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# Professional resilience strategies utilized by occupational therapists to combat occupational stressors in health and social care settings

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## Abstract

*Purpose* The adoption of professional resilience strategies can foster and maintain career longevity in health and social care. This study investigates the professional resilience strategies used by occupational therapists to mitigate occupational stressors in workplaces and enhance career longevity.

*Method* Cross-sectional survey. Participants were occupational therapy practitioners with two or more years work experience.

*Results* The survey was completed by 494 occupational therapists from 29 countries. The most used strategies were: Maintaining a belief in the value of occupational therapy, taking time for reflection on positive outcomes, using personal time management strategies, and engagement in informal and formal professional support networks.

*Conclusions* While health and social care workplaces inherently include occupational stressors, implementation of professional resilience strategies at service-level practitioner-level strategies and education-level assist in mitigating stressors and strengthen professional resilience. The identification of the strategies experienced occupational therapists use to counter occupational stressors and maintain professional resilience may enable practitioners and organizations to adopt effective strategies. For employers, cultivation of work-based professional resilience strategies which mitigate occupational stressors could improve the retention of occupational therapists in the workforce.


## Introduction

Professional resilience is the ability of a practitioner to achieve a balance between occupational stressors and life challenges, while fostering professional values and career sustainability Fink-Samnick [1]. An exploration of professional resilience strategies used by occupational therapy practitioners is a key step because multiple occupational stressors contribute to job dissatisfaction and burnout within healthcare workforce [2, 3] and increase costs for employers [4]. The consequences of these stressors are a poor retention of practitioners, and the associated costs for employers of recruitment and retraining [5–7]. For the professions this leads to reduced practice wisdom (phronesis) [8] and a loss of accumulated clinical skills [9], a paucity of experienced supervisors and reduced clinical leadership.

While all health and social care professionals face challenges and experience occupational stressors in health and social care workplaces [10–12]. Occupational therapists experience additional stressors caused by professional marginalisation in settings where dominant discourses diminish professional identity and where the profession's core focus and domain of practice is inhibited or marginalised [13, 14]. These discourses include accepted bodies of knowledge and language that shape service-delivery and priorities in health and social care. They include biomedical [13], psychological discourses [15], social care, and educational discourses [2, 16]. They can influence occupational therapy practice by minimising the importance of occupation-based practices [14] and lead to practitioners experiencing the perception of poor professional status [3].

Pressure to adhere to these dominant practice discourses often creates a dissonance with professional paradigm which for occupational therapists is underpinned by an occupational perspective of health [14]. An occupational perspective refers to a focus on the necessary and desired occupations of an individual and enabling participation [17]. Pressure to adhere to biomedical and psychological discourses and subsequent tensions in teams contribute to occupational stressors and impacts on personal paradigms because although a profession's broader, paradigm shapes practice, an individual practitioner's personal paradigm may be changed by life experiences, and workplace experiences [18]. For occupational therapists this can be caused by reduced opportunities to the use discipline-specific models, concepts, and skills [15].

In addition, outcome-driven health settings and case management employment [19, 20] often result in pressure upon practitioners to perform genericised roles and to discharge clients within strict timeframes [2]. Subsequently, other common factors which contribute to burnout include unmanageable workloads, lack of autonomy, conflict with expectations and requirements of the organisation, and lack of respect from colleagues [3]. These factors contribute to stress and job dissatisfaction for occupational therapists through lack of time for client interventions due to large workloads, and lack of autonomy due to interdisciplinary and managerial pressures [21].

# Professional Resilience

Within occupational therapy there is a paucity of studies exploring professional resilience. Previous studies have focused on mental health practice and identified the importance of formal, and informal support networks. Informal networks provided opportunities for practitioners to reflect and learn from each other. In mental health practice supportive informal occupational therapy professional socialisation enabled shared reflection-on-practice, and modelling of effective coping strategies. Additionally, formal networking opportunities such as effective supervision reduced burnout by reducing the impact of occupational stressors [5, 22].

