own personal experiences linked to the enhanced development of professional skill and identity development. She also recognised that she felt she was better able to understand the clients she worked with, as a result, of her own experiences.

So, I have got that extra little bit of knowledge of what to look out for and what people are saying and yeah, I have used those skills. It has definitely made me more reflective, which is really useful
(Valerie)

Reflection is a crucial and yet difficult skill for students to master (Mann et al, 2009). Reflection on self and in and on practice provides opportunities for critical thinking, analysis and evaluation of situations, which can lead to modification of action and behaviour (Schon, 1983) as was seen by Valerie. She was able to recognise symptoms in others which would potentially have gone unnoticed as a result of her own experiences.

Valerie demonstrated reticence and an acknowledgment that whilst her mental health was improving, the experience of being unwell had impacted significantly on her and her identity. She stated that it had 'not lifted totally, it is sort of like the damage has been done'. Articulating here that she perceived that her identity had been damaged and she was therefore different or changed, almost suggesting beyond repair or recovery, as a result of her illness. Kamilowicz (2011) suggests that living with illness 'involves a process of shifts in identity as the individual grapples with the changes in the sense of self that existed prior to the illness' (p279).

David appeared to be struggling to assimilate some of the fundamental concepts which underpin OT practice.

There were times when it was like plating the morning mist trying to figure out all about the models and frameworks – I know it is the fundamentals and basics as a qualified OT but I really struggled to get my head around a lot of it (David).

He describes his difficulties, using a metaphor emphasizing the level of difficulty with which this presented him. Understanding the application of models of practice and underpinning frames of reference prove challenging for many students but David's description almost appears to indicate that he found it impossible. The difficulties he experienced in developing this understanding may also have contributed to him questioning his identity as an OT student and if OT was for him. The impact of his condition could also have been a contributing factor as attention and concentration can be affected and this can therefore impact on the development of knowledge and understanding.

Robert appeared to have struggled with his identity, as a result of his disability for much of his life. Robert had only recently sought a formal diagnosis and assessment of his needs, despite completing a previous degree. Perhaps viewing OT as a more supportive and facilitative programme, in which to disclose. Robert had lived in various parts of the world and had been exposed to a variety of cultures, all of whom potentially viewed disability differently. He spoke within his interview of believing that his parents had some awareness of his disability but chose not to discuss this, perhaps fearing the stigmatising effects this may have had.

I was the only *** boy in the school, so if you think about it, you know, being quite an outsider and with these problems I didn't really know about ***, and my parents sort of knew something about it, but they just didn't tell me, they didn't want their kid to be classified as a disabled person, they didn't want me to have additional support initially I think; sort of like a pride thing (Robert)

Robert reflects on his parent's attitude to his disability and views their lack of acknowledgement as 'a pride thing', a rejection of labelling and of additional support. However, it could be argued that this may also have been linked to

their feelings of guilt or shame and of their experiences not only of their own cultural beliefs about disability but those within the culture where he spent much of his childhood. Robert interestingly describes his disability as 'these problems' almost reducing the disability to a list of issues which are detached from him. Robert described an isolated and lonely childhood, one where he was the last to be picked for teams and bullied during his time at school. Robert appears to have experienced marginalisation during his school years and beyond. Throughout, Robert's narrative the need to be accepted and develop friendships and relationships was evident.

So, I just been dealt with a bit of a struggle thing, but it is better now, but I have got poor eye contact, it can be socially awkward sometimes, but the thing is I have really practiced a lot, so a lot of people actually get along well with me, yeah, got quite a few friends
(Robert)

Robert is extremely insightful and demonstrates his determination to achieve his goals. He recognised the challenges he had faced but how he has 'practiced a lot' to overcome the isolation of being a child with a disability and now things are 'better' and he has friends who 'actually get along well with me'. When considering that Robert views his disability as a 'struggle' he has been 'dealt' he appears to be referring to the luck or lack of luck when dealt a hand of cards (his life) but then goes on to consider how his luck appears to be improving through his hard work and determination.

I did develop like a good sense of humour with people so they did actually think I was quite funny and everything, so for that reason I was quite well liked and I liked myself, but there was always something. I reckon if I didn't have that problem I would be one of those physically active guys, I would be a leader of a team or something like that, but then again, I do become quite authoritative and I do become quite a leader of teams anyway (Robert).

Referring to his disability as 'that problem' he fails to see it as an integral part of him or his identity. It seems that he feels that the disability restricts him from becoming who he would like to be. Robert has an image and a perception of who he wants to be and because of 'that problem' he is unable to fulfil his wishes. Robert appears to have experienced disharmony with his

self-perception, indicating that there have been periods in his life when he has not liked himself. Robert's ultimate desires appear to be linked to leadership roles which seem to link to the need to be accepted within teams and ultimately respected, also placing him in a position of authority. There is however a conflict in his words and language as he appears to recognise himself as a leader in some situations. He also appears to equate leadership with authority and being authoritative.

Robert described how some of his previous roles and occupations had negatively impacted upon his health and life satisfaction but how becoming a support worker was like finding his niche. He acknowledged the initial challenges of his support worker role and appears to describe his own personal battles in a disassociated way

...at first it was very hard, I faced a lot of different clients of different ages, both genders, and it was like, at first it was like mirror images or something ...but I learn things from them. They learned things from me. I finally found a job I really liked. It just didn't pay very well; it was like a vocation... I was working 60 hours per week, being paid very small with a lot of responsibility, a lot could have gone wrong ... there is a reason why they can't have friends, to put it bluntly, there is a reason why a lot of disabled people don't have the friends they want because the neuro-typicals find them quite challenging, ... I was good...I, myself became happier, more content because I didn't realise it but I was actually quite down for most of my life (Robert)

Initially Robert appeared to be challenged by the similarities he saw in his clients and himself. Almost like they were mirror images, reflecting each other. Robert did however, recognise that over time this became easier and he was able to engage in a two-way process of teaching and learning with his clients. Again, there appears to be conflict in Roberts words and language, he appears to attempt to disassociate from the similarities he saw perhaps again highlighting his confusion about his own disability. Robert demonstrated his altruistic nature, considering the value and worth of his role over the monetary rewards. He appeared to gain satisfaction, recognition and reward through his work. There was a bluntness to Robert's interview which is perhaps reflective of his culture and his condition.

Whilst Hannah's confidence and competence had developed following her illness and through her studies, she did show some residual vulnerability within her story. Hannah described how she continues to take medication almost as a safety blanket as she fears relapse but she was also philosophical about her illness, recognising it as part of who she is. She valued the opportunities she had whilst acutely ill and during her recovery, viewing recovery thus far, as an 'achievement'.

...but I think that 2 years were actually like a real advantage and although I was ill, like I did loads, you know I saved up money, I passed my driving test, like everything sort of slotted into place during the last year or so and that helped because I felt like I had made a real achievement and it wasn't a waste of 2 years; that in fact I got loads out of it (Hannah).

Hannah's participation and the development of competence in occupations and the achievement of her goals whilst acutely unwell, led to the development of a positive occupational identity prior to her beginning the OT programme. Kielhofner (2008) described occupational identity as:

A composite sense of who one is and wishes to become as an occupational being (p106).

Occupational identity is influenced by the individual's motivation, behaviours, roles and patterns, their experiences and their performance capacity. Hannah's achievements and improvements in health and wellbeing, through participation and engagement in occupation resonated with the MOHO (Kielhofner, 1985) concepts of occupational identity, competence and adaption leading me to further consider how this potentially applied to others within the study. The relevance and application of MOHO to the findings of this research will be further explored in chapter 5.

4.3.5. Theme 5 – ‘The World is my Oyster’: Futures Thinking.

This theme was not applicable to all participants. Carmel and Vicky were only in their first term of study and therefore did not consider their future in OT within their interview. The future for both Cathy and Tina was dominated by not securing a job at the time of interview. Cathy was however, hopeful that a potential employer would soon ‘see the light’ and offer her a job. At the point of interview David was contemplating if he had a future in OT as a result of his identity crisis.

There were however some participants (Hannah, Andrew) who believed that they had strategies for managing their condition and demonstrated confidence in their futures, with aspirations to use their knowledge and experiences in their future careers. Valerie and Natasha viewed their future career almost through ‘rose tinted spectacles’ believing that once qualified the challenges they faced whilst studying to be an Occupational Therapist would disappear.

Valerie and Natasha both felt that working would be less challenging than being on placement. Valerie was optimistic about her future as an Occupational Therapist. She reflected upon her experiences and it appeared that engaging in education, in order to provide for her children in the absence of their father, improved her self-esteem and gave her control and ‘power’, following the disempowerment of the abuse she had encountered. She recognised that through the journey she had taken, including counselling, she had begun to understand her feelings and develop her confidence, becoming an advocate and supporting patients with mental health issues.

Yeah definitely I don’t really know where I am going to end up, but I am looking forward to having, you know, the qualification that’s going to be like the door opener for me, because I don’t necessarily have to stay here, or within the trust, you know, it’s the *world is my oyster* then and that’s a nice feeling definitely, where as if I hadn’t gone for the course, you know, I could likely be in this job role for the rest of my working life and not experience the full OT opportunities (Valerie).

For Valerie successfully completing the OT programme symbolised her freedom and choice to do as she wanted with her life. She believed that becoming an Occupational Therapist would be the 'key' to a world of opportunity.

Demonstrating some realism regarding her future working within health and social care, Natasha, indicated that there would be additional work pressures but felt that these would not be comparable to those during her placements.

I think if I did have a part time job, then it would be a lot more manageable... it would be easier than placement. I sort of know more what to do when you get used to it and not having to do all of the additional work in the evenings, you will have extra work to do I know, but not all the additional work which we have to do when we are really just starting out learning so I am hoping that it will be more manageable (Natasha).

Her optimism was evident within her narrative, she was optimistic about her working life. Working and becoming an Occupational Therapist was extremely important to Natasha and here she chooses to believe that working will be more 'manageable' than her placement. She does not appear to recognise the concerns she echoed earlier in her narrative about her over optimism regarding her health improvements during her first year on the OT programme and the impact that this had.

No one is sure but we are hoping, that I will improve a bit, but I think the reality is that I will have a lot of these problems for the rest of my life (Natasha).

She also does not appear to consider her self-confessed perfectionist behaviours and the potential impact of these and work on her mental health in the future. Perhaps believing that she now has coping mechanisms for managing in the future following psychological therapy.

In contrast to Natasha's belief that the working environment would be easier than practice placement, Tracy believed it would 'be tougher, so more difficult to survive'. Perhaps indicative of a perception that the working environment is

dangerous, that there is a greater possibility of mistakes with less supervision and that she needed to ensure that she was the fittest and most successful to survive. Tracy perhaps also recognises the demands on staff working within Health and Social Care and could envisage the reality of working as a newly qualified Occupational Therapist.

Andrew recognised the importance of being offered a place to study at MSc level for him personally, given the difficulties he had experienced within education until his recent diagnosis. He identified the importance of appropriate support and strategies which he believed had helped him to develop his self-confidence and belief.

It has been a big journey to get onto the MSc for me, partly because there is still some of those rattling issues about confidence, ... will I be able to cope with the actual pain of writing, and there has been a few factors which have made me be able to do it. One of them is that I have had a lot of supportive staff saying you should really think about it, we think you could do well at it, and that's been massive to me, that is probably the single biggest factor in me being on the MSc programme (Andrew).

Throughout Andrew's narrative he was seeking approval from staff with regards to the quality of his ideas and his work, which initially prior to his diagnosis were incongruent. He felt his ideas were worthy and felt that this was reflected within seminar discussions but not reflected within his assignment grades and feedback. The importance of the recognition and belief in his abilities was considerable for Andrew.

Natasha, Valerie and Robert identified an affinity with working in clinical areas that were closely linked to their experiences. Natasha's desire to ameliorate child suffering was evident on numerous occasions within her narrative but she also contemplated working in other areas which were directly linked to her own health and wellbeing.

I love Paediatrics... There is something about seeing children suffer which really gets me and makes me want to help. I am

interested in long term conditions as well and managing them; but I am also interested in the mental health side of things (Natasha)

Robert's aspirations are related also to his past experiences.

... but the profession itself, it's just very rewarding and I had this idea that I would start up my career here and then I would head to ***, because I know in *** it's not very well-respected OT, it's not very well paid or anything. I am not really doing it for the money, but at least I could be helping people there that need help... but that's like a dream really (Robert)

In striving for recognition and acceptance Robert wants to make a difference. He wants to make a valuable and significant contribution to society. He appears to be drawn to cultures with which he is familiar and similarly to Natasha, he wishes to use his personal experiences of disability to change the lives of children in the future. Robert does however; possibly appear to doubt his ability to achieve his aspirations feeling it is a dream rather than a reality.

Similarly, Valerie, saw opportunities for Occupational Therapists to work with those who had suffered domestic abuse and was interested to pursue this non-traditional area of practice but felt that her ideas were unrealistic 'but that's probably not in the real world.' Whilst demonstrating creativity in her ideas, Valerie appeared to feel constrained by a lack of knowledge and confidence.

Participants within this study did not perceive that their disabilities would be a barrier to successful and competent practice and this finding is reflected in the literature exploring the experiences of AHP's with disabilities (Bevan, 2014; Chacala et al 2014; French, 1988; Velde, 2000). All participants within a study of qualified Health Care Professionals with a disability by French (1988) believed that their disability was advantageous in their work, with many identifying empathy and a first-hand understanding of illness and disability to

be crucial in this and some identifying how patients appeared to have a greater confidence in them and therefore be more likely to take their advice. However, these studies are small scale and may have issues of response bias as these individuals are clearly successful and working in practice. Velde (2000) identified that successful therapists with disabilities were well adjusted and had insight into their strengths and areas for development and this is reflective of the findings of this study.

4.4. Summary.

To summarise, this chapter has presented the findings and themes identified within this research. I have analysed and interpreted the findings and discussed my interpretations in the context of the existing literature.

The themes that were identified were all interwoven and were encapsulated by the overarching theme of a journey of highs and lows, 'it's a bit of a rollercoaster'.

The professional journey that participants undertook whilst on the OT programme, reflected the stages of Doing, Being and Becoming (Wilcock, 1999), an Occupational Therapist. Participants were engaged within a meaningful occupation of studying OT. Through their participation (doing) and being an OT student, they aimed to self-actualize (Maslow, 1954) and become an Occupational Therapist. Their ability to become an Occupational Therapist was however influenced by their adaptation and acceptance of their disability; their motivation and resilience; their response to critical incidents during the programme and their access to personal coping strategies and support mechanisms. Previous studies (Brown et al, 2006, Jung et al, 2014; Velde et al, 2005) have highlighted the challenges which face OT students with disabilities, academically and within practice. These studies however, were not conducted within the UK and were completed with small numbers of participants. The findings of this study indicated that whilst 2 participants reported attitudinal barriers, that these were the exception and that others

reported feeling supported academically and in practice, perhaps suggesting that changes in legislation, policy and procedure has led to improvements. The findings from this study indicate that participants recognised the need for and value of reasonable adjustments both within the University and within the practice placement setting (where they chose to disclose). For some (Andrew, Tina, Natasha, Cathy, Vicky) it is evident that they believed without the support they would have been unable to complete the programme and for all participants it is clear that without their IT equipment, software etc. their journey would have been significantly more difficult. The potential changes to the DSA are therefore disappointing and appear to have been implemented, with little or no concern for the significant consequences of this. It is clear that many of these students proactively sought to ensure that they had all the available support and equipment they required prior to entry to the programme. It is unclear what the exact consequences of this significant reduction in resources will be, but it is evident that it is likely to potentially derail the widening participation agenda for those with disabilities within HE including those studying OT.

Previous studies have reported the complexity of disclosure within the University and placement settings. However, all participants within this study had disclosed their disability within the University setting, perhaps suggesting that they were eager to access support. Most students also appeared to view disclosure within the practice setting favourably, a finding which is not well supported within the existing literature.

Interestingly, this study appeared to suggest that the participants, who had successfully completed the OT programme, had found a therapeutic benefit from studying the programme. It is felt that this therapeutic benefit could be attributable to engaging in the meaningful occupation of studying but also the teaching and learning methods used and the content of the curriculum. This finding has not been previously highlighted in any research identified.

It appeared obvious once at this stage that each participant was an occupational being, engaging in the occupation of studying OT and that their

engagement in the occupation held meaning and ultimately if they were able to 'heal thy self', their wellbeing was enhanced. The findings also indicated that there appeared to be a dynamic relationship between the individual, the environment and occupation of studying to become an Occupational Therapist. Consideration was therefore given to the relevance and application of MOHO (Kielhofner, 1985) as a specific Occupational Therapy model.

5. The Relevance and Application of the Model of Human Occupation (Kielhofner, 1985).

5.1 Introduction.

When initiating my research journey, it was never my intention to apply a conceptual model of OT practice to my participants and their stories. However, when reviewing some of the literature describing the experiences of students studying within HE, I began to see a potential relationship between the individual, the environmental context in which they were studying and the occupation of studying. This dynamic relationship was further corroborated as I viewed the data I had collected from my unique perspective as an Occupational Therapist and I began to see how an OT conceptual model could be applied.

Following a critical examination of a number of models it appeared that Kielhofners Model of Human Occupation (MOHO) (1985) resonated most with the participants' journeys and the themes I had developed. Therefore, this chapter proposes that the application of the MOHO (Kielhofner, 1985) is of relevance to this research and seeks to justify the application of MOHO, rather than other conceptual models of OT practice. The chapter also considers how the concepts within the Model apply to the participants within the study and provides examples of the application of the model. A detailed application of MOHO specifically to those who had completed the programme is outlined to demonstrate the potential use of MOHO.

5.2 The Relevance of a Conceptual Model of OT.

Whilst analysing and interpreting my data, I was repeatedly drawn to the relationship between each individual, the context of their environment and how these factors influenced their success. The interpretation I was making linked the concepts of the unique individual (the person and personal factors), the environmental enablers and barriers and how these factors influenced the

participation in studying OT. Surprisingly, it was not until this point that I began to consciously consider an OT conceptual model which was so clearly embedded in the way I was interpreting my data. It was impossible to remove it from my thinking, I am an Occupational Therapist, I think like an Occupational Therapist and I value all that is OT. OT conceptual models are however usually used primarily to guide OT intervention (Wong and Fisher, 2015) with service users and I did not see my participants as service users but as OT students with additional support requirements. Neither did I view myself as a therapist but as a researcher and a lecturer. Perhaps offering an explanation as to why I had not consciously considered this prior to my interpretation of the data collected.

The indication that the participants who had completed the programme had gained therapeutic benefits from their experiences was also influential when considering the application of a model. The potential use of an occupation focused model allowed me to theoretically consider, from my unique perspective as an Occupational Therapist, the participant's ability to participate in the occupation of being an OT student (Cole and Tufano, 2008; Wong and Fisher, 2015).

I began to see my participants as occupational beings, who were engaged and participating in the meaningful occupation of studying OT; the very focus of this study was studying the phenomena of being an OT student with a disability. Through my interpretations and the theoretical knowledge underpinning my profession, I recognised that there was a dynamic relationship between the individual, their environment and the occupation of studying OT. I began to explore OT models initially considering those with which I was most familiar e.g. Canadian Model of Occupational Performance (CMOP) (Canadian Association of Occupational Therapy, 1997), Canadian Model of Occupational Performance and Engagement, the latest extended version of CMOP (Townsend and Polatajko, 2007) and Person-Environment-Occupation- Performance Model (Christiansen and Baum, 1991). Whilst all OT models, 'attempt to explain the relationship of occupation, person and environment' (Cole and Tufano, 2008; p61), none, appeared to link so

explicitly with my findings and particularly with the themes I and the participants had identified as the Model of Human Occupation (Kielhofner, 1985). The fundamental concepts of the person, the environment and the occupations within CMOP and CMOPE are categorized as:

Person:

- Spirituality
- Cognitive
- Affective
- Physical

Environment:

- Institutional
- Social
- Physical
- Cultural

Occupations:

- Self-care
- Productivity
- Leisure

Whilst many of these concepts could be applied to the participant's narratives e.g. the environmental barriers and enablers, others were not explicitly discussed within the interview for example the broader consideration of self-care and leisure occupations, with the focus being on the phenomena of studying OT with a disability. Similarly, within the PEOP model, the person is viewed from 5 dimensions, psychological, physiological, spiritual, neurological and motor and these factors were not explicitly explored within the context of the interview. Nor were they assessed objectively as it was never the intention for the information gathered to guide OT interventions for the participants of the study. The specific concepts within MOHO, with emphasis given to the motivation (volition) to participate in an occupation, such as studying OT, and 'the assumption that skills, performance and ultimately adaptation, will follow' (Wong and Fisher, 2015) were influential in my decision to apply MOHO. The environmental contexts in which MOHO views the enablers and barriers to

participation in a specific occupation and the consideration of occupational identity, competence and adaptation were also aspects of the model, which resonated strongly and more explicitly with the findings of this study. The potential links between the development of occupational identity, from both a professional and personal (adaptation and acceptance of disability) perspective and successful completion of the programme appeared to strongly implicate the application of MOHO. Wong and Fisher (2015) suggest that

...both CMOPE and PEOP focus on occupational performance, as a means to occupational engagement or occupational participation respectively. MOHO is the most unique in the sense that the crux of human occupation is to affect occupational identity and competence, thus resulting in positive occupational adaptation (p306).

MOHO was not a model with which I was particularly familiar, in-fact one I had actively resisted for many years but one that appeared to be the most aligned with the findings of the study and therefore I began to apply the concepts of the Model to my participants (see appendix 10.16).

5.2.1 The Model of Human Occupation (MOHO) (Kielhofner, 1985).

MOHO was originally developed by Kielhofner (1985) and his text has recently been updated, by Taylor (2017). She suggests that many Occupational Therapists have applied MOHO and the concepts within the model to overcome challenges within their own lives. Before the introduction of MOHO, previous theoretical models and concepts which underpinned the OT profession were impairment driven and frequently influenced by the medical model (Taylor, 2017; Wong and Fisher, 2015). The initial development of MOHO aimed to support the OT profession to return to its roots in occupation and humanism, encompassing the influences of the environment and an individual's motivation, roles and behaviours. Thus, resulting in a more holistic view of the person, the impact of the environment and the individual's participation in the occupation.

The Model of Human Occupation (Kielhofner, 1985) provides Occupational Therapists with a framework to understand how human occupation is motivated (volition), organised and patterned (habituation), performed (performance capacity) both objectively and subjectively and influenced within the context of the environment (Kielhofner, 2008). MOHO is a dynamic systems theory, which considers the interaction of the primary concepts of volition, habituation and performance capacity in the context of the environment. It also considers how these concepts influence what and how individuals engage in meaningful occupations (Taylor, 2017). MOHO offers a potential framework with which to consider problems and challenges from either the individual's perspective or the environmental context. MOHO focusses on the individual's

engagement and participation in occupations as the mechanism of change, rather than focusing specifically on remediating an impairment (Taylor, 2017; p 5).

MOHO provided a structure which enabled me to organise my thoughts and the information I had gathered (Taylor, 2017). MOHO is an occupation focused model and, in this case, I focused on the occupation of studying OT. The client centred, holistic nature of the model appeared to be particularly relevant to the findings, as the findings appeared to be more focused on the individual than the environmental factors as has seemingly been identified previously (Jung et al, 2014; Velde et al, 2005), thus further justifying its application.

It is suggested that MOHO can be applied to all individuals who experience challenges in their occupational lives (Taylor, 2017) but frequently it is applied to those with disability or impairment (Cahill et al, 2010; Klinger, 2005). All of the participants within this study either had (Andrew, Tina, Cathy, Hannah, Amanda), were fearful of (Tracy), or were experiencing some occupational challenges (Valerie, Vicky, David, Carmel, Natasha, Richard). MOHO has therefore, provided an interesting, more occupationally focused structure and a deeper interpretation of the results of the study.

MOHO was therefore applied to explore the individual's experiences and challenges in the context of studying the OT programme, in an attempt to explore what factors can positively and negatively contribute to the successful completion of the OT programme. Thus, MOHO allowed me to consider how individuals were motivated to participate in the occupation of studying OT. It allowed for consideration of how individuals organised the experience of studying and the role of being a student. Furthermore, it allowed me to consider how the individual's disability or condition impacted upon them and how this in turn impacted on their abilities to perform the occupation of studying OT, from both an academic and practice placement perspective. It also enabled me to consider how the environment supported or hindered the individual's engagement and participation in their studies.

MOHO also offered me the opportunity to consider how participation in the occupation of studying OT influenced each individual's occupational identity and also how engagement and participation allowed for the development of occupational competence and potentially subsequent occupational adaptation through successful completion of the programme. At the point of interview only 3 participants had successfully completed the OT programme and mastered the occupation, therefore, achieving occupational adaptation.

The application of MOHO allowed me to consider how the individual's determination for success linked to the concept of volition and personal causation, their values and interests. It offered the opportunity to consider the impact of the condition or disability and how this linked to the individual's performance capacity. I was able to explore the importance of identity, the individual's sense of self and their acceptance of disability and consider how this influenced the transition to becoming an OT. Ultimately, I was able to consider how all of these factors linked to occupational identity, occupational competence and occupational adaptation and the successful completion of the programme. The theoretical application of MOHO within this study is based on the data I collected through one semi structured interview. The interviews allowed me to develop an 'empathic understanding' (Taylor, 2017;

pvii) of my participants motivations, abilities and values linked specifically to studying OT. The interview provided me with an opportunity to explore each individual's unique 'occupational narrative' (Melton et al, 2017; p123) as applied specifically to being an OT student. The features of an occupational narrative as suggested by Melton et al (2017) are the narrative plot and the metaphor (in this case the rollercoaster journey). The narrative plot is the

...the way in which an individual characterizes the story of events that they are experiencing over time (Melton et al, 2017; p125).

Kielhofner et al (2004), also suggests that the plot provides an indication of the individual's past and the potential future and can be described as stable, regressive or progressive dependent upon the perceived direction that life is taking. The interviews allowed me to explore how each individual evaluated the events and experiences they described, leading me to conclude that all participants in this study experienced a rollercoaster journey of highs, lows and periods of stability. I was also able to recognise the significance that current events were having on each participant's occupational plot e.g. David was questioning if OT was for him, thus resulting in a regressive occupational narrative.

Within MOHO and IPA, metaphors are used to interpret the meaning individuals ascribe to their often negative or challenging experiences and emotions (Shinebourne and Smith, 2010). Metaphors within an occupational narrative

...succinctly characterize complex or emotionally difficult circumstances by evoking something familiar or readily understood to stand in the place of that which is difficult to grasp and / or face (Melton et al, 2017; p126).

Participants explicitly used metaphors to describe their experiences and this is evident as characterised by all of the superordinate themes.

MOHO describes a process of developmental change which occurs across a continuum (Taylor et al, 2017). Changes occur as individuals

...move into new roles, encounter new environments and make lifestyle changes or when they reorganize their lives in response to a major disruptive circumstance or event (Taylor et al, 2017, p146).

Evidently, all participants in this study were experiencing 'change' but each participant's experience of the change differed. Participants were also at various stages of change which included exploration, competence and achievement. Carmel, Richard, Vicky and David were at the early stages (exploration) of change as they explored their own capacities and capabilities of being an OT student. This is evidenced as Carmel, Richard and Vicky had only just begun their journey to becoming an Occupational Therapist and David was questioning his capacities and capabilities to become an Occupational Therapist as he experienced an identity crisis. Natasha, Hannah, Tracy, Valerie, Amanda had developed some competence as they were developing more skills and habits and 'a greater sense of self efficacy' (Taylor et al, 2017; p146). They developed further OT skills and habits related to studying as they progressed through the course, along with the development of their own personal coping strategies and access to support. Andrew, Cathy and Tina had 'achieved' as successful completion of the programme had enabled them to reshape their occupational identity to encompass the required skills and abilities to become an Occupational Therapist. See appendix 10.16 for further information

Taylor et al (2017) suggests that the individual's readiness for change is crucial, if successful change is to occur. Factors that may influence an individual's readiness for change include the individual's personal belief that the change is possible and the individual's adaptation to their diagnosis, illness and / or disability. Readiness to change did appear to influence the success of the transition to being an OT student as can be seen by Vicky, David, Tina and Carmel. David's transition was influenced by his concerns about his ability to 'fit in' following his career change and this led him to question if OT was for him (see section 4.3.3.2). Vicky's negative self-perception as someone who is 'thick' was significantly impacting on her successful transition to being an OT student and as someone who was 'set in

her ways' Carmel was resistant to change and this was impacting upon her transition (see section 4.3.4.2). However, in Tina's case the positive influence of the environment, in terms of her support networks and adaptations and adjustments supported her to 'achieve' change (see section 4.3.4.2).

Each participant within this study had made the occupational choice to become an OT student and study OT (see section 4.3.1.2). This choice was 'deliberate' and represents a commitment to becoming an Occupational Therapist. Individuals are motivated by occupations they believe they are capable of participating in; they are interested in and hold value (Kielhofner 2008). They are motivated by and enjoy occupations in which they have success (Wook Lee and Kielhofner, 2017). The quality of their performance within the occupation is directly linked to their personal capacity, the demands and complexity of the occupation and the environment. For example, Tracy's success appears attributable to her adaptation to her SpLD, the development of her personal coping strategies, her openness to disclosure and seeking external support (see sections 4.3.2.1 and 4.3.4.2). In contrast Vicky's difficulties appear to be linked to her lack of personal coping strategies and access to support and reasonable adjustment which impacted upon her performance and success in her studies (see section 4.3.4.2). It appears that the demands of the occupation are greater than Vicky's performance capacity. Motivation is strengthened as a result of the occupation being meaningful and as competence in the occupation is developed (Kielhofner, 2008). It appeared that all participants in this study believed that the occupation of studying OT held value and was meaningful. They were all interested and motivated to a greater or lesser extent to participate in the occupation with levels of motivation being crucial to success (see sections 4.3.1.2. and 4.3.2). The hardworking habits of many of the participants supported their determination for success. All participants had experience of studying previously, for some this experience was more recent and at degree level (Amanda, Andrew, Carmel, Cathy, Natasha, Robert) (See Table 5). Previous study had provided all participants with habituated study patterns and a knowledge of the role of being a student albeit not at degree level for all participants.

Tina, Natasha, Robert, Hannah, Vicky, Valerie, Amanda, David, Cathy, Andrew, Tracy were all engaging in the occupation of studying OT for personal fulfillment, to shape or reshape their occupational identity or to provide them with a sense of purpose (O'Brien and Kielhofner, 2017). The ability to perform occupations is directly linked to an individual's perceived quality of life (Wook Lee and Kielhofner, 2017).

The process of participating in occupation or doing shapes and reshapes who individuals are and who they become and therefore the process of engaging in the occupation of studying was shaping and reshaping the identity of all of the participants in this study. Occupational identity changes over time (de las Heras de Pablo et al, 2017) and all of the participants within this study were at various stages of the development of their occupational identity. Occupational identity encompasses all that people do and is strongly associated with the roles they undertake (de las Heras de Pablo et al, 2017) (See section 4.3.4.3). We become what we do (Taylor, 2017). Within this study, each of the participants was unique and therefore the development of their occupational identity was within their own personal context.

Kielhofner (2008) described occupational identity as 'a composite sense of who one is and wishes to become as an occupational being' (p106) and it is influenced by the individual's motivation, behaviours, roles and patterns, their experiences and their performance capacity. Thus, suggesting that occupational identity is shaped by one's history, present and aspiration for the future. An individual's occupational identity in the context of this study includes both personal and professional identities. Therefore, the development of occupational identity was complex as individuals frequently grappled with the notion of becoming an Occupational Therapist whilst also adapting to / accepting and in some cases (David, Vicky) appearing to reject their disability (see section 4.3.4.2). Wook Lee and Kielhofner (2017) suggest that

adapting to disability almost invariably means a quest for new ways of viewing and valuing life (p48).

They also suggest that this requires active engagement in fulfilling occupations (Bontje et al, 2004). Studying OT appeared to be the way in which Natasha, David and Tina were seeking to adapt to their conditions. Natasha was forced to reconsider her valued occupation of performing following her diagnosis and illness thus leading her to re-evaluate her future (see section 4.3.2.1). Similarly, both Tina and David were forced to reconsider their values, beliefs and interests following their life changing injuries / disabilities.

Occupational identity is developed as individuals maintain and repeat patterns of engagement, within roles and occupations. Thus, as the participants continued to participate and engage in the occupation of studying OT the stronger their occupational identity became. Carmel, Robert and Vicky were at the early stages of identity transformation, as they were only weeks into their studies and the role of being an OT student. However, Andrew, Tina and Cathy having successfully completed the OT programme, were now facing a further transition from being a student to becoming a qualified Occupational Therapist and the continued development of their professional identity (see section 4.3.4.3.). The individual's occupational identity reflected their sense of self and who they wished to become as an occupational being based on their varied life experiences (Kielhofner, 2008) and their ongoing engagement in occupations including studying OT.

The development and construction of occupational identity is linked to the consistent and successful engagement within the occupation (Taylor, 2017). Thus, clearly linking to the development of competence within the occupation of studying OT and the role of being an OT student. Occupational competence is defined as 'the degree to which one sustains a pattern of participation that reflects one's identity' (Kielhofner, 2002; p120). It is linked to occupations in which an individual engages including roles and responsibilities, interests and the achievement of the individual's goals. The development of a positive occupational identity and occupational competence

are crucial for occupational adaptation. Occupational adaptation has been defined as

An internal psychic process in which the overwhelming human desire to be engaged in meaningful occupation is integrated with the process of striving for and achieving mastery in desired occupations (Klinger, 2005; p9).

Andrew, Cathy and Tina had all 'achieved mastery' in the occupation of studying OT at an undergraduate level as they had successfully qualified as an Occupational Therapist. Thus, indicating their occupational adaptation in the occupation of studying to become an Occupational Therapist. Andrew was however continuing his studies to Masters level as a result of the 'mastery' he had felt in the final stages of his undergraduate education. Successful occupational adaptation requires an acceptance of the individual's disability or chronic illness, an acceptance of who they are (Klinger, 2005). Within this study, this appeared to be proving difficult particularly for Vicky and David (See 4.3.4.2.).

Occupational adaptation is a continual and ongoing process which life demands. However, the process can be disrupted by disability, circumstances and life events (critical events). Therefore, the reconstruction of a disrupted identity is required and further participation in meaningful occupation can distract (as seen by Tina and Valerie), support reconstruction of life (as seen by Natasha, Tina, David, Hannah, Valerie, Andrew, Cathy) in order to enable an optimistic view of the future (the world is my oyster as seen by Andrew, Valerie, Natasha, Richard, Hannah).

Klinger (2005) completed a qualitative research study exploring the process of occupational adaptation with 7 individuals who had sustained a brain injury. Whilst, Klinger made connections to MOHO and most particularly the relationships between occupational identity, competence and adaptation she did not extensively apply MOHO. The findings identified that whilst participants did describe the adaptations they made to activities, their main concern related to the impact their injury had on their identity and how crucial

the acceptance of the disability was in reconstructing their identity prior to occupational adaptation. Klinger (2005) described how they needed

...to learn new ways of 'being' in order to move on to a new way of 'doing' (p14).

She suggested that the reconstruction of self-identity was essential to enable successful occupational adaptation for those who had experienced a brain injury in her study. The nature of the small-scale study completed by Klinger (2005), specifically with participants with a traumatic brain injury, does not allow for generalisation. However, these findings appear to resonate with the experiences of participants in this study as many (Natasha, Tina, David, Andrew, Robert, Vicky, Valerie) grappled with their new identities, learning to recognise the new sense of self before achieving competence in the occupation of studying OT.

Occupational adaptation and the personal levels of success experienced by the individuals who participated in this study appeared to be linked to:

- the individual's personal characteristics,
- their level of adjustment / acceptance and
- their coping strategies, support mechanisms and acceptance and use of reasonable adjustments (see appendix 10.16).

This also appeared to be linked to the level to which participants were able to 'heal thy self' through participation within the occupation of studying OT.

Environmental barriers to learning frequently impeded participation and engagement in the occupation and the overall success and occupational adaptation experienced as suggested by de las Heras de Pablo et al (2017). Participants (Amanda, Andrew, Cathy, Tracy, Tina, Hannah, Natasha, Valerie) who had a good understanding of themselves, in terms of their strengths and areas of need and were able to actively problem solve and implement actions appeared to be the most successful.

All of the participants within this study demonstrated some resiliency (O'Brien and Kielhofner, 2017) whilst studying OT with a disability. Resiliency is defined as the

...ability to respond to changes and adapt or recovery from some defined event (O'Brien and Kielhofner, 2017; p30).

Greene (2014) suggested that those who demonstrate resiliency are able to adapt in order to continue to engage in occupations which support their identity and are meaningful. Furthermore Law (2002) suggested resilience is cultivated when individuals feel in control of their participation in occupation. Thus, within this study each participant's level of resiliency fluctuated during the 'rollercoaster' journey they were experiencing (See section 4.3.2.1.).

Participants demonstrated their ability to adapt their behavior as a result of problem solving, the implementation of coping strategies and / or accessing support. For example, Natasha actively sought psychological therapy to address her negative thoughts following her level 1 placement (see section 4.3.4.2), Andrew went paperless following his diagnosis with SpLD (see section 4.3.4.2), Amanda sought family support for proof reading (see section 4.3.4.2), Tracy proactively chose to disclose her dyslexia (see section 4.3.4.2). These strategies demonstrated the individual's resilience and allowed them to recreate meaning in the occupation. Others, however, experienced a lack of control whilst engaged in the occupation of studying OT e.g. Natasha and Tina during their practice placements (see section 4.3.2.1).

The need for resilience is highlighted within the literature from multiple perspectives. McAllister and McKinnon (2009) highlight the importance of the development of resilience within education. They suggest that the educational environment is crucial to the development of resilience. Supporting the need for a nurturing and supportive approach to student centred learning. They believe that transformative education, which stimulates critical thinking and empowers students to analyse and evaluate their practice and to be creative and develop problem solving skills, is the key to developing resilience.

Stuntzner and Hartley (2014) acknowledged the importance of resilience as an influencing factor in the successful adaptation and acceptance of disability. They recognised that individual characteristics such as motivation, commitment and locus of control were important intrapersonal resilience factors and that support from family and friends were important interpersonal factors. They suggested that the greater the level of resiliency an individual has, the greater their chances of success. Thus, it could therefore be hypothesised that those participants who demonstrated high levels of resilience were more likely to be successful in their quest to become an Occupational Therapist.

Becoming an Occupational Therapist and an AHP is highlighted as stressful and as such warrants the development of resiliency for future practice (Anderson and Burgess, 2011; Grant, 2013). Health care programmes within the UK are integrating strategies to further develop and enhance student's resilience and emotional intelligence within the curriculum.

The concept and theme of 'heal thy self' was related to the MOHO concepts of occupational identity, occupational competence and ultimately occupational adaptation. It appeared that through engaging in the occupation of studying OT and learning about the philosophy, values and beliefs of the profession some participants were able to apply the fundamental principles of OT to themselves in order to 'heal thy self'. For example, as Tina learnt about SMART goals, she was able to apply the principle to herself and her situation (see section 4.3.4.1.). It is also suggested that the experiential styles of teaching and learning utilised within the programme were also potentially facilitative in the 'heal thy self' process. The programme encourages students to become critically reflective and apply the principles of OT to themselves in order to promote the development of transformational learning. The ability to 'heal thy self' appears to be dependent upon the individual's performance capacity, self-efficacy and resilience (personal causation), their interests and values (volition), their potential to adapt and reshape their habits and roles (habituation) and the influence of the environment (see appendix 10.16). If

individuals are able to 'heal thy self' then the potential for occupational competence, adaptation and successful completion of the programme is increased as can be seen by Tina, Cathy and Andrew (see section 4.3.4).

MOHO is traditionally used by Occupational Therapists to plan, guide and direct intervention with service users. However, it became apparent in this research, it could also be used to potentially understand and offer an argument that the participants experienced therapeutic benefits and to a greater or lesser extent 'intervention and therapy' through their engagement and participation of studying OT and being an OT student.

I therefore suggest that the occupation of studying OT was therapeutic and that the 'therapy' process enabled participants to reshape their occupational identities and competence, following disruption by disability or chronic illness, circumstances and life events resulting in occupational adaptation e.g. Tina (see section 4.3.4.1) (Kielhofner, 2008). I hypothesise that the therapeutic benefits of engaging in the occupation of studying OT also led to a positive impact upon their health and wellbeing. This finding and subsequent hypothesis does require further Post-Doctoral research and exploration.

All of participants who had successfully completed the OT programme (Andrew, Cathy and Tina) described a therapeutic benefit to the occupation of studying OT (see section 4.3.4.1). Thus, suggesting that they experienced a 'therapeutic transformation' (Wook Lee and Kielhofner, 2017; p52) whilst engaged in their studies. The degree to which they appeared to engage with the programme from a therapeutic perspective differed, but all acknowledged a therapeutic benefit. For Tina, the need for therapeutic intervention appeared greater than for either Cathy or Andrew, but both Cathy and Andrew appeared to have occupationally adjusted and gained a stronger occupational identity and occupational competence than Tina (see section 4.3.4.1).