While multiple studies identify the occupational stressors which reduce professional identity, create a lack of job satisfaction and ultimately cause burnout there has been a paucity of research about the professional resilience strategies which enable practitioners to maintain career longevity. This is a key step in reducing the costs associated with poor occupational health, loss of productivity and the recruitment and training of new employees. Thus, this study aimed to better understand the professional resilience strategies utilized by the international occupational therapy community to combat occupational stressors.

## Method

This study utilized a cross-sectional survey method to collect date from occupational therapists using SurveyMonkey™. Ethical approval was provided by the University of Newcastle Human Research Ethics Committee (H-2017-0041).

## Participants

Participants were recruited through announcements on occupational therapy social media sites, online newsletters, and email invitations to 31 professional associations which contained a hyperlink to the online questionnaire. As the survey tool was only available in the English language, 31 World Federation of Occupational Therapists member organisations from predominantly English-speaking countries were contacted to assist in the recruitment of participants.

## Instrument

Data were collected using a study-specific questionnaire. It consisted of 39 self-reported questions across four broad sections: i) participant demographics, ii) current position, iii) factors shaping professional resilience, and iv) supervision and mentoring (see Appendix A). These sections were based on previous research which had identified occupational stressors [23], professional resilience [22] and burnt out [24] in occupational therapy populations. The survey tool was piloted on experienced practitioners who provided feedback about length and veracity of questioning.

Participant demographics were gathered through multiple choice and short answer questions, and Likert-scale and longer answer questions were included to investigate factors relating to professional resilience. Open-ended questions gathered reflections about workplace difficulties, use of professional resilience strategies, and experiences of professional supervision and mentoring. The section on professional resilience included questions on role clarity, professional relationships, use of occupation-based practice, workload and autonomy, and use of and satisfaction with a range of strategies identified in the literature review.

## Procedure

Participants opened the electronic link. Preceding the survey was a recruitment statement. This informed participants that participation in the study was voluntary, and that completion of the questionnaire would be considered consent for the study. All responses were anonymous. Data were used if respondents completed the demographic information but did not answer all subsequent questions.

## Data Analysis

Demographic data were summarised using descriptive statistics, and percentages were used to report categorical variables such as country, years of practice, speciality, and nature of role. Quantitative responses were further analysed using IBM SPSS (version 24; SPSS Inc., Armonk, NY: IBM Corp). Pearson Chi-squared test of independence determined association between country and use of professional socialisation (supervision and mentoring), and years worked and leaving the profession. For any analysis that violated the assumption of Pearson Chi-square test of independence, a likelihood ratio was used. Cramer's V was then used to determine the strength of association with 0-0.1 considered weak, 0.11–0.3 moderate and > 0.3 strong [25]. It is a measure of association between two nominal variables, giving a value between 0 and + 1 (inclusive). Qualitative data from open-ended questions about the "most stressful position" were coded and common themes determined using the methods described by Braun and Clarke [26].

## Results

Table 1 presents the demographics of the 489 occupational therapists from 29 countries who completed the survey. While 100 responses contained missing data, these surveys were included in the overall analysis for questions completed. Twelve countries had one respondent, and nine had four, or less respondents these countries are represented in the results as 'other'. Occupational therapists from Australia comprised the largest respondent group by country (46.9%, n = 229) followed by United Kingdom (n = 112), United States (n = 63). Respondents were predominantly female (90.2%, n = 441/489), with a mean of 13.6 (SD, 10.2) years' experience and the majority had an average of 4.9 occupational roles during their career.