O'Brien and Kielhofner (2017) suggested that therapists design interventions based on their knowledge of the individual's capabilities, motivations, roles and habits and that through their knowledge and critical thinking they are able

to facilitate change and support individuals to develop new occupational identities. Within this study it appears that most participants were able to actively apply this therapeutic process to themselves. Thus, they planned their own interventions and guided their own 'therapy' as required during their studies. Perhaps reflecting their ongoing professional journey and development, alongside their personal journeys.

5.2.2 Applying MOHO to those who had successfully completed the OT programme (Andrew, Cathy and Tina).

Within this study, the application of MOHO allowed an additional interpretation of the data gathered. It enabled me to further explore the therapeutic benefits that those who had completed the programme described by considering the occupation of studying OT as meaningful and highly valued and therefore potentially of benefit to the individual's health and wellbeing.

The application of MOHO also allowed me to identify barriers and enablers both from a personal and environmental perspective which influenced the overall success and development of occupational competence and adaptation.

The development of occupational competence and subsequent occupational adaptation appears important to the successful completion of the programme. I have therefore considered how the concepts of volition, personal causation, values, habituation, coping strategies, performance capacity and the environment were all influential in the development of occupational identity, competence and adaptation for those who had successfully completed the OT programme.

5.2.3 Volition / personal causation / values.

Tina, Andrew and Cathy were all highly motivated and demonstrated a strong volition whilst studying OT and their determination for success was clearly influential in achieving their goal of becoming an Occupational Therapist. For example, Tina's determination to achieve a first class honours degree (see section 4.3.4.1).

During the programme and following the implementation of reasonable adjustments both Cathy and Andrew demonstrated a high level of self-efficacy and personal capacity for success. Their self-belief and determination were evident in their narratives.

Tina however appeared to have a reduced self-efficacy whilst studying OT and this was further demonstrated upon completion of the course when she resisted applying for HCPC registration fearing rejection (see section 4.3.3.3).

Becoming an Occupational Therapist was valued by Andrew, Tina and Cathy, they all derived 'a sense of self-worth' (Sun Wook and Kielhofner, 2017; p46) from the occupation of studying to become an Occupational Therapist and the role of being an OT student. For Tina studying OT provided her with a clear direction and focus post diagnosis (see section 4.3.2.1).

5.2.4 Habituation.

The individual's ability to positively engage with the role of being an OT student and patterns of behaviour / habits that support this role were shown to be of importance for those who were able to demonstrate successful completion of the OT programme. Andrew, Tina and Cathy all developed their study skills and competence in activities linked to their success on the programme. For Tina establishing new routines and patterns of study proved challenging as she adapted to her condition (see section 4.3.3.1). However,

Andrew appeared to establish new routines and patterns of study quickly once he was diagnosed with his SpLD and reasonable adjustments were made (see section 4.3.4.2). Cathy also had well established routines and patterns associated with studying as a result of her previous experiences and her adaptation to her condition (see section 4.3.4.2).

5.2.5 Coping strategies.

The individual's personal coping strategies appear to be a significant factor in the successful completion of the OT programme as can be illustrated by those who had recently qualified. Andrew was able to implement strategies such as going paperless and disclosure quickly once he received his diagnosis (see section 4.3.4.2). Andrew was proactive in learning about his condition and strategies which could prove helpful and subsequently he implemented these strategies. Both Cathy and Tina were well organised and prepared. Cathy was aware of her entitlements and was proactive to ensure that she received these (see section 4.3.4.2). Tina had appeared to have used her studies to avoid attending to psychological and emotional concerns (see section 4.3.2.1) but in the short term this strategy appeared to have been of benefit in achieving her goal of becoming an Occupational Therapist.

5.2.6 Performance capacity.

The individual's performance capacity was also an important factor for consideration in the development of occupational competence and adaptation. The physical impact of both Tina's and Cathy's disabilities e.g. levels of fatigue, headaches, decreased concentration impacted upon their performance capacity (see section 4.3.2.1.).

5.2.7 The Environment.

The environment proved to be both an enabler and a barrier for those who had successfully completed the OT programme. Enablers for Tina, Andrew and Cathy included access to DSA and support workers, the use of technology, the support of practice educators and reasonable adjustments whilst in practice (see section 4.3.4.2). However, some barriers were also described for instance for Cathy her barriers included the lack of funding to support a support worker whilst on placement and the attitudes of others in practice and within the university (see section 4.3.3.1). Tina also felt that the attitude of staff within the university had proven to be a barrier to her success (see section 4.3.3.1). Once diagnosed Andrew described few environmental barriers to his success (see section 4.3.4.2).

5.2.8 Occupational Identity, Occupational Competence and Occupational Adaptation.

Whilst Andrew, Cathy and Tina had successfully completed the OT programme, they had all experienced challenges to their identity and competence during their training which impacted on their occupational adaptation. For Andrew, this was linked to his fears prior to his diagnosis that he 'was not going to make it' but once diagnosed and his reasonable adjustments were implemented, his identity and competence in the occupation grew leading to enhanced self-efficacy and a 'sense of personal capacity' (Sun Wook and Kielhofner, 2017; p42) and occupational adaptation (see section 4.3.4.2).

For Cathy, she was primarily challenged by the attitudes of others and the financial constraints of the DSA which did not allow her to have a support worker with her whilst on placement which potentially impacted upon her occupational competence (see section 4.3.3.1). However, her personal capacity attributes including her knowledge and activism regarding disability

matters and the support and reasonable adjustments (see sections 4.3.4.2 and 4.3.4.3) implemented enabled occupational adaptation.

For Tina, the challenges appeared more systemic, she felt unsupported by the practice placement team, believing that reasonable adjustments had not been made during her placements and that her final placement had been inappropriate for her (see sections 4.3.3.1 and 4.3.3.2). This thus impacted upon her occupational competence, identity and self-belief (see section 4.3.3.2). She was however able to reflect how the support of her peers and her support worker were crucial to her success (see section 4.3.4.2) and therefore ultimate occupational adaptation. Tina’s determination (volition) and the adaption to her condition (personal capacity) were also crucial factors which impacted upon her success (see section 4.3.4.1).

The relationship between the superordinate themes identified within this research and the concepts within MOHO are illustrated in figure 2 below

Figure 2 - Super-ordinate Themes and MOHO

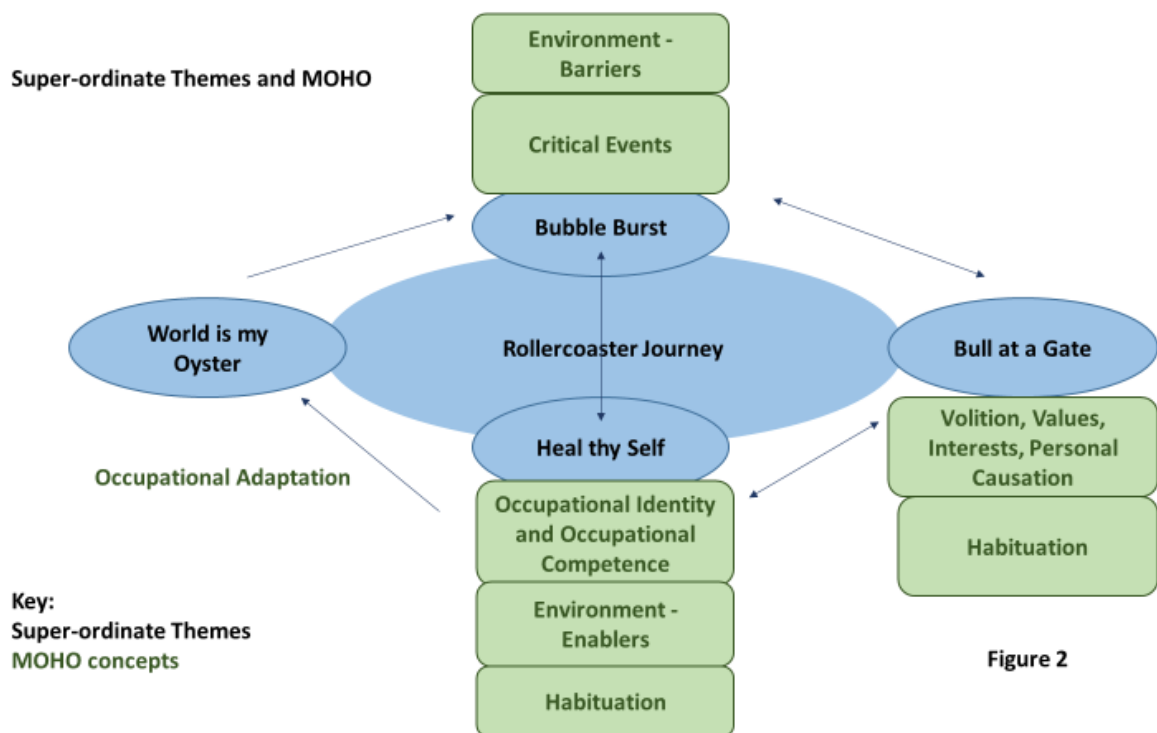


Figure 2

5.3. Summary

All participants within this study were engaged and participating in the occupation of studying OT. Each participant's goal was to successfully become an OT and the journey whilst studying OT proved to be a 'rollercoaster' with highs and lows experienced by all. All participants demonstrated a determination for success, 'like a bull at a gate' and high levels of motivation, synonymous with MOHO's concept of volition, which encompasses the individual's values and interests. The role of being an OT student was important and commitment to the role was demonstrated by all. However, participants also experienced critical events and environmental barriers (MOHO) which impacted upon their learning, participation within the occupation and in some instances their health and wellbeing. This was frequently when 'the bubble burst'. Participants recognised the impact their disability had on them and their occupational identity and battled to develop occupational competence in-order to 'heal thy self'. The process of active engagement with external support systems, developing internal coping strategies and accessing reasonable adjustment was instrumental in the reconstruction of occupational identity and occupational competence through the process of 'heal thy self'. These were viewed as environmental enablers within the MOHO framework. If able to 'heal thy self' participants demonstrated occupational adaptation and were potentially able to see 'the world is my oyster'.

6. Conclusion.

6.1. Introduction.

Within this research, I have used IPA to explore the lived experiences of being an OT student with additional support requirements. This study was the first UK based research exploring this phenomenon. Autobiographical experiences of being a student with a disability are presented within the literature (Archer, 1999; Bennett, 1989; Guitard and Lirette, 2005; Sivanesan, 2003) and whilst relevant to this research, the age and predominantly international context of these personal reflections limit applicability. Two small scale studies specifically exploring OT student experiences have also been conducted in the USA (Velde et al, 2005) and Canada (Jung et al, 2014) and whilst both used qualitative approaches neither used IPA specifically.

The voice of the participants was crucial within this research, in-order to truly understand how the individual's disability or additional support requirements impacted upon them. Thus, enabling the experiences of a minority and marginalised group to be heard (Bulk et al, 2017; Gibson, 2015) and responded to (Vickerman and Blundell, 2010).

The use of IPA allowed me to interpret the data and to identify themes within the findings. The uniqueness of each participant's journey made it difficult at times to identify convergence and I therefore adopted a client centred view of the data. My participants gave their time willingly and I wanted to reciprocate by listening to and valuing each person's story and experience. Viewing each individual participant as a unique occupational being proved more satisfactory from a personal and professional perspective. This also allowed me to uncover findings which have been previously unidentified and unexplored. The themes identified a journey which each participant appeared to make as they strived to become an Occupational Therapist (see figure 1). Each individual experienced highs and lows within the journey (see sections 4.3.1, 4.3.2.1, 4.3.3.1). They were required to demonstrate determination to succeed (see section 4.3.2) but with support, personal coping strategies and active

engagement with the OT programme (see section 4.3.4.2), those who had successfully completed their studies described the therapeutic benefits the programme had offered (see section 4.3.4.1). The potential to view the future positively as a result of becoming an Occupational Therapist was also a theme identified by participants within the study. Whilst recognising each participant's journey to becoming an Occupational Therapist and viewing each individual holistically, I began to consider the possibility of applying an OT conceptual model to each participant and their experiences (see chapter 5).

The application of an OT conceptual model was unexpected and has not previously been explored in this context within the existing literature. Justification for the application of MOHO (Kielhofner, 1985), as a conceptual model is presented within chapter 5. (The relationship between the superordinate themes and MOHO are shown in figure 2).

This chapter will be structured to demonstrate achievement of the study aim and objectives (see section 2.8). To conclude, consideration will be given to how MOHO (Kielhofner, 1985) has been used to further explore and interpret the findings of the study.

6.2. The Meaning of Disability.

For each of the participants within this study, the meaning their disability held was unique. For some their impairment formed a distinct part of their identity but others appeared to reject their diagnosis. Tracy recognised her disability as part of who she was. Tracy viewed her SpLD as a distinct characteristic of her identity, a strength which provided her with creativity (see section 4.3.1.2 and 4.3.4.2). In complete polarisation other participants (David, Vicky) appeared to view their SpLD with embarrassment. David and Vicky actively chose not to implement strategies within the classroom environment, which may have identified their SpLD (see section 4.3.4.2). Andrew welcomed his diagnosis as it provided answers to the difficulties he had experienced within his life previously (see section 4.3.4.2). Cathy fought for disability rights but

recognised everyone as an individual (see section 4.3.4.3). Hannah did not perceive herself, as someone with a disability, prior to enrolment at University but became aware of the need for a label, in order to access support services (see section 4.3.4.2).

6.3. The Student Journey and Experience.

This research revealed that each participant's experience of studying OT was unique. These unique experiences were reflected within the individual's journey to 'become' an Occupational Therapist (see sections 4.3.1 and 4.3.1.1). Each participant's experience was shaped as their personal and professional identity developed. Whilst it was clear that their professional identities were developing, for some this was also a significant period of identity change as a result of their impairment and this impacted upon their overall experiences and journey.

The analysis and interpretation of the data and the identification of the superordinate themes was representative of each individual's journey to becoming an Occupational Therapist. The journey was described as a 'rollercoaster' by both Tina and Natasha and this represented the overall theme, as applied to all participants (see section 4.3.1). The participant experience was one of highs and lows. Subsequent superordinate themes were descriptive of the 'rollercoaster' and the individual's experiences; each theme demonstrated a component of the individual's journey. The first superordinate theme 'like a bull at a gate' represented the determination and motivation that the participants required to be successful within their journey (see section 4.3.2). The second superordinate theme 'that was when the bubble burst' represents the lows experienced as a result of pivotal events and experiences which occurred whilst studying to become an Occupational Therapist (see section 4.3.3). These events led some participants (David, Tina) (see section 4.3.3.2) to question if OT was for them or indeed if they would make it and be successful in their journey to become an Occupational Therapist (Cathy, Tina) (see section 4.3.3.3). However, those who were able

to address the challenges either by developing their own coping strategies or through access to reasonable adjustment and external support such as counselling and coaching (Natasha, Andrew, Valerie see section 4.3.4.2) appeared more likely to be successful. Most participants within the study demonstrated resilience and the ability to 'heal thy self', the third superordinate theme (see section 4.3.4).

Whilst it appeared that both intrinsic and extrinsic factors impacted upon the individual's experiences, those who had successfully completed the programme (Tina, Cathy, Andrew) all reported therapeutic benefits of studying OT which is of significant interest (see section 4.3.4.1).

The use of experiential learning and the aims and philosophy of the OT programme allow students and the participants in this study to develop skills in critical thinking, reflection and clinical reasoning. Studying OT provided the opportunity to apply OT principles and concepts to themselves in order to develop, enhance and practice the theoretical application and skills learnt within the classroom environment. The application of these skills and principles appeared to allow Tina, Cathy and Andrew to 'heal thy self' (see section 4.3.4.1) and be successful in their journey to becoming an Occupational Therapist. Seeming to suggest that engagement and participation in the occupation of studying OT offers therapeutic benefits which could be linked to improved health and wellbeing (see section 4.3.4.1). The potential therapeutic benefits of studying Occupational Therapy is also worthy of further investigation, as it appears this is not an area which has been previously considered and was not the purpose of this study.

6.4. Motivation to become an Occupational Therapist

The participant's motivations to become an Occupational Therapist were explored in section 4.3.2.1. Some of the motivations described by participants in this study were reflective of the wider literature exploring why OT students generally choose to study OT (Byrne, 2015; Craik and Napthine, 2001). This

is also reflective of those who have individually described their experiences of being an OT student with an impairment (Bennett, 1989; Guitard and Lirette, 2005). Motivations included a desire to help others and exposure to OT either from a personal or professional perspective. Interestingly, however, and not identified within the existing literature, some participants (Robert, Natasha, Tina) described how they were attracted by the underpinning philosophy of the profession and its client centred, humanistic and holistic values. Participants also considered their pre-existing skills and the attributes they believed they had when they considered becoming an Occupational Therapist. Some (Robert, Vicky) were attracted by the professional status becoming an Occupational Therapist offered (see section 4.3.1.2).

6.5. Factors which Hindered and Supported the Successful Completion of the Programme.

The impact of support and barriers to learning have been extensively discussed in sections 4.3.4.2 and 4.3.3.1. The factors which hindered learning as identified within this study are reflective of the barriers identified within similar studies (Maheady, 1999; Storr et al, 2011) and included delayed access to assessment, resources and reasonable adjustments. Tina and Cathy experienced cultural and attitudinal barriers to learning and these barriers are also reflected in the literature (Jung et al, 2014; Velde et al, 2005). Both were surprised and disappointed to experience negative attitudes to their disability from Occupational Therapists within the University and in practice. Both felt these attitudes were incongruent with the philosophies underpinning the OT profession and this is also reflected within the existing literature (Bennett, 1989; Jung et al, 2014). They were however, in the minority, perhaps supporting the suggestion that improvements to university processes and procedures have been made (Jung et al, 2008; Velde et al, 2005). In stark contrast most participants described the support they received from placement and academic staff as valuable (see sections 4.3.3.1 and 4.3.4.2). Like the findings of other studies (Brown et al, 2006; Velde et al, 2005), the importance of accessing support and reasonable adjustment was

seen to be essential for success in this study. Professional support from counselling and psychological services as well as support from academic staff, support workers, mentors, coaches and peers were all reported to aid individuals to be successful.

More recent studies supported by the findings of this study conclude that OT students with disabilities experiences of studying OT is largely positive (Jung et al, 2014; Velde et al, 2005). These studies were however, small scale and may not be reflective of the experiences of all OT students with disabilities. The wider literature suggests that students with disabilities, including those studying to become a health professional, continue to experience marginalisation and stigmatisation (Bulk et al, 2017; Easterbrook et al, 2015).

The positivity identified by the majority of participants regarding the support they received may not remain given the changes to DSA and reduction in central support staff within the University in which the research was conducted. Changes to DSA and reductions in student services are worrying at a time when it is reported that increased numbers of students within higher education are experiencing mental health difficulties and that there has been an increase in the number of student suicides (Thorley, 2017). The reduction in support services and access to technology and reasonable adjustment is likely to significantly impact upon retention and attrition as is alluded to within this research and that of others. Within this study, Andrew is clear that he did not feel 'he would have made it' if he had not been diagnosed with his SpLD and received support, reasonable adjustment and developed personal strategies to better manage his workload (see section 4.3.4.2). It is also clear that without greater support and strategy development that the challenges facing Vicky will be difficult to overcome (see section 4.3.4.2). The potential impact of changes to DSA funding and a reduction in support services could also impact on the widening participation agenda. The reported improvements including increased accessibility to physical environments and the development of local policy and procedures which appear to have led to an improvement in education and attitude toward disability in HE, following the introduction of the Equality Act, are all at risk as a result of the changes in

funding and reduction in services. Therefore, further research is required to investigate the impact of these funding changes on the student experience.

6.6. Preparedness for the Workplace.

The final superordinate theme identified, 'the world is my oyster' (see section 4.3.5), whilst not applicable to all participants, was indicative of the hope some participants (Valerie, Natasha, Andrew, Hannah) felt about their future once qualified as an Occupational Therapist. Cathy and Tina, however, even though they had successfully completed their studies, expressed concerns about 'being good enough' to be an Occupational Therapist (see section 4.3.3.3). Their doubts appeared to stem from an inability to secure a job during a time when there was a lack of job opportunities. Both feared discrimination as a result of their disabilities at this time (see section 4.3.3.3). Other participants did not directly discuss their future when qualified perhaps because this was difficult to envisage as they had only just begun the journey to becoming an Occupational Therapist.

6.7. Applying MOHO (Kielhofner, 1985).

Whilst not an intention of this study, the application of MOHO allowed me to integrate my professional knowledge into my interpretation of the data collected (Larkin and Thompson 2011). It also allowed me to take a holistic view of each participant, their motivations, their habits and roles and their performance capacity both from a physical and psychological perspective within the context of their environment. This holistic view of the individual, their environmental context and their participation in the occupation of studying OT allowed me to recognise the impact and therapeutic benefit studying OT had on the individuals who had completed the programme in this study.

The participants who had completed the programme had demonstrated their determination to succeed (their high levels of volition and motivation) (see section 5.4.1), they valued and had a significant interest in the role of being a student (habituation) (see section 5.4.2), they had developed an understanding of the impact their condition / disability had on them (performance capacity) (see section 5.4.4) and they actively sought to develop their own coping strategies (personal capacities) and external support (see section 5.4.3) through reasonable adjustment (environmental factors) (see section 5.4.5).

Being an OT student and engaging in the occupation of studying OT appeared to lead to the development of occupational competence, i.e. the participants developed their abilities and habituated patterns in the occupation of studying. Resulting in a greater sense of occupational identity as the individual adapted and accepted their diagnosis and disability whilst also developing their professional identity through the process of becoming an Occupational Therapist (see section 5.4.6). The journey undertaken was complex as occupational identity encompassed the development of personal and professional identity through the process of engaging in the occupation.

The successful development of occupational identity and occupational competence through participation and engagement in the occupation of studying OT led the participants who had completed the programme to occupational adaptation. These individuals demonstrated their abilities to adapt to the demands of the occupation of being a student and successfully complete their studies resulting in becoming an Occupational Therapist.

The application of MOHO (Kielhofner, 1985) was never the focus of this research and therefore further exploration of this is required. Exploring the application of MOHO to those without additional support requirements would also be of benefit in the future.

6.8 Limitations and Reflections of the Study.

When initiating the study, my proposal and inclusion criteria were driven by an attempt to group and classify individuals by disability as I had seen in previous literature. Perhaps naively, I expected to find greater similarities between those who had a similar diagnosis e.g. SpLD, or a mental health condition etc. However, as I became immersed within my research the importance of the individual's true voices became clear. Their journeys demonstrated a uniqueness which was not defined by their diagnosis. In hindsight, I would have been less focussed on the individual's disability or impairment and identifying similarities, instead focusing on the true experiences from the start.

Similarly, in an attempt to make comparisons, I was driven to include students from all stages and levels of the OT programme. However, with hindsight and if redesigning the study, I would seek to invite those who have completed the programme and have successfully become an OT and those who were not successful in their studies. This would allow for a further understanding of the barriers which those with impairments face and how this impacts upon their ability for occupational adaptation. Further research is planned to explore this. The possibility of self-selection bias by my participants cannot be excluded. All those who responded to the recruitment advert were invited to participate and whilst they did not all choose to participate, those who did were clearly interested in the exploration of the topic. The findings of this study may not be reflective of those who chose not to volunteer and / or participate.

Since the interview schedule was based on existing literature the initial focus was less on underpinning OT theory such as MOHO (Kielhofner, 1985) and doing, being, becoming and belonging and the influence this has on health and wellbeing. I suggest that further research in the area should be based on these theoretical perspectives. Within this it would be of benefit to complete multiple interviews with participants. This would potentially allow for further application of MOHO (Kielhofner, 1985) and opportunity to access students who are not successful in becoming an Occupational Therapist. Thus

enabling a greater understanding of the barriers and challenges these individuals face.

As I had not anticipated identifying a therapeutic benefit to studying OT, this theme was not a thoroughly explored within the interviews. Refutation or further substantiation of this finding would be a worthwhile focus for further study.

6.9. Summary.

The application of MOHO and the findings of this study identified that factors which were crucial to the successful completion of the programme included:

- The individual's volition and their determination for success despite their illness and impairment.
- The individual's acceptance and adjustment to their disability.
- The individual's personal causation, performance capacity, occupational identity and occupational competence.
- The development and use of individual's own coping strategies (personal capacities).
- Access to and acceptance of resources, reasonable adjustments and support.
- Barriers to learning.

All participants within this study experienced a 'rollercoaster' whilst engaged in studying OT and this may be true of all students. However, this is not an assumption which can be made and would require further research and exploration. It would also be of interest to further explore if a similar journey is experienced with other students with disabilities nationally and internationally and if the journey is heightened or more acute as a result of disability?

This study has explored the experiences of individuals studying to become an Occupational Therapist with a variety of additional support requirements and disabilities. Their experiences have been critically considered to evaluate the

meaning of disability and their experiences of academia and practice placement. The factors that hindered and support successful completion of the OT programme have been considered from the individual participant's perspective and this has identified the need for further studies to be undertaken following the recent changes to DSA funding.

Whilst it was not the purpose of this study to evaluate the findings alongside a Model, it became clear, specifically during the stages data analysis and interpretation, both from the language the participants used and their journeys that links could be made to the OT model of MOHO (Kielhofner, 1985). Therefore, recommendations are made for further research to explore whether this is just a phenomenon for this group of students with additional support requirements **or** indeed for all students studying OT.

7. Future Research.

There are potentially many areas of future research which have been highlighted from this study and these include:

- Exploring the experiences of all OT students as occupational beings and the potential therapeutic benefits of studying OT (see sections 4.3.4 and 4.3.4.1).
- Investigating the application of OT principles to self during the training to become an Occupational Therapist (see section 4.3.4.1).
- Evaluating the potential transformative effects of studying Occupational Therapy: A longitudinal study (see section 4.3.4.2).
- Exploring the application of MOHO (Kielhofner, 1985) to all students studying to become an Occupational Therapist. This may highlight the need for strategies to minimise the barriers and enhance the successful engagement and participation in the occupation of being an OT student (see chapter 5).
- A longitudinal study throughout the duration of the programme, completing multiple interviews and considering how professional identity develops alongside how the content of the programme and the teaching and assessment methods impact upon self and adjustment to disability (see section 4.3.4.3).
- Exploring the individual's perceptions of disability? How do OT students view their impairment? And does this impact on their training to become an OT? (see section 6.2)
- Evaluating the implications of the DSA funding changes for students with disabilities (see section 6.5).
- Considering the impact of practice placement on health and wellbeing, specifically for those with a disability (see section 4.3.2.1).
- Understanding the Practice Educators experiences of supporting students with disabilities in practice? (see section 2.5).
- Exploring what is reasonable, when applied to reasonable adjustments (see section 2.2).

8. Recommendations for Future Practice.

The findings of this study not only have implications for the education of OT students with disabilities both within the university and practice placement settings but also potential applicants with disabilities and additional support requirements. Some of these recommendations were offered by some of the participants within this study. Other recommendations have been formulated as a result of the findings. These recommendations are based primarily on the findings of this study, i.e. the student's actual voice and my interpretations or as a result of literature which is integrated into this research.

Recommendations include:

- Greater information provision and education regarding what the course entails including the sorts of activities, assessments and expectations there are and the potential impact the 'therapy' can have on individuals.
- The increased use of peer support groups (Communities of Practice, Wenger, 1998) by disability (where possible) and more generally. Networking will facilitate support and decrease feelings of isolation. Support groups can be facilitated using a variety of methods including anonymous online discussion forums. The introduction of a SpLD support groups prior to placement has recently been initiated and will be evaluated. The support groups will offer opportunities to share experiences but also to offer advice and 'top tips' to each other e.g. useful software, Apps, where to find quiet spaces, what time is best to use the library, when it is quietest and there are the least distractions (see section 4.3.4.2).
- Greater consultation with students with additional support requirements through an OT student with disability forum (Vickerman and Blundell, 2010)
- Using practice placement preparation to raise awareness regarding the expectations and consequences of placement transition and consideration and promotion of healthy coping strategies to decrease stress and anxiety (Mitchell and Kampfe, 1990).

- The enhanced development of coping strategies such as resilience training (Grant, 2013), WRAP (Hamilton et al, 2015), empowering, peer coaching, mindfulness, greater understanding of the purpose and use of supervision and development of reflective skills (see section 4.3.4.2).
- Increasing awareness and understanding of disability within student cohort to peers (Jung et al, 2014).
- Further embedding personal and professional development throughout the programme incorporating employability and career development advice and opportunities (Vickerman and Blundell, 2010) (see section 4.3.3.3).
- The importance of providing informative information about HCPC registration from programme commencement for all but especially to those declaring a disability of some form. Clarity that the course entitles people to be eligible for registration but that this is not guaranteed (see section 4.3.3.3).
- Continued training and education for academic staff and practice placement educators including specific information about the findings of this study (see section 4.3.3.1).
- Greater promotion and marketing of the support offered to students with disabilities, with opportunities to meet lecturers, other students with disabilities which may encourage more students with disabilities to enter OT (Vickerman and Blundell 2010)
- The development of departmental processes and procedures which include clarity regarding the roles of the personal tutor, disability support tutor and the practice placement team (see section 4.3.4.2).
- The continuity of support from university tutors whilst on practice placement as suggested by Sivanesan (2003) has been implemented and this allows risks to managed and addressed and reasonable adjustments to be negotiated and renegotiated as suggested by Tina.

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APPENDICES

APPENDIX 10.1 Participation Information Sheet

Study Title: Understanding the experiences of Occupational Therapy students with additional support requirements whilst studying BSc (hons) in Occupational Therapy.

You are being invited to participate in a study exploring the experiences of occupational therapy students' who have additional support requirements, during their training to be an occupational therapist. This study is being undertaken as part of a Doctorate in Education at the University of Derby.

About the researcher

Teresa Rushton is undertaking an EdD at Derby University and is a Senior Occupational Therapy Lecturer at Coventry University

What is the study about?

The aim of this research is to explore the experiences of occupational therapy students with additional support requirements at one University within the United Kingdom. The study will consider your experiences of being a student on a professional programme from both academic and practice placement perspectives. The support offered to you will be reviewed from your perspective and consideration given to how prepared you feel for the workplace following qualification.

What is the purpose of the study?

More information is required which explores the experiences of different groups of students studying the BSc (hons) in Occupational Therapy. This study will specifically focus on the experiences of students who have additional support requirements.

Why have I been chosen to take part in the study?

You have been chosen, as you are an occupational therapy student who has self-declared additional support requirements.

What will happen if I do take part?

You will be invited to participate in an interview. If you consent to participation within the research, the interview will last up to 45 minutes. This interview will be tape recorded (with your permission) and the transcript typed up. The interview transcript will be returned to you for review and approval. You will have the right to amend the transcript if you wish.

Do I have to take part?

No, taking part in this study is voluntary. Even, if you decide to take part, you are free to withdraw, until the transcript has been agreed, without giving a reason. There are no consequences if you decide that you no longer want to be involved in the study.

What are the possible disadvantages and risks of taking part?

It is not envisaged that there are any disadvantages or risks in taking part in this research. It is, however, appreciated that sharing your experiences may be upsetting at times. If at any time you do feel upset, you are free to stop the interview and as necessary gain information about support networks such as student support and counseling services.

What are the possible benefits of taking part in this study?

There is no direct benefit associated with taking part in the study. It is however hoped that the information you provide will help the occupational therapy team to further understand your experiences which may be of benefit to you in the future or to other occupational therapy students.

How will I know what I say will be treated confidentially?

Any information you choose to share will be treated confidentially and your anonymity maintained by allocating your data a number and you a pseudonym. Data protection will be observed.

What happens to the information?

The information gathered will be used as part of a Doctorate in Education. You will not be identified individually and pseudonyms will be used at all times. All data gathered will be securely stored on password protected laptop / data storage device. Transcripts will be destroyed following successful

completion of the project. A copy of the final dissertation will be available within the University of Derby library.

What else can I expect from the researcher?

You can ask any questions about the study that occur to you during your participation and request a summary of the findings.

When will the results of the research be available?

The findings of the research should be available in 2015. The findings of the research will be disseminated in a variety of ways for example conference events, publications.

What if something goes wrong?

As mentioned previously you are free to withdraw from the research. The research has been reviewed from an ethical perspective. However, if anything goes wrong you have the right to make a complaint and this will be dealt with in accordance to the policies and processes at Coventry University and the University of Derby.

Who can I speak to if I need to make a complaint?

If you are unhappy with any aspect of the research you should contact the principle investigator, in the first instance. If you still have concerns and wish to make a formal complaint about the conduct of the research you should contact Professor Ian Marshall. Pro-Vice Chancellor of Research. Coventry University. Coventry. CV1 5FB. Email I.Marshall@coventry.ac.uk

Who will oversee this project?

The project will be supervised by Dr Helen Stoneley. Senior Occupational Therapy Lecturer at Derby University

Thank you for considering participating in this research if you require any further information please do not hesitate to contact the research via email T.Rushton1@unimail.derby.ac.uk

Volunteers Required

Are you an Occupational Therapy Student with Additional Support Requirements?

I am really interested in exploring your experiences and hearing your story of studying occupational therapy.

I am a Senior Lecturer at Coventry University who is completing an EdD at Derby University and would like to explore the experiences of occupational therapy students with additional support requirements whilst studying BSc (hons) in Occupational Therapy.

I would like to hear from students within all levels of the programme and with a range of support requirements.

As part of the study you would be required to complete a 45 minute interview.

If you are interested in participating in the study or would like some further information about the study please do not hesitate to contact me via email at ab0148@coventry.ac.uk

Thank you for considering this request

Teresa Rushton
Senior Occupational Therapy Lecturer

APPENDIX 10.3 Interview Schedule / Topics and Questions

Background detail.

What level of student and FT / PT / PTIS?

What are the additional support requirements / what is the disability?

How and when were you diagnosed?

Impact of diagnosis.

Can you tell me a little about how impacts upon you?

Motivation to become an OT.

Why OT?

Was your disability influential in your choice / decision to train to become an OT? If so, how?

Support and barriers to entry, learning, teaching and assessment.

Did you experience any support or barriers prior to entering the programme?

- Admissions process – any challenges / barriers / what support offered?

Could you tell me a little about your experiences of the programme so far

- Teaching and learning perspective / assessment perspective
- Thinking about any challenges faced / how have you overcome barriers during the programme / strategies

- Thinking about any support that you may have had / what has been beneficial / how have you benefited

What support systems have you found beneficial? How have these been of benefit to you?

- APPT
- Student support
- OT link tutor
- Seminar tutors

Disclosure.

Did you disclose your additional support requirements at entry to the programme / when diagnosed? What influenced your decision to disclose / not to disclose? How do you feel about disclosure?

Placement.

Could you tell me about your placement experiences so far?

- Thinking about any challenges faced / how have you overcome barriers during the programme / strategies
- Thinking about any support that you may have had / what has been beneficial / how have you benefited

The Future.

Work / future work – what are your plans for the future? How do you feel about becoming an OT?

APPENDIX 10.4 Ethical Approval Documents



Approval Letter

Date: 15th May 2013

Name: Teresa Rushton

Dear Teresa,

Re: Request for ethical approval for study entitled 'Understanding the Experiences of Occupational Therapy Students with additional support requirements Whilst Studying BSc (hons) in Occupational Therapy.'

Thank you for submitting your application for the above mentioned study which was considered by the Social Studies and Post Graduate Research Ethics Committee (SSPG REC) on Monday 13th May 2013 by Chair's Action.

Your study has been **unconditionally approved** and you are advised that you have clearance to begin the data collection phase of your study.

Yours Sincerely

A handwritten signature in black ink, appearing to read 'N Radford', written in a cursive style.

Dr Neil Radford

Chair of the Social Studies and Post Graduate Research Ethics Committee

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Teresa Rushton

Faculty/School/Department: [Faculty of Health and Life Sciences] Occupational Therapy

Research project title: Understanding the Experiences of Occupational Therapy Students
with additional support requirements Whilst Studying BSc (hons) in
Occupational Therapy

1. Evaluation of the ethics of the proposal:

This proposal has the potential to add to the knowledge base at this University as to how existing mechanisms of support operate/are experienced by the very participant group that are affected. This appears to be a well thought out proposal with enough checks and balances in place to negate potential ethical issues, such as the fact that the researcher is also a teacher. Participants are students who, whilst in need of additional support are studying a degree level programme leading to professional registration and therefore would have the necessary mental capacity to decide for themselves whether to volunteer through a Moodle platform to take part in this research project. The researcher is also a registered professional adhering to professional codes of conduct and well aware (as per the proposal) that any attempts at coercion to recruit participants would be unethical. It is up to the student whether to take part and divulge information on how effective support has been as per comments below.

The use of the Moodle platform is innovative and adds a layer of anonymity into the recruitment process yet does not exclude a group of students who some may argue, deserve to have more of a voice within such research, about support at their university, very much upho

2. Evaluation of the participant information sheet and consent form:

These appear very clear and state from the outside exactly who the researcher is and why they are performing the research, students can then decide as autonomous individuals as to whether they consent and share their lived experience or not.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

<input checked="" type="checkbox"/>	Approved - no conditions attached
<input type="checkbox"/>	Approved with minor conditions (no need to re-submit)
<input type="checkbox"/>	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
<input type="checkbox"/>	Rejected for the following reason(s) – please use other side if necessary
<input type="checkbox"/>	Not required

Comments by the reviewer

Name of reviewer: Anonymous.....

Date: 27/09/2013.....

APPENDIX 10.5 Informed Consent Form

Title: Understanding the experiences of Occupational Therapy students with additional support requirements whilst studying BSc (hons) in Occupational Therapy.

- Please tick**
1. I confirm that I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions.
 2. I understand that my participation is voluntary and that I am free to withdraw until the interview transcript has been agreed without giving a reason.
 3. I understand that all the information I provide will be treated in confidence.
 4. I agree to take part in an unstructured interview and that anonymised quotes may be used as part of the research project.
 5. I agree to be recorded as part of the research project
 6. I have the right to review, comment on and / or withdraw information prior to publication. The data gathered in this study will remain confidential and anonymous with respect to my personal identity.
 7. I agree to the information given being used within the EdD thesis and that a copy of this will be available following successful completion of the programme in the library at the University of Derby.
 8. I agree to the contents of the thesis being used in the future for journal articles and conference publications
 9. I agree to take part in the research project.

Name of participant:

Signature of participant:

Date:

Name of Researcher:

Signature of researcher:

Date:

APPENDIX 10.6 Initial theme development spreadsheets.

	Valerie	Tracy	Natasha
Theme 1	Competing roles	Embracing dyslexia	High expectations
Theme 2	Support	Increased expectation	Impact of condition
Theme 3	Stigma	Impact of condition	Support
Theme 4	Distraction through study	Support	Need for success
Theme 5	Fear	Positivity about diagnosis	Challenges
Theme 6	Personal development through illness experience	Challenges	Fear
Theme 7	Functioning as usual	Ideas for future work	Past experience influenced career choice
Theme 8	Coping and Coping strategies	Past experience influenced career choice	Maintaining a normal life
Theme 9	Control	Coping strategies	Coping strategies
Theme 10	Loss	University of choice	Responsibility not to let people down
Theme 11	Placement	Placement	Placement
Theme 12	Hope	Need for success	Hope
Theme 13			
Theme 14			
Theme 15			
Theme 16			
Theme 17			
Theme 18			
Theme 19			
Theme 20			

	Tina	Hannah	Carmel
Theme 1	Impact on others	Impact of condition on self and others	Impact on others
Theme 2	Complexity of disclosure	Not identifying with being disabled	Impact of condition
Theme 3	Impact of condition	Impact of illness experience	Support & reasonable adjustments
Theme 4	Support systems	Support & reasonable adjustments	Impact of others
Theme 5	OT programme as therapy	Challenges	Challenges
Theme 6	Barriers to learning	Fear of the unknown	Sense of worth / importance / not prepared to compromise
Theme 7	fear for the future	Past experience influenced career choice	Coping strategies
Theme 8	Past experience influenced career choice	Coping strategies	Knowledge is power
Theme 9	Need for success	Knowledge is power	Placement
Theme 10	Coping strategies	Placement	Sense of purpose / productivity
Theme 11	Incongruence with OT philosophy	The road to recovery	
Theme 12	Complexity of condition		
Theme 13	Placement		
Theme 14	Sense of being lucky		
Theme 15	Importance of good communication		
Theme 16	Control v Lack of control		
Theme 17	Emotional consequences of programme / illness		
Theme 18			
Theme 19			
Theme 20			

	Robert	Amanda	Andrew
Theme 1	Impact of condition	Head start	Impact of diagnosis
Theme 2	Support & reasonable adjustment	Impact of condition	Impact of condition
Theme 3	Being an outsider	Support & reasonable adjustment	Barriers to learning
Theme 4	Challenges	Disclosure	Support & reasonable adjustment
Theme 5	Why OT?	Challenges	OT programme as therapy / self-development
Theme 6	Personal development through illness experience	Coping strategies	Challenges
Theme 7	Coping strategies	Diagnosis	Being the odd one out
Theme 8	Diagnosis	Placement	Impact on future practice
Theme 9	Placement		Coping strategies
Theme 10	Pursuit of OT / becoming an OT		Knowledge is power
Theme 11			Placement
Theme 12			Striving for success
Theme 13			
Theme 14			
Theme 15			
Theme 16			
Theme 17			
Theme 18			
Theme 19			
Theme 20			

	Cathy	Vicky	David
Theme 1	Need for personal proactivity	Impact of diagnosis	Proactivity / fighting for access to equipment
Theme 2	Disclosure	Impact of others on perceptions of self	Disclosure
Theme 3	Impact of condition	Impact of condition	Impact of condition
Theme 4	Support & reasonable adjustments	Getting support right	Support & reasonable adjustments
Theme 5	OT programme as therapy	Concerns re being judged / stigma	Challenges
Theme 6	Challenges / barriers to learning / environment	Barriers to learning	Is OT for me?
Theme 7	Facing fears	Failure of the system	Coping strategies
Theme 8	Using disability to educate others	Diagnosis	Identity Crisis
Theme 9	Being a role model	Sense of luck	Placement
Theme 10	Coping strategies	Coping strategies	
Theme 11	Knowledge is power	Embarrassed to use obvious support systems	
Theme 12	Diagnosis or label does not define who I am	Identity	
Theme 13	Placement	Placement	
Theme 14	Developing identity through hearing therapy		
Theme 15	Discrimination		
Theme 16	Why OT		
Theme 17	Potential solutions		
Theme 18	Incongruence with OT philosophy		
Theme 19	The future in OT		
Theme 20	Am I good enough to be an OT?		