Table 1
Demographic Information of Respondents

| Country (N) | % | Gender (n) | | | | Age (n) | | | | | | Years Worked as OT (n) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Female | Male | Other | Not stated | 20–30 | 31–40 | 41–50 | 51–60 | 61+ | Not stated | 2–5 | 6–10 | 11–15 | 16–20 | 21 |
| Australia (n = 229) | 46.8 | 213 | 15 | 0 | 1 | 65 | 82 | 47 | 33 | 2 | 0 | 58 | 43 | 39 | 38 | 51 |
| United Kingdom (n = 102) | 20.9 | 91 | 10 | 0 | 1 | 24 | 39 | 25 | 12 | 2 | 0 | 41 | 24 | 8 | 15 | 14 |
| United States (n = 62) | 12.7 | 59 | 3 | 0 | 0 | 6 | 23 | 14 | 12 | 6 | 1 | 20 | 9 | 5 | 8 | 20 |
| Canada (n = 36) | 7.4 | 35 | 1 | 0 | 0 | 6 | 11 | 4 | 14 | 1 | 0 | 10 | 3 | 3 | 6 | 14 |
| New Zealand (n = 18) | 3.7 | 14 | 3 | 1 | 0 | 3 | 7 | 5 | 3 | 0 | 0 | 2 | 5 | 2 | 4 | 5 |
| Ireland (n = 5) | 1.0 | 5 | 0 | 0 | 0 | 1 | 3 | 1 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 1 |
| South Africa (n = 4) | 0.8 | 4 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 1 | 3 | 0 | 0 | 0 |
| Chile (n = 3) | 0.6 | 0 | 3 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 |
| Greece (n = 3) | 0.6 | 3 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| Hong Kong (n = 3) | 0.6 | 2 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 |
| India (n = 3) | 0.6 | 2 | 1 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 0 |
| Indonesia (n = 2) | 0.4 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| Israel (n = 2) | 0.4 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| Japan (n = 2) | 0.4 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Malaysia (n = 2) | 0.4 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| Belgium (n = 1) | 0.2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| China (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Denmark (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| France (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Mexico (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Palestine (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Philippines (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Puerto Rico (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Saudi Arabia (n = 1) | 0.2 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Taiwan (n | 0.2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| = 1) | | | | | | | | | | | | | | | | |
| Trinidad (n = 1) | 0.2 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| United Arab Emirates (n = 1) | 0.2 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Not stated (n = 1) | 0.2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Total % (n) | 100.0 (489) | 90.0 (440) | 9.0 (44) | 0.4 (2) | 0.6(3) | 23.9 (117) | 36.2(177) | 21.2 (104) | 15.7 (77) | 2.5 (12) | 0.4(2) | 71.2(348) | 22.9 (112) | 3.5 (17) | 0.8 (4) | 1.( (8 |

Table 2 presents the respondents' practice contexts. Due to the scope of current occupational therapy practice, it was not viable to provide categories for all international areas of practice and roles of practitioners, therefore respondents that selected 'other' represented the largest group. Paediatrics was the most common current area of practice (n = 61/472, 12.9%), while the smallest sector was aged care (4.9%, n = 23).
Most respondents (n = 285/462, 61.7%) identified their current primary role was 'occupational therapy intervention and assessment. Over half worked in the public sector (n = 267/472, 56.6%). Three quarters (n = 358/471, 76%) of respondents were on permanent tenure. The mean hours worked per week were 35.5(SD, 10.4), with 19.8% (n = 93/470) working more than 40 hours in an average week. Most worked in a multidisciplinary team (n = 380/471, 80.7%) with at least one other occupational therapist (n = 238/470, 50.6%). Half of all respondents (50.6%, n = 238/470) had considered leaving the occupational therapy profession; the most common reason identified was workplace related reasons (39.5%, n = 98).

## Workplace Occupational Stressors

The experience of common workplace stressors for occupational therapists was measured on Likert scales and Fig. 1 presents responses for each country. Overall, the most common stressors respondents agreed with were: "I invest too much energy into my role" (n = 258/451, 57.2%), "there is a lack of occupational therapists in my workplace (n = 199/451, 44.1%), "I experience pressure to work outside of my domain or role" (n = 191/451, 42.4%).

Respondents agreed with the following statements: "I am able to control my workload" (n = 231/452, 51.1%), "I am able to maintain a work/life balance (n = 276/452, 61.1%), and that "my role is understood by most team members" (n = 332/451, 73.6%). There was a strong association between years worked as an occupational therapist and considering changing profession ($C^2(3) = 17.0$ $p < 0.001$). In response to being asked if they had considered leaving the profession 37.4% who had worked between 2–9 years reported that they had considered leaving the profession. This was also 37.0% for 10–19 years. There was a reduction to 16.0% in the 20–29 years worked group and only 8.8% in the 30 + year group.

Analysis of qualitative responses to the open-ended questions in the survey identified 8 themes. The most common themes were i) difficulties in managing clinical and ii) non-clinical duties and dissatisfaction with service provision due to lack of time. Other common themes were iii) difficulties within staff or team, iv) challenging clients or families, v) size and complexity of caseload, vi) inability to engage in occupation-based practice, vii) lack of understanding for occupation-based perspective, and viii) role blurring.

## Strategies for Professional Resilience

Table 3 presents the professional resilience strategies utilized in practice. The most common factors and strategies reported as fostering professional resilience were: a supportive home environment (n = 392/452, 86.7%), utilising breaks and annual leave (n = 340/452, 75.2%), professional socialisation (n = 368/452, 81.4%), engaging in professional development (n = 362/452, 80.1%), maintaining professional boundaries (n = 322, 71.3%), using time management strategies (n = 373/449, 83.1%), reflecting on positive outcomes (n = 381/452, 84.3%), and financial reward (n = 178/452, 39.4%).

Table 3

Professional Resilience Strategies

| | Strongly Agree % (n) | Agree % (n) | Undecided/ Not Sure % (n) | Disagree % (n) | Strongly Disagree % (n) | Not Applicable % (n) |
|---|---|---|---|---|---|---|
| **Statements about current workplace** | | | | | | |
| I understand my role clearly (n = 452). | 56.9(257) | 39.4(178) | 2.4(11) | 1.1(5) | 0.2(1) | - |
| I have good relations with my team colleagues (n = 450). | 44.9(202) | 48.2(217) | 5.3(24) | 1.3(6) | 0.2(1) | - |
| I have the skills to be effective in my role (n = 451). | 40.1(181) | 53.2(240) | 4.9(22) | 1.8(8) | 0 | - |
| I can use occupational-based practices in my workplace (n = 452). | 38.1(172) | 51.1(231) | 6.9(31) | 3.5(16) | 0.4(2) | - |
| My role is valued by most team members (n = 450). | 32.9(148) | 48.4(218) | 11.8(53) | 5.3(24) | 1.6(7) | - |
| My role is understood by most team members (n = 451). | 25.9(117) | 47.7(215) | 12.2(55) | 12.4(56) | 1.8(8) | - |
| I invest too much energy into my role (n = 451). | 22.8(103) | 34.1(154) | 20.0(90) | 22.0(99) | 1.1(5) | - |
| Overall, I am satisfied with my role (n = 453). | 21.6(98) | 53.9(244) | 16.8(76) | 5.5(25) | 2.2(10) | - |
| There is a lack of occupational therapists in my workplace (n = 451). | 18.8(85) | 25.3(114) | 12.0(54) | 31.0(140) | 12.9(58) | - |
| I can control my workload (n = 452). | 15.3(69) | 35.8(162) | 12.6(57) | 26.5(120) | 9.7(44) | - |
| I experience pressure to work outside my domain or role (n = 451). | 13.1(59) | 29.3(132) | 13.3(60) | 37.0(167) | 7.3(33) | - |
| I can maintain a work/life balance (n = 453). | 9.5(43) | 51.4(233) | 17.0(77) | 18.5(84) | 3.5(16) | - |
| **Professional Resilience Strategies** | | | | | | |
| Supportive home life (n = 452). | 46.0(208) | 40.7(184) | 5.8(26) | 5.3(24) | 1.3(6) | 0.9(4) |
| A belief in the value of occupational therapy (n = 452). | 45.1(204) | 41.8(189) | 8.8(40) | 3.5(16) | 0.7(3) | - |
| An informal professional support network (n = 452). | 36.7(166) | 44.7(202) | 8.2(37) | 5.3(24) | 1.1(5) | 4.0(18) |
| Pursuing career building opportunities (n = 452). | 31.0(140) | 49.1(222) | 11.5(52) | 5.8(26) | 1.3(6) | 1.3(6) |
| Reflecting on positive outcomes (n = 452). | 29.0(131) | 55.3(250) | 10.0(45) | 4.4(20) | 0.7(3) | 0.7(3) |
| Maintaining an occupation-based focus (n = 451). | 27.3(123) | 45.5(205) | 16.0(72) | 9.8(44) | 0.9(4) | 0.7(3) |
| Personal time management strategies (n = 449). | 27.2(122) | 55.9(251) | 9.6(43) | 5.8(26) | 0.7(3) | 0.9(4) |
| Regularly utilising breaks and vacations (n =). | 26.3(119) | 48.9(221) | 10.8(49) | 9.5(43) | 2.2(10) | 2.2(10) |
| Setting boundaries and structure (n = 452). | 23.5(106) | 47.8(216) | 10.6(48) | 14.4(65) | 2.0(9) | 1.8(8) |
| Reflecting on professional values (n = 452). | 22.1(100) | 47.6(215) | 16.6(75) | 11.1(50) | 1.8(8) | 0.9(4) |
| Formal support from a supervisor (n = 450). | 20.0(90) | 42.7(192) | 11.3(51) | 14.0(63) | 5.1(23) | 6.9(31) |
| Reflecting on financial reward (n = 452). | 6.2(28) | 33.2(150) | 18.6(84) | 27.2(123) | 11.1(50) | 3.8(17) |