Am I good enough to be an OT?	1
Barriers to learning	3
Being a role model	1
Being an outsider	1
Being the odd one out	1
Challenges	8
Challenges / barriers to learning / environment	1
Competing roles	1
Complexity of condition	1
Complexity of disclosure	1
Concerns re being judged / stigma	1
Control	1
Control v Lack of control	1
Coping and Coping strategies	1
Coping strategies	11
Developing identity through hearing therapy	1
Diagnosis	3
Diagnosis or label does not define who I am	1
Disclosure	3
Discrimination	1
Distraction through study	1
Embarrassed to use obvious support systems	1
Embracing dyslexia	1
Emotional consequences of programme / illness	1
Facing fears	1
Failure of the system	1
Fear	2
fear for the future	1
Fear of the unknown	1
Functioning as usual	1
Getting support right	1
Head start	1

High expectations	1
Hope	2
Ideas for future work	1
Identity	1
Identity Crisis	1
Impact of condition	10
Impact of condition on self and others	1
Impact of diagnosis	2
Impact of illness experience	1
Impact of others	1
Impact of others on perceptions of self	1
Impact on future practice	1
Impact on others	2
Importance of good communication	1
Incongruence with OT philosophy	2
Increased expectation	1
Is OT for me?	1
Knowledge is power	4
Loss	1
Maintaining a normal life	1
Need for personal proactivity	1
Need for success	3
Not identifying with being disabled	1
OT programme as therapy	2
OT programme as therapy / self-development	1
Past experience influenced career choice	4
Personal development through illness experience	2
Placement	12
Positivity about diagnosis	1
Potential solutions	1
Proactivity / fighting for access to equipment	1
Pursuit of OT / becoming an OT	1
Responsibility not to let people down	1

Sense of being lucky	1
Sense of luck	1
Sense of purpose / productivity	1
Sense of worth / importance / not prepared to compromise	1
Stigma	1
Striving for success	1
Support	3
Support systems	1
The future in OT	1
The road to recovery	1
University of choice	1
Using disability to educate others	1
Why OT	2
Support & reasonable adjustments	7

APPENDIX 10.8 Images of Grouping and Regrouping Themes



APPENDIX 10.9 Example of Participant Summary Document.

Participant 9 summary document.

Overall summary

She appeared to have had some challenges and battled for her rights and that this had potentially taken its toll – similar to participant 3.

Partially accepted diagnoses but full acceptance? E.g. XX – distinct part of her identity

Sub consciously drawn to OT as a person with a disability but not a conscious decision – links to disability culture / identity / need to help others

By chance – links to luck, gambling odds betting etc.

Whilst P9 had previously worked within healthcare, she also recognised the therapeutic benefits of studying occupational therapy.

She viewed her position on the course as offering a real life opportunity for her peers to work with someone with a disability. She also felt that she had opportunities to widen her own experiences of working with people with a range of disabilities.

Participant 9 described 2 university experiences. Initially she went to University at 18, 17 years earlier and described a lack of support and understanding regarding how her disability impacted on her ability within the teaching environment. She described a dichotomy of disclosing her disability but also 'wanting to blend in' and 'not stand out'. She did not want to be seen as a problem or causing / creating work for others. She wanted to be unidentifiable / invisible within the university setting. She developed her own strategies for managing. however, these strategies were not always successful and her perception was that 'scraped through' her first degree. She

recognised the competing (components?) of university life the first time around as she wanted to experience and enjoy university life and recognised as a result of this she did the 'bare minimum'.

In contrast her second university experience, she worked harder and following experiences and greater knowledge and awareness regarding entitlements and technology, she had greater support. Recognition that her own personal working experiences provided a greater awareness of what was available and would help – p5 quote.

Participant 9 demonstrated determination and fought to access the support she felt she required. She was no longer passive and 'not wanting to make a fuss' but she was 'determined to get what she thought she needed' p5 as a result of her experiences and knowledge. She was an activist in terms of disability rights (as was participant 3 and Andrew and pilot).

Participant 9 described the complexity and need to conform to being 'labelled disabled' recognising her rebellion against this as a younger person during her first degree but her greater understanding through experience of disability legislation enabled her to compromise and 'be labelled'. She did however (proudly?)... negative connotations with label. Needs must – in-order to be able to access what is required – need to accept the label but still important to articulate how you want to be referred to – what preference the individual has – links to being treated as an individual / client centred – OT philosophy.

Challenging experiences of payment support systems for support workers – 2 different systems NHS course different to previous course. NHS perceived to be more challenging – wanted to hold budget self as a person centred approach p 7

P8 uses the term 'they' when referring to people with disabilities rather than us – almost external and not inclusive of self
'they should be seen, they should be heard and their views are important, you don't always see that in the workplace.'

Is there a personal experience here of not being seen, heard or listened to and now she feels that the course is more inclusive in its 'openness to people with disabilities' which is extraordinary rather than the norm.

I am XXX... I don't use the telephone, I do use email a lot as an alternative communication method... it's more about reading, I don't like printing things out, I much prefer to have it on computer, so I can make it bigger for my needs, but the hearing side of things is very difficult, you quite frequently miss; I only hear about 30% - 40% of what people say, so a lot of that is missing, and I am having to read a lot more maybe than other student have to, to keep up, so that is the biggest affect it has on me because it makes me tired because I am having to do more reading than, it does make me feel physically and mentally tired

Increases in workload. Impact in terms of fatigue – very difficult 'physically and mentally tired – level of tiredness – affects everything.

Eye strain is the biggest and the fact that I can't really see when it is dark so that part of the syndrome that I have, so when it is dark I don't see very well anyway, so when I am reading I have to have a well lit room and again for lip reading, but in particular for reading just to make it easier for me to see

Environmental impact on disability

I was XX for a very long time, and I still refer to myself as being XX, rather than XX, one because the XX affects me more than XX at the moment, and two I don't feel I should be giving that much information to every single person that I meet.

Prickly within the interview – very private person – does not want to disclose to all. ** part of her identity**

I don't think it is anybody's business... if I think they are going to do something productive and positive with it, otherwise what is the point.

'productive' strange word to use – defensive about the diagnosis

I have to disclose that from the very beginning

Almost forced to disclose at university or is it because it is 'productive' to do so here?

however I was impatient at that particular point because every student they have got on a course and I did have anxiety because I have a disability and wondered if that would hold me back from getting on the course, in one train of thought and the other train of thought, I thought it might be quite a positive thing because occupational therapy being what it is, it is about helping people through the impairment and disabilities and helping them get back to where they want to be or to a new stage of their life, so I did think that would be a big positive thing, but you can't help thinking in the back of your mind, is it going to affect my ability to get onto the course.

Fear regarding acceptance to the course because of disability but recognised how inequitable it would have been given the profession and its philosophy to reject her based on her disability / impairment. ?was there a previous experience of discrimination or a fear of discrimination

I decided to do XX, I loved it for the freedom that it gave me as a XX person and consolidating my identity if you like, as a XX person and I really like talking to people

Journey to OT links with previous roles and experiences of the NHS / transferable skills. Cross roads in life – feeling unfulfilled and dissatisfied with work which affected feelings of self-worth

I thought I had a couple of the transferable skills that I could use as a XX and having experience in the NHS and transfer that and use that in OT and even though I haven't got a job yet, I still think it was the best move that I ever made
Reticence that 'even though I haven't got a job yet' – tinged with sadness / frustration but still 'best move I ever made'

I did it subconsciously, it must have been the reason why I made that decision in the first place, although at the time I wasn't thinking along those lines, I didn't think it was disability therefore it must be OT, so the answer to that is at first no; but when you think about it, if you think about what disability is and what it

means to various people with a disability and without, then I think it probably was and the more I think about it, the more I think how much of an impact my disability has had on other people and it has been quite therapeutic for myself being on the course where I could see some of the issues that I had when I first came on the course, that I wasn't just looking at the world and people and seeing people who are just XX; it kind of opened me up to other disabilities and that was one of the reasons why I chose occupational therapy because it didn't hold me into dealing with people who are XX... you know when you have a disability you always think how I am going to help other people; well I certainly do.

Feels that potentially may have been sub consciously drawn to OT as a disabled person but this was not conscious at the time. Disability culture / identity – wanting to help others??

I did one year of working at XX and I hated it because there was no mental challenge what so ever, you weren't speaking to people and just by chance I went to a recruitment fair

Not knowing what wanted to do with her future – needed mental challenge – 'just by chance'

I remember disclosing that I had a disability, but I didn't have any contact from a disability unit and I think 3 years I went and that shows how much they were not helpful and every tutor that I had when I was there, they all knew that I had a disability in terms of my XX, but I don't think they quite knew how to deal with that from a teaching and learning perspective, so being 18 – 19 you want to blend in, you don't want to make a fuss, you don't want to stand out in any way... but I probably scraped through

Original degree 17 years previous – felt unsupported following disclosure of disability – time frame and a lack of knowledge / support at this time would have influenced the experience – linked to 'not wanting to make a fuss'. Didn't want to be seen as causing a problem, causing work for staff, wanted to blend in and not be identified by the disability – unidentifiable within the university – 1st time – developed personal strategies – recognised strategies were not always

successful – ‘scraped through’ – whilst wanting to explore university life as a young person.

I put a lot more hard work in and it paid off, but equally I had a lot more support, so I didn't like just to put it down to hard work, it was the support that I had compared to the first one, but the second one I did have a lot more support and that probably in some ways because of the XX diploma, because I had the knowledge and I knew what technology I needed, I knew what help I was entitled to, so that gave me all of that information and I used it for my benefit when I came to occupational therapy, so yeah, I put down that I had a disability, they contacted me, and I was invited to an interview

Hard work and support, proactivity

a lot more determined to get what I thought I needed, so I felt in some ways I knew more about my needs and what I wanted, than the disability office

determination and knowledge important

so we did have words and I wasn't particularly happy about some of the things that went on, I felt I needed more support, but luckily being that bit older and knowing the information I did, I was able to verbalise that so yeah, there were times when I couldn't get what I wanted for those reasons, but at least I could actually verbalise that and not just sit back and just accept things.

Knowledge of own needs and legislation etc.

when I did my first degree just wanting to blend in, not to be labelled disabled, but I think, because of legislation and the equality act, and the way things are from a policy point of view, you do have to label yourself as being disabled or someone with an impairment to get what you need, but I think as long as you are able to actually say, this is what I am labelled with, but actually I prefer to be described, or be known, I think that's a good thing because you have to conform, but you also have the abilities to say how you would prefer to be known as

I felt I knew what I needed so I told her and I told her the reason why, she agreed with me and she also actually said do you think this might help so she was very helpful in that sense and did suggest other things including the information software like mind mapping type of software and I have to say I think I have used that twice, I found it a little bit complicated

Somewhat dismissive of professional support

probably need a little bit of training, maybe a couple of hours here and there to play about with it

Need for additional training in IT. Importance of support being right. Personal 1:1 support from someone who 'knows you'

but it made me quite cross about the way that the funding is handled and I don't think the NHS bursaries should take hold of that funding and it should be either left with the person with the disability, much like a personalised budget, personal budget or it should be held within the University and I feel very strongly about that... you have got to be a lot more resourceful in the use of your pot of money and use it to the best of your ability.

strong sense of knowing what is best for self

so I have to think do I really need to know this information, so you have to be quite picky

Discerning about information and what exactly is essential – strategic learning as things take greater time – similar to others. Key roles of the support worker – negotiated by each student / differs including 'keeping me up to date with the gossip'.

the information that I had to read, do I really have to read it, or is it something I can read at a later date from the comfort of my own home but my attendance levels are incredibly good, or were incredibly good so I always attended because I didn't want to miss anything; that's partly being nosey and partly being a good student

her perception of a good student links to attendance even though she questions the amount of information / knowledge she is able to gather / understand within a lecture

that happens to be quite hard work and is incredibly tiring, particularly in the first year, you know where it pretty much lectures and seminars back to back and I can't tell you probably how much I slept during that and I am usually, I don't want to appear to be lazy or you know, sleeping too much, but it was good because it relaxed me, it fed my brain if you like and I think it is very important to have good quality sleep

work, rest and play – occupational balance and need for good quality sleep
'fed my brain' provided nourishment for the brain that was working overtime – recognition of the impact of fatigue and the need to sleep

Understanding the complexities of systems - timetabling / provision of resources e.g. support workers 'done by different bodies'

I have enjoyed; every single one of my placements.

Joy around placements

I never had any support in terms of XX on any of them, purely because of the money situation, I can't afford to, which is quite galling, when you have had support from access to work in a previous working capacity and you know they are available there all day

Disappointment / frustration at the inequity of not being able to access XX whilst on placement because of financial restrictions / budget constrictions compared with previous employment – anger that systems and resources do not support the perceived need

so going into the placements caused me a lot of anxiety

placements provoked anxiety particularly with regards to fear of the unknown. Fears related to XX difficulties and whilst she had worked previously and accessed access to work funding, she was unable to access the resources she felt would have been of benefit because of her DSA budget allowance did not cover this support. This led to feelings of anger and frustration at the

inequity of the situation and it being 'particularly galling'. However she acknowledged that preparation and planning with support from the practice placement team had been crucial in reducing the stress and anxiety. She perceived the joint pre-placement visit to be 'invaluable' when discussing and agreeing reasonable adjustments. Recognising the value of the visit, she proposed that all students should have one. The nature of her feelings toward the pre-placement visit were potentially linked to the supportive nature of the visit, with a representative of the university, who validated the request for reasonable adjustment, perhaps removing the potential for discrimination?? so that was very stressful, thinking about it, although not necessarily show it, but I think what helped was the fact of the planning aspect and planning was very important, so when you plan things and know what is going to happen, so planning it with the placement team was a good starting point that was invaluable and I think everyone should have one, if just to settle anxieties alone, but from a disabled student point of view it was very important from any reasonable adjustments

almost like having a taster and in the back of my mind thinking, ok this isn't working, and if it was happening in the work place what would I do, and I always thought how useful having XX would be for things like people you had communication deficits or their own communication needs XX, and that made that very difficult, so obviously it wasn't my fault, it's not their fault, you can't help feeling that somehow it is your fault, and you should make it better, make this process a lot easier, though sometimes you do have to say, there is nothing you can do about it

Feelings of inadequacy / accepting the inevitable sometimes you can't support – talks of fault like potentially should be someone to blame / apportion blame to but recognises that this potentially links to the philosophy of helping and wanting to facilitate making it better for others – supporting them to do what they want to do – OT – professional role – gain information – unable to do this – how does this therefore make her feel?

get help from someone else who is able to help better than I can

importance of good communication with supervisor / PE being prepared
proactivity

we were able to empathise with each other.

Empathy and therapeutic use of self to establish a therapeutic relationship
with the patient – the use of own disability when working with others with
disability.

I think what brought it home to me was actually when the lead of that
department said, we weren't sure about having a XX and I think at that point I
realised that how actually people's attitudes were and being an OT is not as
easy as I thought it might be in terms of attitudes, I know OT's are supposed
to be very non-discriminatory and we have a code of ethics and standards of
proficiency to abide by, the reality of that is not the same and I think at that
particular point in my third year **that was when that bubble was burst** and I
didn't say anything and I think I probably did, but I can't remember what it
was, and I think it didn't turn out to be too bad then, was it? So I probably
made some sarcastic comments, but I think in that particular instance,

Realisation that potential discriminatory practices can and still do occur.

Cathy's realisation that she had been compared with another student with a
similar disability was interesting – she was clear within the narrative that she
her views of people with disability was individualistic – she did not want to
conform to a 'label' and she believed that Occupational Therapy was a client
centred profession.

Cathy had expectations that because she was working with OT's, that they
would practice in a non-discriminatory way and that practice would be
underpinned by OT philosophy in terms of both their work with patients and
service users but also when working with students.

She used sarcasm, potentially to deflect from the situation but also to
demonstrate her dissatisfaction. She demonstrated her skills, adaptability and
her knowledge within the placement but also in terms of how her condition
impacts on her and what strategies help.

Cathy has a high level of experience and she applies this to herself and her
situation well (technically, knowledgeably and personally)

had already been through that phase previously so it is interesting to see how they judged that person, but as a disabled person you do have to be proactive because nobody else is going to do it for you and you do have to open your mouth and you do have to say and you do have to almost campaign for yourself and that again is tiring, it really is tiring, just to keep carrying that baton for yourself and it can get quite lonely if you are the xx or person with a disability, but at the same time it keeps you going because there is going to be more after me; so there have been some before me, and I am here, then there will be more after me, so all the times you want to make things easier **constant campaign for justice, equity and rights but this has its consequences – ‘tiring’ and lonely battle**

But discrimination is something that you can't prove and it doesn't matter how many anti-discrimination policies that you have, it doesn't matter about all the legislation because people that really hold the power

Sad – is this based on experience cynicism regarding the challenge of proving discriminatory practices – linked to power and not fairness and equity to all – similar to participant 3

but I can't prove it, and maybe that's me being cynical, but I have told other people my thoughts disabled and otherwise and the one thing they always both said is keep going, keep going, so eventually someone will hopefully see the light, but all throughout University people say to me you will make a great OT, you are an inspiration and that's coming from people who are disabled themselves and so it made me think more and more about being this role model, I am not very uncomfortable with, the title of being a role model, I don't feel very comfortable with that title at all because I don't think I am doing anything special and then hearing that, you think, then what makes them inspirational... was that I will do anything that I can to be involved in things that will hopefully make things easier, so maybe I am a role model, so I can come round to that way of thinking now, but it is the title that initially didn't sit very well with me.

'see the light' – take a chance on her and employ her – canvassed the opinions of others to add validity to her beliefs that she is being discriminated against in terms of her employment. Determined to 'keep going'
Role model for others – inspirational in terms of the tireless effort to improve things for others with disability – campaign, crusade, military operation, fight, battle etc. struggle so that people better understand disability and its impact

I wish I had done things differently, but you can't know that until you have gone through the experience, you have to experience the lows and the negativity then, even though you don't want to, so that you can come out the other end and use that experience and change things for the positive
Recognition, reflecting back that she has regrets about the past but remains philosophical about experiences and the impact these have

It helps me, I think, to empathise definitely, I can't pretend to know what it feels like to have a different disability, but I can say **I have walked in those shoes** as a disabled person

Importance of empathy but not 'knowing' what it is like for others – again linking to the uniqueness of an individual's experience of disability

I would like to think it would probably make me a better OT, if I am honest I think I would like and I hope it would make me a better OT... but did it make me a better OT, I don't know because I haven't been a proper OT yet, I haven't been an employed OT yet, I haven't worked outside of placement as an OT, but I have as xx, and I have got a number of letters, I have got cards, I have got thank you's and I have got acknowledgements from consultants to say that I did a good job, you know, that's all very nice to hear, to know I am doing a good job in that respect, but as an OT I don't know yet.

When reflecting on her own experiences of disability and practice she 'hopes to be a better OT' as a result of her experiences but is unable to be definitive in her answer because of her current lack of opportunity to demonstrate her skills and abilities as she has been unable to secure a job. She is however able to link her own perception of the therapist she will become based on previous experiences of professional work and her interpretations of being a

'good therapist' – acknowledgements and thank you's from patients and staff that she worked with – external recognition – not necessarily her internal recognition

but they didn't respond to my constant emails and the responses from the disability unit, that in the end I just got so fed up with it, I just left it because I wasn't getting anywhere with it, I was in my first year and I wanted to get on with that, that was more important so again, that added to my frustration and my anger that I feel about the NHS bursaries and their inability to, what I feel, they can't deal with it, I didn't know to pass that baton onto the University and individual Universities, so that made very cross to that situation and yeah, so I had a laptop and inspiration software and a non-medical helper. Very little, I don't really need, like a laptop stand, I hired a key board and an arm rest, but I don't really need them, it almost feels like you are supposed to be grateful for being given something, you don't need or want. I am sure in my report and my second report I got given other things, but I used them, things like internet line, because I live with my mom and dad, my dad pays that bill, so is it worth putting my name on the bill to get it paid, it just seemed a lot more hassle than what it is worth, so some things would have been nice, but is it really worth going down that just to save a bob here and there, I was supposed to get my laptop reimbursed, both books and resources reimbursed and I didn't get any of it reimbursed, so that all came out of my pocket.

Challenges of systems failure / paid for equipment herself as easier – as did participant 12

Felt the most important aspect of support for her was the support worker 'I got what I needed, was most important that was my non-medical helper 'but at the end of the day I can say that I put myself through University'

Reticence / Pride in achievement without support but a disappointment in not having all of the support required. Picking your battles – knowing that she could afford and access equipment etc. was easier than trying to get the system to sort it

I think they both enable and also disable like DSA, like you know, you can have it, but don't have too much and it forces you to make decisions that you

hope that you wouldn't have to make in terms of prioritising where you would have your non-medical helper, deciding you know what type of laptop you should decide to have.

Barriers and enablers – DSA funding linked to how to prioritise and use resources

Disablers – environment and staff attitudes. Lighting and sound quality particularly difficult – this is reflected for others too – tape 3. Not all support is available or helpful. Very clear that the responsibility for teaching in her opinion lies with the university – again the external

Teaching and learning styles are important – not to be discriminatory in approaches to teaching – the move to increased use of technology – does not suit all

Responsibilities for equity and resourcing individuals needs

So I think some people's attitudes as far as learning and being engaged in learning seemed to be aimed in one direction, you know this is the way I am doing it, if you can't access it; well tough.

Issues identified with some staff / individuals attitudes again links to participants 3– attitude – unsympathetic, unsupportive, unprepared to make reasonable adjustments – discriminatory.

Frustration and anger when support is not forthcoming – issues with staff attitudes which results in an impact on engagement and motivation with teaching and learning and negativity. But also a recognition that everyone reaches their limits when battling and fighting for justice, understanding and the 'cause'. Selective again potentially about the battles you choose to engage in based on your chances of winning the battle or the importance of the fight.

so in my mind I had done my job and that was to be a good student, so that was it, and I can forget about it once I finished the course, so let somebody else deal with it, it sounds horrible, but I just didn't have any fight in me to the end of that.

The idea of the 'good student' again – perception of what a good student is and fits the perception.

Like I said I feel like I did everything proactive, I let people know, which you are encouraged to do so, but there is a way staff members are, not what you would expect with being on a health and social care course, but what do you do, at the end of the day they are there in their job, so you complain about them what is going to be the end result, they are not going to get kicked off because that is not what I want them to do, I don't want them to get kicked off, I want them to actually take action, a positive action, to feel that you are actually listened to and things are happening.

Wants to facilitate a behavior change not just educate – similarly to earlier in terms of the simulation exercise she conducted in placement. Complaining is not about getting people in to trouble/ sacked but to encourage reflection on action and behavioural change as a result

which goes back to what I said about, doesn't matter about the equality act, the DDA, you know, it all boils down to people at the end of the day, because those people are responsible for rather a lot that you can access, learning potential, you have got to look up to these people as your professional peers and when sometimes these professional peers of yours are maybe doing less of a good job in your eyes, so yes I mean going back it directly the changes in technology, yes it has been very good, in terms of email, it was unheard of then, in the early days, but you know, things like emails are fantastic, but going back to technology, still disables certain disabilities xx so when you have both, it's almost like a double disabler. It has been interesting to see the changes, but it doesn't surprise me that there is still work to be done on people individual levels.

Take placement first and they were good because you could work collaboratively with the PEs and with the placement support apprehensive and very nervous about it, but as always the key is preparation, so you do the leg work before hand and the rest comes and on all the assessments I managed to do very well, but sometimes I do have this nagging doubt thinking am I good enough, and I think every disabled person probably thinks that, or maybe it is just me, maybe I have just got this chronic nagging doubt that actually I am not that good.

Anxiety linked to placement, importance of support.

Importance of preparation and 'leg work' similar to participant 3

'nagging doubt' about being good enough because of disability – this links to participant 3 too – and participant 2 – thinking about 'perfectionism' amount of work – importance of achieving a first – their need to prove to themselves and others that they can do it and do it well. Links also to Andrew and his desire to complete a Masters – mastery of education and study. Something which for some participants they demonstrated excellent achievement. Also links with participant 12 in terms of his fears / concerns about becoming an OT – although this is quite different.

Uncertainty and fear linked to worth and value and linked to future – despite 'doing very well on all assessments' and successfully qualifying Cathy described a 'nagging doubt' about being 'good enough' to be an OT. This seemed to be reinforced by her inability to secure a job at the time of interview.

it did make me wonder what she was there for from the perspective; I know she was an OT and she is a lecturer, but from a link tutor, what does that actually mean... I got the feeling she was there more for people with dyslexia, rather than other disabilities.

Lack of understanding of some of the support roles within the department / team. Knowledge base of staff within the team / link tutor post – experience but also commonality of conditions – so SPLDs most common 'disabilities' identified within the university and within OT and this study – reflection

Yes because of the sheer tiredness and I know tiredness isn't a reason for an extension and the exhaustion that I felt, I felt better going to bed than forcing myself but may be better coordination could be, you know discussed, in terms of having breaks in between, so that it enables, not just disabled people, but everybody, then disabled people don't feel like you have got to go and request these extenuating circumstances and request an extension or a deferral whatever, so that would make it feel more normal

occupational balance

so yes I do think sometimes I have had to work a lot harder, I feel as though people are here, for people who don't have a disability because of not being able to xx; means that I have got to read it on the way home or when other people maybe can just relax or I have to read it when I get home and when I don't really want to, all I want to do is just stare out of the window so quite often towards the end I would instead it would just take my mind off somewhere else, so that is how I coped with it; but when you are a student and in that situation you don't feel like, oh I don't want to do it, I feel so tired and it is almost like you making an excuse and I absolutely hate it when people do use their disabilities and make excuses because I have seen it happen before and I don't agree with it and I have always been the person who puts his head down and get on with it and sometimes I think that shows that is what people with disabilities do, so there are 2 groups, those you do and those who don't.

needs to do nothing at times. Conflict in terms of tiredness and its impact and making excuses – strongly disagrees with what she perceives as some individuals with disabilities making excuses.

I was so looking forward to getting a job at the end of it and thought that I would have no trouble in getting a job and the particular module, ... and maybe that should have been the clue; the clue there was there are no jobs, or it's harder to get a band 5 entry level job and that's why you are teaching the student to be a bit more entrepreneurial to think outside the box, but the penny didn't drop at the time, had it had done that, but not every student is entrepreneurial and if you are someone with a disability, having gone through that process and you god, I have got to fight, I don't know, I have never set a business up, I don't know how to do it, ... even though you are a graduate, you don't really know what you want to do, it makes you think, oh what am I going to do based on the placement experiences that I have had, so I know myself that I find the acute sector particularly challenging and difficult because of the fast paced nature of it, the people who are acutely unwell and may not be able to articulate anything, makes communication difficult, the sheer worry about how a support worker will quite fit in to that when you are on a ward environment, do they wear a uniform, will I even get a job, so yeah that's how I now feel, so I think I was in this very hazy yes, nearly there, going to get a

job, can't wait, but now I feel quite deflated after having the amount of interviews that I have had an almost getting there, but not quite getting there and it's almost like the carrot has been dangled, you know, you still try to grab it, but as a disabled person I can't help thinking, yeah, you have the policy, but there is always a way round it, you can always use an excuse not to employ me and say because I said something or I didn't add something, but that is me being cynical.

Frustration at not being able to secure a job and the underlying concern about discrimination – remains cynical about why she has not been employed, recognising that policy and legislation count for little. 'carrot has been dangled' feels that her disability is the reason for not securing a post or will make it harder and feels this has been reinforced by attitudes of others including the OT manager whilst on her final placement. There is a recognition that the job market is difficult and feels that a final university module aimed at entrepreneurship was encouraging students to set up their own businesses which she feels she is neither skilled in nor wants to do. She is somewhat naïve in her thinking at times – doesn't always see the bigger picture nor the potential relevance of some modules to her future. Therefore believing them to be not useful. This is also perhaps her desire to understand why she hasn't been successful in gaining employment and the need to rationalise this in her own mind.

Does it happen? I would never know because I can't prove it, so there are those concerns as well and having spoken to prospective employers and I say do you have people who are disabled or people with any additional needs on your work force, most of it seems to be centred around dyslexic people ... I haven't heard of anyone having someone with a physical disability or anything like that, so that kinds of adds to my growing concerns, it's how do future employers view me and will I be able to get a job after people saying yes you will make a really good OT, yes you are an inspiration and yes you are this, but how does that translate into the work place because you have had great experiences placements where people get to know you... but you are not able to show who you are and hopefully the benefit that you will provide that

organisation and patients with and that is very very difficult and makes me wonder, well how am I ever going to get a job.

Feels she has tried to do what has been suggested in order to be noticed within the work environment e.g. volunteering but has not been successful in securing these options either. Feeling disheartened by her situation.

Continued anger and frustration regarding the final modules not being of greater personal use when considering employability in the future.

why did I choose to become an OT, I thought the profession was more disability aware, more disability friendly, so that obviously encouraged me to apply.

APPENDIX 10.10. Stage 2 Theme Development.

Super ordinate and Sub ordinate Themes.

Theme 1 – Placement

- Support and reasonable adjustment
- Impact of placement on health and wellbeing – Boom or Bust

Theme 2 – The Occupational Therapy Programme as Therapy

- A journey of self-discovery / the road to recovery – Doing, being, becoming an OT
- Is OT for me? / Am I good enough to be an OT?

Theme 3 – The future is bright. The future is.....

- The future through 'rose tinted spectacles'
- Fears for the future – 'will I ever get a job'

Theme 4 – Striving for Success / determination to succeed

- Personal characteristics and identity
- Motivation to become an OT

Theme 5 – Support / reasonable adjustment and coping strategies / disclosure / barriers.

APPENDIX 10.11. Stage 3 Theme Development.

Following further review in light of metaphors used by participants and following deeper interpretation, themes were restructured to reflect the participants own words.

Theme 1 – ‘It’s a bit of a Rollercoaster’

- Doing, Being and Becoming an Occupational Therapist
- Motivation to be become an OT

Theme 2 – ‘Like a Bull at a Gate’

- Demonstrating Determination for Success.
- ‘Boom or Bust’

Theme 3 – ‘That was when the Bubble Burst’

- Barriers to Learning
- Is Occupational Therapy for Me?
- Am I Good Enough to be an OT?

Theme 4 – ‘Heal thy Self’

- Occupation as Therapy
- Disclosure, Support Systems, Reasonable Adjustment and Coping Strategies
- Developing Identity

Theme 5 – ‘The World is my Oyster’

- Looking to the future.

APPENDIX 10.13 Participant Synopsis Document.

Participant Synopsis Document.

Tracy.

Tracy was at the beginning of her level 2 studies and had completed a placement when the interview was conducted.

Tracy is someone with dyslexia, who was diagnosed during her school years and which resulted in very good support and the development of successful strategies for learning and achieving her potential. She has personal traits including an excellent work ethic, determination, she strives for success, organised, prepared, fear of the unknown and failure?

She has developed personal strategies for learning and has insight and high degree of self-awareness in terms of her strengths and potential areas of weakness. She links her personal skills to those of being an OT and is passionate about OT as a career but recognises that some of the essential job roles will be challenging for her (note writing and conducting initial interviews). This raises fears with regards to forthcoming placement experiences and work within the future. Has strategies and support whilst at university – familiarity in terms of learning but working will pose different challenges and will require ‘survival’.

Through her own personal placement experience she recognised the need for occupational balance and to be aware of her limits.

She recognises the need for support and understands what support she perceives to require or be most helpful for her specifically.

Natasha.

Natasha was at the beginning of her level 2 studies when the interview was conducted.

Natasha has a chronic illness, she was diagnosed over 10 years ago. She was diagnosed in her teenage years, which had a significant impact upon her identity at the time. She has experienced episodes of serious illness, resulting in hospitalisation and frequently uses 'war like' metaphors to describe the battles she has experienced with her illness. The fluctuating nature of the condition is troublesome. Natasha is desperate to become an OT, having her previous dreams of becoming a performer dashed as a result of her illness.

She sees the opportunity to become an OT as almost her second attempt at happiness. Natasha has a desire for equity, she wants to be able to work and provide for her family. She recognises the impact her condition has had on her and on her family – with her mum giving up much to 'care for' and almost go to extreme lengths to support Natasha – taking her to and from placement in an attempt to reduce her fatigue and continue with the placement.

Natasha described a difficult journey prior to entering the OT programme, she also described assessing the timing of her return to study (she had previously studied an academic degree, which she had struggled to complete) believing herself to be well enough to manage the demands of the programme.

Natasha proactively sought support prior to beginning the programme and identified strategies which would support her learning throughout the programme.

Natasha experienced a significant relapse at the end of her first year, leading her to question the decisions she had made in terms of the timing of her return and the impact her health had had on her occupational performance within the programme but most specifically the level 1 placement. Her major concern, anxiety and fear was if the condition would ultimately strip her of her opportunity to become an Occupational Therapist – she was not questioning her motivation or desire or academic ability to be an OT but her physical and mental capacity to complete the practice aspect (predominantly) of the programme.

Natasha is a self-confessed perfectionist, whose desire to excel and prove her value and worth to herself and others, drove her to a relapse, physically and mentally. The impact of the relapse led to depression, for which she was given 'happy pills'. However, Natasha, seeking to have greater control over her situation sought professional psychological support. She engaged with CBT and returned to University with more hope and optimism and better able to challenge the negative thoughts she had experienced following completion of her first year.

Determined to succeed she also sought professional support for her physical ill health during the summer months in preparation for her level 2 studies. Became emotional within the interview demonstrating the level of importance, significance but also the level of fear and anxiety that she felt. Appreciative of support e.g. pre-placement visit, support worker / note taker, Fears being judged as not interested – prompted disclosure to all, need to live up to her own expectations but also her perceived expectations that others have of her – PE and staff – opinions and views are of paramount importance to the way she views herself

Tina.

Tina had successfully completed her degree, was awaiting graduation but had not applied for HCPC registration, when interviewed. She had however, enrolled on a Post Graduate course.

In short, Tina experienced a XX which resulted in experiencing seizures, 18 months prior to entry to the programme, lots of new experiences / challenges in terms of her need to adapt to new environments, new tasks.

Inspired to become an OT by an OT – modelling, pedestal effect with this OT that perhaps other staff did not live up to.

Many disappointments within the University identified – felt that there was a lack of support for her specific needs – she found environments and attitudes challenging – continued to be 'recovering and adjusting' to her own disability which possibly led her to use the programme – therapeutically. Applying the

principles and teaching directly to herself and her situation. She appeared to continue to be challenged by multiple identities and roles – particularly in terms of her role as a patient which was in direct conflict with her roles and responsibilities as a student OT – ‘care plan’ language, her fears around applying to HCPC – related in part to a fear of being rejected but also was this also a fear to taking responsibility for others.

Peer support crucial – Wengers communities of practice – also seeking support and to identify with other students / qualified staff who have a disability. Desire to learn from their experiences – attended the initial day prior to starting the programme in an attempt not only to learn but also to identify with others – she found this difficult though as she did not feel that she ‘fit in any box’ and therefore could not liken her experiences to those of others – ‘most people have dyslexia’ – complexity of her condition – disappointed again by what she perceives to be a lack of interest in OT’s with disabilities by the professional body itself – believing that this feeds into the perception that they are undervalued.

Lack of OT philosophy applied to disabled students / OT’s by staff at the university and COT

Placement issues – impact on health, development of strategies to manage placement period, incongruence in terms of her personal expectations e.g. to be practicing independently at level 3 and achievement – resulted in disappointment but also fear and anxiety linked to her confidence to do the job – despite passing all placements and academic work and achieving a first class honours degree. The success of completing the programme, achieving a first appears to be undermined by her confidence to do the job – which she perceives to be as a result of her final placement being based within the community.

Tina’s perception of the challenges within her final placement were multifactorial –

1. She did not feel that the placement had been adequately risk assessed and she felt that she should not have been placed within a community setting.
2. She also felt that this placement was therefore not relevant to her future practice, as it would not be an area in which she perceived she would work as a result of her own risk assessment and condition.
3. She did not feel that reasonable adjustments had been considered / offered or made – in terms of working PT hours
4. She did not feel that the placement, as a result of her condition, had offered her the opportunity to become independent, a factor she perceived to be essential within a final placement, in developing confidence and in preparation for her transition following qualification.

Naivety and blame associated with her rationale for the lack of success within her final placement.

Challenges and perceived risks during the placement.

Hannah.

Hannah was on her final year placement, when interviewed.

Hannah was diagnosed with various mental health conditions, following her GCSE's. The condition when originally diagnosed was severe and resulted in agoraphobia and the need for prolonged intervention from the CMHT.

Hannah's recovery was graded by her CPN, who along with her mum provided support. Hannah returned to her school to work in a supportive environment and this along with her reflections on the impact of the CPN she made the decision to train to become a health professional. Choosing OT over nursing initially for practical reasons – no exams which she believed to be the trigger for her earlier mental ill-health. Hannah proactively sought support from the central support services team, opting not to disclose her condition to the PPT nor to her PE's.

Hannah recognised that her illness had offered her an opportunity to reflect and time to get skills which would be helpful in her future – this also served to build her confidence in her ability to manage her illness. She saw the benefits and linked her personal characteristics such as empathy to her career. She recognised challenges and some anxieties she had experienced – potential for being placed away from her support network for placements, sitting in lecture theatres, final placement in mental health but was able to rationalise and be proud of her achievements and how she had managed these challenges.

She had a rationale fear that she may suffer a relapse and whilst had reduced her medication significantly she admitted to increasing her medication at a time she felt vulnerable.

She appeared to have adjusted well to her illness and was able to seek problem solving strategies to ensure that she was in greater control. She talked of the pride she would feel when qualified and that of her parents. Hannah did not associate herself with a label of being disabled – she needed this to be explained to her in order that she then accessed IT and support.

Carmel.

Carmel was in her first term at University, when interviewed.

Carmel has SpLD and a musculoskeletal condition. She was diagnosed with dyslexia during previous HE. She has studied and has additional qualifications related to SpLDs. She is confident and assertive in the knowledge of her condition, her rights and the strategies that she perceives to be successful in her learning. Carmel demonstrated an arrogance about her needs at the expense of others – the challenges she was experiencing at the time of interview related to working with others – a key skill of an OT. She was dismissive of other group members believing that their methods of studying were not appropriate and would not work for her. She appeared to believe that her age and experience gave her authority within the group. She was a contradiction in terms – she appeared to be well adjusted in terms of her

SpLD, she was certainly knowledgeable and able to articulate strategies which supported her learning but her inflexibility, inability to adapt and her attitude to others were causing significant challenges.

Carmel was driven by her understanding of how she worked best and a desire to be strategic in her learning, perhaps recognising that tasks took her longer to complete. Carmel recognised that dividing tasks within a group would be more time efficient but appeared to lack the people skills to negotiate a positive solution for all. She talked in a derogatory manner about her peers and it appeared that she had not formed relationships with her peers within her seminar group.

Carmel did not foresee any issues initially when considering her placement but again seemed to make assumptions and lack a clear understanding of the requirements.

Robert.