Of the professional resilience strategies utilized in current workplaces, the largest proportion of respondents (n = 393/452, 86.9%) agreed that 'a belief in the value of occupational therapy' mediate work-related stressors, followed by a 'supportive home life' (n = 392/452, 86.7%), 'reflecting on positive outcomes' (n = 381/452, 84.3%), 'personal time management strategies' (n = 373/449, 83.1%), 'an informal support network' (n = 368/452, 81.4%) and 'pursuing career building opportunities' (n = 362/452, 80.1%) (see Table 3 for all strategies).

# Professional Supervision and Mentoring

As presented in Table 3, 62.7% (n = 282/450) agreed that formal supervision was a professional resilience strategy that mediated work-related stressors with 86.0% (n = 277/322) agreeing that it was beneficial. Of the 332 respondents who utilized professional supervision during their career, 72.9% (n = 242) had received supervision within the last 6 months. The reasons provided by the 21.2% (n = 93/450) of respondents who had never accessed professional supervision were primarily that it was not available, or not necessary. There was a significant, strong, association between the country of practice and whether professional supervision was received ($C^2$ (5) = 63.9, $p < 0.001$). Those who had never used professional supervision were predominantly from Canada (59.4%,) and the United States (46.2%).

Of the respondents who reported never utilizing supervision, 40.9% (n = 36/88) stated they had access to mentoring. In contrast there was no significant association between country and having access to mentoring ($C^2$ (5) = 3.8, $p < 0.58$,), with 58% (n = 236/407). Of those access mentoring 70.1% (n = 155/221)

reported they utilized it as needed. The majority of respondents (n = 200/218, 91.7%) who reported utilizing mentoring agreed that it was worthwhile. In response to an open question asking respondents to outline experiences of mentoring, responses included that they enjoyed the informal nature of it, that their mentors provided encouragement and boosted confidence, provided guidance and support, and that the process allowed respondents to debrief.

## Discussion

This study identifies the professional resilience strategies used by experienced occupational therapists to counter occupational stressors and maintain professional resilience. These professional resilience strategies can enhance career longevity; over half of the experienced practitioners in the survey had considered leaving the profession during their careers but remained by using a range of strategies.