Robert was in his first term when interviewed.

Robert had recently been assessed and diagnosed with SpLD prior to the interview and was awaiting his IT and support. Whilst previously undiagnosed Robert had an awareness of the impact his SpLD had had on him since childhood. Robert had lived in various parts of the world and had been exposed to a variety of cultures, all of whom potentially viewed disability differently. He spoke within his interview of believing that his parents had some awareness of the potential of his SpLD but chose not to for this to be investigated or diagnosed – perhaps fearing the stigmatising effects this may have had. Robert felt isolated, last to be picked for teams and bullied during his time at school and as a result of this was striving to be a leader etc. He recognised the need to get stuck into his work and was determined to spend time working on his assignments in order to be successful. He was actively looking for support and mentorship as he believed this would help him. He recognised areas for development and was optimistic that the programme would support his development in these areas.

He had no expectations regarding his forthcoming placement

Amanda.

Amanda, was in the second year of her studies but had not completed a placement when interviewed.

Amanda was diagnosed with SpLD during her first year on the programme. She had previously studied within HE and whilst undiagnosed had implemented many strategies which had helped her. She continued to use these strategies, as well as using other strategies e.g. glasses with coloured lenses, implementing the use of software packages which had a significant impact on her success.

Amanda was matter of fact in her approach to her SpLD, she had a good understanding of the impact it had on her and had adjusted well.

Amanda was working within healthcare and so was familiar with the working environment and the strategies she used to ensure she was successful at work and had the foresight to see that these strategies should be of benefit and enable her to be successful during her placements.

Amanda's main anxiety was related to presentations and speaking out in public, particularly if she had not had the opportunity to prepare and this did provoke some anxiety about her forthcoming placement – she did however have strategies for managing this including preparation etc.

Andrew

Andrew had successfully completed his degree and was awaiting graduation. He had enrolled on a Masters programme and was self-employed but not as an OT, when interviewed.

Andrew was diagnosed with a SpLD during his second year at university – his diagnosis was prompted by working alongside a student with severe dyslexia who was able to complete work more effectively and efficiently than he resulting in him seeking assessment and diagnosis. He described the pain of

writing and the liberation of becoming paperless – he described a relentless experience of making notes within lectures / sessions but of these being useless and never utilised because of his poor handwriting and thus being supported to take the decision to go paperless and use alternative methods for recording information was liberating. He described learning to understand himself and his limitations and working within these limitations – short – term memory difficulties and how he had overcome these.

He described placements and how they had improved following his diagnosis but how he still recognised that he was susceptible to inhibition within the practice setting which can cause difficulties. He described a transformation and a desire to help others in similar situations to understand themselves and to reach their potential. He had previously battled, prior to diagnosis with an incongruence that he felt he portrayed. He believed that his ideas were good and this was reflected with seminar discussions but struggled to understand why his assessments did not reflect the effort and knowledge he believed he had.

He was seeking approval of his worth from lecturers. He wanted his personal belief in his abilities to be seen and reflected by those he perceived as experts.

Saw the diagnosis as a 'gift'. He believed the course had been transformational and therapeutic. Recognised he was still developing strategies but that his diagnosis had kept him on the course.

He was looking to a future where he could fulfil long held dreams of studying at Masters level and beyond, presenting his undergraduate research at international conference.

Cathy.

Cathy had successfully completed the programme, she was awaiting graduation and had applied for a number of jobs but had been unsuccessful in securing one at the time of interview.

Cathy had sensory impairment. Cathy had studied a previous degree, almost 20 years previously and at that time did not have any adjustments.

Cathy was a disability activist, who wanted to change the attitudes and behaviours of others towards disability – through being within the classroom and teaching her peers about her experiences, within practice placement undertaking training with those in practice simulating what it is like to have a hearing impairment, through discussions with staff (lecturers and OT managers alike), through participation within the interview for this study. Cathy, as a result of her experiences and knowledge, knew her entitlements, understood her support requirements and was vocal when discussing this – she felt it was inequitable that she was unable to have a communication support worker whilst on placement as a result of a lack of financial support, that she was unable to hold a ‘personal budget’ for her support worker, that the financial support available for students with disabilities was only £10,000 at Masters level prohibiting many to undertake education to this level.

Disclosure on a need to know basis. Viewed placement positively, as an opportunity to practice and identify potential barriers for future working environments. Valued pre-placement visit and support from the placement team.

Identified barriers – environmental within university – loop systems, difficulties with podcasts and some videos / activities etc. on Moodle as no subtitles / transcription.

Sense of putting self through university – own steam largely unsupported – purchased own laptop etc.

Felt a sense of being let down at the end of her training – had worked hard but to no avail – no job at the time of interview and she appeared to think this was a result of discriminatory practice

Seemed to imply that she felt that a final year module focussed on employability and entrepreneurship was a hidden attempt to encourage students to set up private practices as a result of the job shortages at the time.

Disappointment at not securing a post was evident – nagging doubt of not being ‘good enough’ – reflective of unsuccessful interviews.

Very client centred in her approach – didn’t always feel that that was reflected by others – bubble burst – linked to an event but also very much linked to her perception of OT as a non-discriminatory profession and those that work within profession upholding those beliefs.

Identified with being a person with a disability and possibly a culture linked to this in terms of helping others, being an advocate, ‘walking in the same shoes’.

Vicky.

Vicky was in the first term, she had yet to submit any academic work, when interviewed.

Vicky was diagnosed with a SpLD during a training course, some years previously. Since diagnosis she had undertaken some further education and training and had attempted degree level studies twice previously but had been unsuccessful in gaining a degree qualification.

Vicky described her SpLD as debilitating. Vicky was emotional during the interview demonstrating the depth of desperation fear and anxiety but also guilt and shame she felt. Vicky was determined to be successful – she had experienced some successes when undertaking training and education and therefore believed that with the right support – that documented in her support plan she would be successful but in reality this had not transpired within the HE setting. Vicky did not appear to have taken responsibility for developing strategies to support her learning and development. She seemed to

experience difficulty in knowing what she needed or how to access what she needed.

Issues with accessing a dyslexia tutor

External locus of control? Lack of acceptance – denial in terms of family, in terms of peers within the classroom and potentially in terms of placement and academic staff.

She has high fears of being judged as a result of disclosure. Her self-perception / self-worth is extremely low – she is derogatory about herself consistently through the interview – talking of being thick and stupid – these seem to be long held beliefs which possibly stem from childhood which are being perpetuated now in HE. She seems to be searching for a degree which maps to her practical skill set and that she can be successful in completing academically.

Loves the content of the programme, which appears to reinforce that this is the right course but she is approaching a time when she needs to submit assignments and acknowledges that she will not meet the deadlines and does not know how to tackle them. She has sought support from seminar tutors but feels that their explanations have not provided her with what she requires
She wants to be a role model for her children

Searching for professional recognition to develop self-confidence and self-worth

David

David was at the beginning of his level 2 studies and had completed a placement when interviewed.

David had sustained a XX and was diagnosed with a SpLD during his needs assessment. David was searching for a new career following redundancy and his injury. He recognised the impact that his injury had on his cognitive functioning and had seen how this had emerged when he was working within

a XX environment but didn't appear to see how this potentially related to the challenges he was facing at the time of the interview.

During the interview David was preoccupied with a couple of incidents which he had felt were somewhat unfair. He described exchanges with his seminar tutor and his PE in which his interpersonal skills had been questioned / criticised. He attempted to redress the criticism outlining how he had following feedback from his PE he had addressed the concerns, resulting in a 'glowing report'. He also identified volunteering within a different OT service where again his interpersonal skills had been commended – leaving him feeling confused. As a result of his previous careers he also respected those he perceived to be figures of authority.

These exchanges with staff, left David questioning if he had made the right decision to become an OT if he didn't have the key skills and would not 'fit in'. This questioning was also linked to feeling that he did not fit in with his friends either – his friends were 'hard lads'

He was struggling to identify with David of the past – but also struggling to feel accepted within the world of OT. He was feeling a sense of rejection from the profession that he had invested much time and effort into

He was unsure that he wanted to continue but had sought support and discussion with his family and close peers and was planning on continuing but not ready to commit to working as an OT in the future. His placement experience whilst successful was not an area of practice he wished to work in in the future, which had perhaps also led him to question his career choice. He had disclosed to his PE, but chose not to share his diagnosis with more than a couple of close friends within his seminar group fearing that he would become a 'specimen' within the classroom. Lack of confidence in who he is and who he wants to be

Identity crisis – ‘a period or episode of psychological distress, often occurring in adolescence but sometimes in adulthood, when a person seeks a clearer sense of self and an acceptable role in society’

Unresolved issues with anger which he seemed unable to recognise

Valerie.

Valerie was at the beginning of her level 3 studies and had completed one placement when the interview was conducted.

Valerie experienced an acute episode of mental ill health as a result of work place stress and the potential threat of redundancy. Many other underlying issues present – roles and responsibilities – bread winner, single parent, university studies dependent upon job also in an abusive relationship previously.

High levels of fear and anxiety regarding her place on the course – rectified by discussions with APT

Addressed the issues with mental health via GP

Need to distract self and focus on study – importance and determination apparent but at the cost of working through other possible psychological issues – which manifested following trigger and diagnosis of MH condition. Managing all balls in the air but suddenly came crashing down – resulting in potential to harm self – waited until she felt able to address and think about her issues / distress before taking time off work – felt she would have been a danger to herself before this

Disappointment with placement results, desire to do well – aspirations for the future – linked to own experiences and a desire to help people in similar situations

Developed a greater understanding of mental health, empathy, advocate – speaking out, knowledge, self-awareness and reflective skills

Chose not to disclose the nature of her illness but to stay safe and explain her situation to her PE – fearing stigma or rejecting mental illness – has a self-belief that she is able to leave her worries at the door and not take them to work with her

Relief at passing placement. Confidence in doing the job and in her own abilities academically – growing confidence

Self-perception / self-worth building on this wants recognition for achievements.

Impact of the recognition that the damage has been done.

APPENDIX 10.14. Reflection Example.

Wright St-Clair (2015) suggests that phenomenology is inextricably linked to 'thinking and writing and writing and thinking' (p53). She heeds a warning of the need for patience, as thinking can not be requested on demand, when completing phenomenological research and this was something I was not expecting! Wright St-Clair suggests that the illuminating 'aha' moments occur 'when immersed in, and staying engaged with, the data' p 53. I experienced three major 'aha' moments whilst completing this research. Two came in the middle of the night when I was struggling to sleep and feeling overwhelmed by data. The first instance, helped me to rearrange my themes and present the super-ordinate themes as metaphors, in the words of my participants. The second 'aha' moment occurred during a supervision session, when discussing and debating the theme structure and how the themes were presented and were drawn together (as suggested by Smith, Flowers and Larkin, 2009) as a journey. The final and perhaps most significant 'aha' moment was the realization that MOHO (Kielhofner, 1985) was the model which could be applied to each student, most effectively and appeared to present a theoretical application which could be indicative of a student's success on the programme.

Following data collection, analysis and interpretation, I recognised the original simplistic ideas I had conceived initially prior to completing the research were somewhat naïve. The process driven, mechanistic research I initially believed I was completing evolved into a complex 'bowl of spaghetti' as described by Wagstaff et al (2014), who acknowledged the complexity of data analysis and interpretation within an IPA study. The data collected was in-depth and rich, as would be expected, but somewhat surprisingly it was also completely unique to each individual. Where I had naively believed that I may be able to group some participants by diagnosis in order to compare and contrast my findings this proved impossible, with each participants narrative being individualistic. My belief that I could potentially group those with a SpLD together, as I had seen previously reported within the literature (Pino and Mortari, 2014) was not possible. All of my participants were at different stages

of adjustment and or rejection of their diagnosis, were individually motivated, had various established patterns of behaviour related to studying and commitment to the role of an OT student, had varying levels of occupational performance including self-efficacy and were all influenced by the environment to varying degrees (barriers and enablers) and each of these factors was influencing their participation within the occupation of studying OT.

It became clear to me that I was envisaging the impact that the person and the environment were having on the occupation of being an OT student and successfully completing the OT programme. Thus leading me to consider how an OT model was influencing my thinking and data analysis and interpretation. I was able to identify that my thinking was underpinned by an OT model relatively quickly but I needed to explore which model I felt was best suited to my participants, my findings and my interpretations. The similarities with the concepts specifically identified with the Model of Human Occupation (MOHO) (Kielhofner 1985) were uncanny, the participants all spoke of their strong motivations and personal desires to become an Occupational Therapist (their volition and personal causation). They all described their occupational narrative with a plot and frequently used metaphors within their plot to describe their experiences (Melton et al, 2017).

APPENDIX 10.15 Participant in Brief Document.

Tracy - was not known to the researcher. She was a level 2 student. She was interviewed in the university. She has dyslexia, which was identified at school, she had learnt strategies to manage her dyslexia prior to attending university.

Natasha - was known to researcher, as I had supported her on her level 1 placement completing pre-placement visit and multiple visits thereafter. She was a level 2 student. She was interviewed within the university. She had a previous degree. She had both physical (primary) and mental health conditions resulting from her long term physical condition. She was diagnosed prior to entry to the programme and seen by the central disability support services team, who provided equipment, software and a note taker prior to commencing the programme.

Tina - was a recent graduate, who was known to the researcher, as I supported her on her final year placement. She was interviewed within her home environment as requested. She had an XX and had not applied for HCPC registration, nor secured a job when interviewed. She was seen by the central disability support services prior to starting the programme and was provided with equipment, software and a note taker.

Hannah - was not known to the researcher. She was a level 3 student. She was interviewed within the university. She had experienced mental ill health, whilst studying her GSCE's. She was seen by the central disability support services prior to commencing the programme, who provided equipment, software and ad-hoc support.

Carmel - was known to researcher as a personal tutee, I had met Carmel twice previously. She was a level 1 student. She was interviewed within the university. She had not completed a placement. She had a previous degree. She has dyslexia, which was diagnosed prior to commencing the programme but not during her schooling years. She also had back and neck pain. She did

not seek support from central disability support services prior to commencing the programme.

Robert - was not known to the researcher. He was a level 1 student. He was interviewed within the university. He had not completed a placement, and he has SpLD. He had completed a previous degree. Robert had not been assessed for or provided with any adapted equipment or reasonable adjustments as suggested by the central disability support team when he was interviewed.

Amanda - was not known to the researcher. She was a level 2 student and was interviewed in her work environment at her request. She had completed a previous degree. She has SpLD and was diagnosed at the beginning of the OT programme. She had learnt to problem solve when faced with challenges as a result of her undiagnosed dyslexia and therefore when faced with difficulties in lectures she demonstrated proactivity and her OT skills by self-referring to the disability support team, who following her diagnosis, provided equipment, software and access to a dyslexia support tutor. She had not completed a placement at the time of interview.

Andrew - was a recent graduate, who was known to the researcher. He was interviewed within the university. He had a previous degree. He had been diagnosed with SpLD during his second year studying occupational therapy, consequently he was seen by central disability support services who provided equipment, software and access to mentor support. Andrew was not working as an OT at the time of the interview but was studying a part-time MSc.

Cathy - is a recent graduate, who was known to the researcher. She was interviewed in the university. She has a previous degree. Within her first degree she did not request nor have any reasonable adjustments or support to complete the programme. She has a sensory impairment. She was assessed by the central disability support team and provided with equipment, software, a note taker / sign language interpreter. She had not secured a job as an OT at the time of interview.

Vicky - was not known to the researcher. She was a level 1 student. She was interviewed within the university. She had initiated degree level study previously but not completed it. She has SpLD and has sought support from the central disability support services, she has equipment and software but has been unable to access 1:1 support as there is a waiting list. She had not completed a placement at the time of interview.

David - was not known to the researcher. He was a level 2 student. He was interviewed within the university. He sustained injuries following a road traffic accident. He was also diagnosed with SpLD, following assessment for reasonable adjustments by the disability support team. He was provided with equipment, software and access to 1:1 support. He had completed one practice placement.

Valerie – was known to the researcher as I had taught and visited on her placement. She was a level 2 student. The interview was completed in the workplace. She had a recent onset and diagnosis of mental ill-health prior to her level 1 placement and following the potential threat of redundancy / change in work role.

APPENDIX 10.16. Initial Application of MOHO to Participants

Tracy

Volition / Personal Causation / Values.

Tracy was highly motivated to be successful. Tracy was driven to achieve 95% in level 1 placement. She had high self-efficacy and valued her role as an OT student.

Habituation

Dyslexia was an accepted and welcomed part of Tracy's identity – it made her who she was and gave her qualities others lack such as creativity. Her dominant role was that of a student. She was however new to studying at degree level and was required to develop new habits and patterns linked to study and practice placements.

Whilst successful on her first placement, Tracy was concerned regarding her level 2 placement and the development of adapted patterns of behaviour to manage initial interviews and writing at the same time.

Coping strategies

Tracy was prepared and well organised. Her coping strategies were well established as a result of being diagnosed at school. She was proactive and researched the course before applying. She chose to disclose and justified her decision.

Performance capacity

Tracy was independent, a high achiever and was striving to continue to achieve. Tracy had self-belief.

Tracy had some anxiety and fear related to writing up notes in future placements.

Environment

Enablers

Tracy had proactively sought and accessed reasonable adjustments, she valued 'Echo' recordings of lectures and access to power-point slides etc., she had a 1:1 tutor, used Centre for Academic Writing (CAW) and proactively sought support prior to enrolment.

Barriers

None highlighted.

Occupational Identity / Occupational Competence / Occupational Adaptation

Tracy had a strong identity following her diagnosis at school. This offered opportunity for occupational adaptation at this time. She was developing her occupational competence within the HE setting and developing OT / occupational identity. She was experiencing some anxiety regarding her future placements specifically related to completing initial interviews and note writing simultaneously but she was proactively looking at ways to overcome this – utilising problem solving strategies.

Tina

Volition / Personal Causation / Values.

Tina was highly motivated and driven to prove self. She was a perfectionist and an advocate and valued the role of being an OT student and becoming an Occupational Therapist.

Tina had decreased self-efficacy.

Habituation

Tina was in the process of adapting to and accepting her injury and seizures. She had been required to develop new patterns and habits which have been challenging. Tina needed to establish new ways of studying / working within new environments. She needed to establish routines and habits re being an

OT student whilst learning to adapt and accept her disability which proved complex and challenging.

Tina's dominant roles were that of a student, which appeared to be the current focus of her life but she also appeared to view herself as a patient at times

Coping strategies

Tina displayed some avoidance strategies, particularly with dealing with psychological issues, preferring to focus on study.

Tina was well organised and prepared. She had good time management e.g. adjusted deadlines, strategic in her learning

Performance capacity

The physical impact of her disability e.g. fatigue, headaches, decreased concentration, seizures impacted on her performance capacity. Along with her own self-belief.

Environment

Enablers

Support was crucial for Tina e.g. peer support, support worker. Tina accessed reasonable adjustments which were negotiated through her support plan. She valued opportunities offered for networking with other students with disabilities e.g. pre-enrolment meeting

Barriers

Tina felt that the attitudes of some university staff were a barrier. She also felt pressure to achieve and demonstrate worth both from an internal and external perspective.

Occupational competence / occupational identity / occupational adaptation

Tina's occupational competence and identity were compromised as she adjusted to living with her disability and the seizures she was experiencing. Tina experienced difficulties with new environments, new tasks, new situations (e.g. placements challenging). Tina initially lacked an understanding of what would / could help – 'blind leading blind' whilst establishing new patterns of behaviour and habits. However, over the duration of the programme Tina's understanding grew, as did her identity and competence leading to occupational adaptation and becoming an Occupational Therapist. Successfully completed programme

Natasha

Volition / Personal Causation / Values

Natasha was highly motivated, a self-confessed perfectionist, who was striving for success, a career and normality. She was a good student, who demonstrated empathy and determination. She valued the role of being an OT student and becoming an Occupational Therapist.

Fear was impacting upon self-efficacy and this was linked to the impact of level 1 studies and placement.

Habituation

Natasha was learning to live with chronic illness. She had completed a previous degree and so had an awareness of academic expectations and study. Although now, she was required to develop habits and patterns of behaviour to successfully manage the added demands of placements.

She was battling her anxiety and fears about possibly not being well enough for the demands of the programme.

Natasha's dominant role was that of a student, but also someone who requires care and was dependent upon her family, which she wanted freedom and independence from. A key goal for Natasha was to provide for herself and her family.

Coping strategies

Natasha was well organised, hardworking, prepared and had good time management skills e.g. adjusted deadlines

Performance capacity

The symptoms of Natasha's condition impacted upon her mind and body, the physical restrictions impacted on her psychological wellbeing. She experienced fatigue, low mood, a fluctuating condition, pain and discomfort all of which impacted on her performance capacity.

Environment

Enablers

Natasha valued her support network e.g. parental support, support worker, access to reasonable adjustments, practice educator. Natasha sought psychological intervention.

Barriers

Initial access to note taker when she was ill was a barrier, however this was rectified following discussions with student support services.

Occupational competence / occupational identity / occupational adaptation

Natasha's illness had significantly impacted on her identity, initially diagnosed during adolescence this impacted on her identity as it developed. Whilst she had adapted somewhat the fluctuating nature of the condition and demands of the programme meant that she experienced difficulties with occupational performance. Natasha had managed the demands academically but struggled more with the physical demands of placement and her own personal expectations linked to concerns about completing programme and achieving occupational adaptation. Whilst her illness did impact on competence and

identity, she was determined, hardworking and sought support to further develop competence and achieve occupational adaptation.

Hannah.

Volition / Personal Causation / Values

Hannah was motivated and quietly determined to be successful. She had insight and recognised what she has been through to access university. She had empathy and was enjoying course. She had realised that OT was what she wanted to do. She demonstrated pride in her achievements. She demonstrated self-efficacy.

Habituation

Hannah's habits and patterns of behaviour were developing as she adapted to and accepted her disability. Her dominant roles included that of a student and a child. She was however becoming more independent and testing of herself. Hannah had completed all academic work and placements successfully to date thus demonstrating her abilities to develop habits and patterns to become a successful student.

Coping strategies

Hannah had previously worked with a CPN and had developed personal strategies. She researched sources of support and accessed them prior to enrolling on the programme. She was aware of her triggers and had strategies for coping with them – e.g. sitting on the end of a row in a lecture theatre demonstrating her adapted behaviours to compensate. Originally Hannah lived at home but recognised her abilities and moved out to live with peers.

Performance capacity

Hannah performance capacity was good – she was mostly independent and recovering well. She had experienced expected levels of anxiety prior to placement etc. Hannah recognised the relationship between mind and body e.g. links to self-medication / continued use of medication.

Environment

Enablers

Hannah engaged with a range of environmental enablers including medication, reasonable adjustment, biofeedback machine, counselling, family support / networks close by

Barriers

Hannah had initial anxieties re managing university as a result of her mental health condition. She feared being placed away from home for placements but was able to actively and positively implement coping strategies to reduce fear and risk and had lived away for all placements.

Occupational competence / occupational identity / occupational adaptation

Hannah did not see herself as an individual with a disability. She chose not to disclose, her mental health condition. She had adapted well. She had time and support to adapt following initial episode of illness. Hannah expressed expected fears and anxiety about placements and being away from home but tested self and managed, building confidence. Hannah recognised her journey and how far she had come from. Through programme, Hannah had developed a good occupational identity, she was nearing the conclusion and completion of the programme and so had developed competence through studies and role of OT student leading to occupational adaptation and potential subsequent qualification.

Carmel

Volition / Personal Causation and Values

Carmel exhibited some motivation to being an OT student / becoming an OT but not it was not strong within her narrative. She demonstrated self-efficacy.

Habituation

Carmel demonstrated an inflexibility -, 'set in ways'. She had a specific way of doing things, which appeared non-negotiable. Carmel was unaware of the expectations of placement but was not concerned about this.

Carmel had some awareness of the demands of study but was required to develop new habituated patterns to support her transition in to being an OT student.

Coping strategies

Carmel demonstrated some coping strategies which were directly linked to her SpLD e.g. planning, preparation, strategic learner etc.

She had limited coping strategies however in terms of working with others, linked to becoming an Occupational Therapist.

Performance capacity

Independent

Environment

Enablers

Lap top and software, access to Echo and notes on Moodle

Barriers

Other people in the seminar group

Occupational competence / occupational identity / occupational adaptation

Carmel had adapted to SpLD and had strategies for managing this – it was part of who she was. She was in the early stages of transition, into being an OT student and was experiencing challenges with this from an occupational identity and competence perspective. This was therefore causing difficulties with occupational adaptation currently – **if she is unable to adapt to working in groups, it is hypothesized that it will be difficult to become an Occupational Therapist.**

Robert

Volition / Personal Causation / Values.

Robert was highly motivated. He was seeking professional status through his studies. He was striving for recognition, for friendships, to make a difference, to be a leader, to be liked. He demonstrated self-efficacy.

Habituation

Robert had begun to establish routines within university in terms of workload and study. He had prepared plans for his role as an OT student and his studies. Robert had studied previously and so had an awareness of the demands of studying and had pre-established habits and patterns which reflect this.

Robert was unaware of the expectations from a practice placement perspective but was highly motivated to learn.

Coping strategies

Robert used coping strategies to support him e.g. meditation, being organised, being proactive.

Performance capacity

Robert had insight and hoped that the programme would support his communication and social skills development.

Environment

Enablers

Robert actively sought support e.g. CAW. He was awaiting support from student support as he had only recently been diagnosed but was also hoping for mentor support, IT etc.

Barriers

None identified

Occupational competence / occupational identity / occupational adaptation

Robert was newly diagnosed had only recently begun his studies. He did however, seem to be aware of his challenges prior to diagnosis. He had made some adjustments previously and was now proactively seeking 'therapy' through engagement in activities to improve communication and social skills in-order to develop his competence. His occupational identity appeared to be growing, as does his occupational competence.

Amanda

Volition / Personal Causation / Values

Amanda was highly motivated and successful in completion of her academic work. She valued and enjoyed OT. She demonstrated self-efficacy.

Habituation

Amanda was a worker and a student. She had a good understanding of OT. She had previously undertaken study to degree level and so had habits and patterns of behaviour to support her success. She had not experienced a placement, but was willing to disclose and had adapted patterns for success in her working environment.

Coping strategies

Amanda was proactive, strategic in her learning, prepared and organised.

Performance capacity

Amanda exhibited **some fear and anxiety related to presentations** but had established coping strategies which she has practiced within the University setting and therefore she planned to employ similar strategies in the placement setting.

Environment

Enablers

Amanda used a range of environmental enablers to support her success including technology, reasonable adjustments, coloured glasses, access to 1:1 support, support from family

Barriers

Time was a barrier for Amanda, as a worker and as tasks took longer to complete.

Occupational competence / occupational identity / occupational adaptation

Although only recently diagnosed formally, Amanda had completed a previous degree and so understood the roles and activities which were required to be undertaken as an OT student. She also has a good understanding of OT and had absorbed many of the values and beliefs of the profession. Her occupational identity was developing, along with her competence in being an OT student.

Andrew

Volition / Personal Causation / Values.

Andrew was highly motivated. He valued his role of being an OT student and of becoming an OT. He was motivated to continue to study and achieve his long term goals of a MSc. He demonstrates self-efficacy.

Habituation

Andrew was diagnosed part way through his training and his diagnosis was almost transformative in terms of providing him with a rationale for his previous struggles. He had developed habits and patterns of behaviour by integrating what he had learnt about his learning needs and as result was able to perform more efficiently and effectively until the completion of his degree.

Coping strategies

Going paperless, disclosure.

Performance capacity

Andrew demonstrated decreased inhibitions as a result of his SpLD which impacted on his social skills. Prior to diagnosis Andrew described the pain of writing

Environment

Enablers

Andrew described many environmental enablers which had supported his success including the use of technology, 1:1 coaching, supportive educators in placement and university.

Barriers

Once diagnosed Andrew described few barriers to success. He did however, continue to experience difficulties with handwriting e.g. patient notes

Occupational competence / occupational identity / occupational adaptation

Andrew was able to develop occupational competence and occupational identity following his diagnosis with a SpLD. Following the implementation of reasonable adjustment and the development of his personal coping strategies he was able to demonstrate occupational adaptation and successful completion of the OT programme.

Cathy.

Volition / Personal Causation / Values

Cathy was highly motivated. She was a disability activist, with a strong will. She was determined and client centred. She was a 'good student'. She demonstrated empathy as someone who had 'walked in their shoes'

Habituation

Cathy had previously undertaken study at degree level, without reasonable adjustment. She therefore had existing habits and patterns of behaviour related to studying. She also had experience of working and had some understanding of the demands of working in health and social care. She developed habits and patterns of behaviour within placement.

Coping strategies

Cathy was prepared and organised She ensured that she got enough rest and sleep recognising the impact fatigue had on her abilities. She had a good knowledge and understanding of entitlements.

Performance capacity

Sensory impairment, fatigue, headaches

Environment

Enablers

As a disability activist Cathy had an awareness and knowledge of her entitlements and therefore accessed external support appropriately e.g. support worker, power-point slides, technology, supportive educators in practice and university, reasonable adjustments in placement

Barriers

Cathy felt that the attitudes of others were her main barrier e.g. OT manager / university staff. She also feared discrimination whilst looking for a job and felt that her DSA funding had not allowed for a support worker during placement.

Occupational competence / occupational identity / occupational adaptation

Cathy was well adjusted to her disability. She recognised it as part of her identity / culture. She was however complex and rejected the 'disabled' label at times within her narrative. She demonstrated the successful development of occupational identity and competence specifically applied to being an OT student and becoming an OT. Ultimately demonstrating her occupational adaptation and successful completion / qualification from the programme. Cathy held core values of OT like client centredness and the uniqueness of individuals.

Vicky

Volition / Personal Causation / Values.

Vicky was seeking professional status and showed determination to achieve this. Vicky demonstrated her motivation to study as indicated by her previous attempts to complete degree level education.

However, she appeared to exhibit an external locus of control believing that it is the responsibility of others to do what it says in her support plan whilst being reticent about requesting support and help.

Habituation

Vicky's dominant roles included being a student and a mother
Vicky appeared to be experiencing feelings of shame and guilt attached to her diagnosis. She held deeply ingrained negative views about herself, as someone who was 'thick and stupid'. She had some previous success in education but was also unsuccessful at degree level.

Coping strategies

Vicky appeared to lack personal coping strategies.

Performance capacity

SpLD had a significant impact on memory, recall and learning. It was 'debilitating'

Environment

Enablers

Vicky had accessed some technology to support her but she was not prepared to use it within seminars. She also had a support plan

Barriers

Vicky had not been able to access 1:1 support as a result of a waiting list. She was extremely fearful of people's attitudes and being judged. She feared disclosure and was not prepared to disclose to peers or family about dyslexia. She had attempted to set up peer support groups but this was not successful.

Occupational competence / occupational identity / occupational adaptation

Vicky's self-perception was that she was 'thick and stupid' and this significantly impacted on her ability to develop her occupational identity. Her memory and recall also posed significant challenges to developing her occupational competence. Her desire to hide her diagnosis hindered her ability to seek support, which further impacts upon the development of competence.

Hypothesis – occupational adaptation and success are unlikely unless able to identify personal coping strategies, access support and adapt from an occupational performance perspective.

David

Volition / Personal Causation / Values

David was motivated but circumstances were impacting on his levels of motivation. David was considering giving OT. He values his role as an OT student post disability but in a dilemma as he was unsure if he 'fitted in'. He did not want to accept or ask for support.

Habituation

David was attempting to develop habits and patterns of behaviour in terms of his studies. He was demonstrating his progress – previously 'lastminute.com' and therefore recognising and learning from previous behaviours. Dominant role was OT student.

He was demonstrating some challenges transitioning from previous work roles to that of an OT student. Some challenges experienced in placement.

Coping strategies

Limited personal coping strategies demonstrated. David did not want to share his diagnosis within the seminar group. He feared the consequences of disclosure to peers. He did not want to access counselling despite the recognition that he was struggling.

Performance capacity

David's disability impacted on his ability to encode new information. He exhibited signs of anger and frustration and some challenges had been reported in his communication / interpersonal skills.

Environment

Enablers

David reported gaining support from his wife, he also had a support plan and so had accessed technology. David had also previously engaged other services prior to enrolling on the programme.

Barriers

David experienced delays in assessment of his needs and the provision of technology.

Occupational competence / occupational identity / occupational adaptation

David was experiencing an identity crisis – he was struggling to identify with OT philosophy, models and OT theory. He was also struggling with not appearing to fit with OT peers / profession nor with his previous careers and friends etc. David was struggling to achieve competence as an OT student and therefore struggling with occupational adaptation. Adaptation was linked to both his disability and adapting to the OT profession.

Hypothesis – without ‘intervention’ David may struggle to successfully complete the programme.

Valerie

Volition / Personal Causation / Values.

Valerie was highly motivated. She valued her roles as a ‘good’ mother, a worker and an OT student. She was optimistic and determined, reflective and self-aware. She was ‘damaged’ by abuse but focussed on study / education as a diversion / distraction from psychological distress.

Habituation

Valerie's roles included being a worker, student, mother, bread winner. The roles were frequently competing and demanding. She has completed some previous study and so has some understanding of the demands of the programme. She also has worker experience and knowledge and has completed a placement successfully. She has learnt behaviours, work and student well established patterns.

Coping strategies

Valerie had some coping strategies which supported her success including recognising the need to take time off work, being a strategic learner and a support seeker.

She used study as an avoidance mechanism to avoid tackling psychological distress.

Performance capacity

Valerie's low mood had impacted upon ability to study and she recognised a potential for self-harm whilst her mood was low.

Environment

Enablers

Support from APT, medication, counselling

Barriers

Threat of redundancy

Occupational competence / occupational identity / occupational adaptation

The threat of redundancy triggered an episode of mental ill health which impacted significantly upon Valerie's occupational identity. This therefore also impacted upon her occupational adaptation and led to the need to address issues of psychological wellbeing related to previous abuse. Valerie demonstrated that she was beginning to address her psychological distress but recognised that 'damage has been done'. She had however, completed all academic work and a placement successfully and was optimistic about the future. She was determined to be successful. Integrating her learning about herself and her situation into her future practice seeing the world as her oyster once qualified.

APPENDIX 10.17 Participant Vignettes Following Application of MOHO.

Applying the concepts of MOHO to each of the participants individually highlights the individual's potential to 'heal thy self' and develop occupational competence and adaptation.

Tracy, who was diagnosed with a SpLD at school, was well supported and developed adaptive coping strategies from an early age. She had a positive attitude to her disability believing that it offered her a different skill set. She had an openness to disclosure and whilst she had some concerns about future placements, she was highly motivated to achieve. Tracy was able to quickly utilize her previously learnt habits for studying and learning. Tracy actively sought support and made use of technology to minimize the impact of her SpLD.

Natasha, was challenged by the fluctuations and symptoms of her condition, her belief that she would have been 'better', her own perfectionism and her desire to prove her worth. She was however, highly motivated to achieve and demonstrated insight and recognised the importance of seeking and utilizing professional support in order to be successful. Natasha was also able to utilize previous habits but also with the professional support begin to reconstruct her study habits.

Tina, had successfully completed her degree but not without its challenges. Tina's condition was unpredictable and quite recently diagnosed when she began her studies. Following the onset of disability, Tina required a focus and routine to provide 'structure and predictability to life' (Wook Lee and Kielhofner, 2017; p62). Tina had, therefore, not only made the occupational choice to become a student Occupational Therapist but was also in the midst of adapting to her disability which provoked anxiety and fear in new situations. Tina proactively sought support from her peers and student support services but was frustrated by a perceived lack of support from academics whose attitudes she perceived were not underpinned by the philosophy of the profession. Tina was currently in the midst of making a further occupational

choice at the point of interview. She had yet to apply for her HCPC registration and as such appeared to be delaying working as a qualified Occupational Therapist. A further decision perhaps linked to fear and anxiety.

Hannah, experienced a significant mental health illness but had been recovering for 2 years prior to beginning her studies and becoming an OT student. The intervention she received during this time, alongside her development of her personal coping strategies, provided Hannah with the time and resources to make the occupational choice and be successful thus far in her training. Hannah had proactively sought support, as she felt necessary, enabling success. Hannah was highly motivated to become an Occupational Therapist and had developed successful patterns of study and engagement in the occupation of studying OT.

Carmel, had only just begun her OT studies and whilst appearing to be well informed regarding her SpLD and to have strategies in place to support her learning needs, she was experiencing significant challenges working with groups, an essential skill required by Occupational Therapists. Carmel appeared to be experiencing difficulties adapting her deep rooted habits. She, had developed a habituated pattern of learning and studying, as a result of understanding her diagnosis and identifying strategies which enabled her to be effective and successful. However, Carmel's habituated pattern of learning and studying was entrenched and 'resistant to change' (Wook Lee and Kielhofner 2017 p63) but incongruent with the habituated behaviours of the student group she was required to work with causing her distress and anxiety. Carmel had yet to complete a placement.

Robert, was very recently diagnosed with an SpLD but appeared to have been aware of the challenges he had faced prior to his diagnosis. Robert was keen following his diagnosis to access support available to ensure his success. He was highly motivated to become an OT and appeared to be developing habits associated with his academic study. He had yet to complete a placement.

Amanda, whilst diagnosed with an SpLD during her studies, also had insight into the challenges she had faced whilst completing a previous degree. Amanda had sought support and had many coping strategies she had developed during her previous studies and working career, which had enabled her to adapt well to her disability. She also had established patterns of studying and learning.

Andrew, since being diagnosed with a SpLD, in the second year of his studies to become an Occupational Therapist, had become more successful and adapted well as a result of support and the implementation of coping strategies. Andrew demonstrated an ability to develop new habits and routines and integrate these successfully into the occupation of studying OT. Andrew had successfully completed his OT degree and had initiated studying a Master's degree as a result of his new found confidence and self-efficacy.

Cathy, whose disability onset occurred at an early age, appeared to place herself at times within a culture associated with her disability but at other times appeared to reject a disability culture. Cathy had adapted well to her disability and was very aware of her rights. She actively advocated on behalf of herself and others and was highly motivated to be successful. Cathy had successfully integrated patterns of habituated behaviours into her study and placement activities and as a result successfully completed the OT degree and despite facing attitudinal barriers felt it was the best occupational choice she had made. Cathy was actively looking for an OT position and was extremely disappointed by what she continued to view as discriminatory employment practices.

Vicky, had only just begun studies and was experiencing significant difficulties. Vicky was previously diagnosed with a SpLD and had had 2 recent previous attempts at degree level study within the health and social care subjects. Vicky had successfully completed NVQ level studies and she felt that could experience success if given the appropriate support. Vicky's successes had occurred where she believed that staff working with her had followed her support plan. Vicky had experienced some challenges with

accessing 1:1 support and was very frustrated and disappointed by this, she had also attempted to meet seminar tutors on a 1:1 basis to gain support regarding her assignments but following the meetings admitted that she still did not understand the requirements, nor did she tell the tutor this. Vicky appeared to be ashamed by her diagnosis, she was not prepared to disclose to her family nor would she use her coloured overlays or Dictaphone within seminars as she did not want her peers to know. She appeared to be experiencing difficulties accepting and adapting to her diagnosis which was impacting upon her success. Vicky's performance capacity was reduced as a result of her memory and processing skills and her self-efficacy. Vicky may have been experiencing some regret of her occupational choice, although she remained determined that she wanted to become an Occupational Therapist. There appears to be a conflict between what Vicky deems to be 'reasonable' in terms of her adjustments and what is reasonably practical within HE settings. Whilst Vicky did not specifically discuss her previous adjustments she continually reported that academics had not followed her support plan and if they had broken the assignment requirements down in to understandable chunks she would be successful. There appeared to have been either a breakdown in communication between support staff, academics and Vicky in terms of the actual implementation of the support plan or that the adjustments required were too significant to enable Vicky to be successful. It was clear that Vicky would require significantly greater support and the development of coping strategies if she were to be successful. Vicky appeared to be struggling to reconstruct her what appeared to be ineffective habituated patterns of behavior related to studying OT.

David, had experienced a number of life changing events during a short period of time and he was in the process of adapting to his disability and condition, when making the occupational choice to become an OT student. David was adapting to his disability but also to his recent redundancy and a complete career change. His decision to become an OT student appeared to have been informed and well-motivated. He was however, experiencing challenges as a result of feedback he had received regarding his interpersonal skills. The feedback had prompted David to question his

occupational choice. David appeared to be experiencing challenges with his habits and performance capacity as a result of his condition.

Valerie, experienced an episode of mental ill health following the threat of redundancy. She also disclosed a history of domestic abuse which had significantly impacted upon her identity. Valerie's occupational choice was driven by desire for a better life for her and her children. Valerie was a highly motivated OT student, who had developed well habituated patterns of study. Whilst the onset of her mental ill health had affected Valerie's concentration and motivation, she had appeared to have regained her motivation, pleasure and satisfaction in studying through her level 1 placement, where she felt more confident and competent.