# Professional Resilience Strategies

The professional resilience of occupational therapists is diminished when there is an inability to maintain a work life balance and there is a need for excessive investment of effort and energy in work. When practitioners have large, unmanageable workloads and resultant lack of time for occupational therapy it impacts on professional resilience. This is often caused by insufficient numbers of occupational therapists in workplaces, pressure to work outside domain or role and an inability to control workload [2, 3]. The protective professional resilience strategies to mitigate these stressors were trying to maintain boundaries, negotiating workload and the development of time management skills. It was also considered important to take available leave and to have a supportive, family life. Practitioners report that ongoing, unmanageable workloads lead creates a dissonance between occupation-based practice and service productivity demands leading to marginalization of occupational therapy practice and job dissatisfaction. This finding supports the work of Wressle and Samuelsson [19] identified that for health professionals 'working at a superficial level due to lack of time' is stressful.

The occupational stressors of excessive time spent on non-clinical duties eroded professional resilience. Thus, organisational steps to improve investment in systems and procedures which reduce time spent on reporting can alleviate these stressors. Practitioners indicate their enhancement of time management skills was a professional resilience strategy which mitigates the high clinical workloads associated with high stress, job dissatisfaction [19, 27, 28] and burnout [24]. While larger organisations often provide training for occupational therapists these skills can be taught in entry-level programs and reinforced by training opportunities through professional organisation.

The current study indicates that the ability to use of occupation-based practice and achieve positive client outcomes is associated with wellbeing at work and can mitigate the impact of other workplace stressors [20]. At a practitioner-level strategies which sustain professional resilience are the maintenance of an occupation-focus through ongoing education, intentional use of discipline-specific skills and theory, and skills in advocating for occupation-based practices. This is of particular importance in practice areas such as mental health, where there is often pressure to perform a generic health worker role which inhibits practitioners from engaging in occupation-based practices [15].

The findings reinforced that management strategies which encourage supportive teamwork are paramount in health and social care settings. Organisations seeking to retain practitioners need to ensure they support all professionals when they are sole therapists or in a minority within teams as professional isolation is a key occupational stressor. Indeed, this can improve recruitment as practitioners select positions which have strong professional networks within a workplace [12, 22, 29]. Additionally, retention is improved by supportive workplace environments, which include supportive management policies and responsive, respectful colleagues [7]. Indeed, promotion of staff cohesion and positive relationships which reinforces being a valued team member are integral to retention of all health care workers [10, 11, 30].

For retention rates to improve it may be necessary for health and social care organisations to adopt recommendations to ensure workplaces provide effective management, opportunities for career progression and a supportive workplace culture [12].

Professional resilience and career longevity are sustained by knowing when it is time to resign from jobs with 30% of experienced practitioners reporting that they had left a workplace to avoid burnout. For employers and managers, it is important to note that for practitioners who had resigned from positions reported resignation was a last resort. Resignation occurred only when they experienced cumulative negative experiences resulting from a lack of leadership, role blurring, and lack of validation. These negative experiences reflect the issues found in other studies which explore professional burnout and causes of lack of job satisfaction [6, 7, 27]. The time frames indicate that managers and supervisors have time to rectify these issues as leaving only occurred when practitioners perceive they have no agency, or support from managers to make changes.

Collectively, the findings indicate that while practitioners can implement strategies an organisational, managerial approach to rectifying these problems could maintain workforce retention and reduce recruitment costs [12]. Indeed, Opoku et al. [12] argued that in health and social care improved leadership and validation of discipline roles can reduce the impact of occupational stressors. Furthermore, implementation of training for managers should be a key strategy for those concerned with workforce stability in health and social care. In addition, employers seeking to improve retention should consider the implementation of strategies which enable, support, and validate evidence-based, occupation-based practices, and reduce the pressure to work outside of professional domains and expertise. Other issues needing to be addressed are civility and valuing of all perspectives [3].

Key organisational-level steps involve organisations employing sufficient staff to meet workload as an insufficient number of occupational therapists within a workplace was a key stressor. This inevitably leads to the allocation of additional tasks and larger workloads increases stress and dissatisfaction, and likelihood of staff turnover. The imperative for occupational therapy managers and employers to consider the evidence which supports employing more practitioners is cost effective, improves services [31] and overtime may reduce recruitment and retraining costs.

# Professional Supervision and Mentoring

For all locations and particularly where recruitment and retention are difficult, employers can activate formal and informal professional socialisation opportunities such as monthly meetings for occupational therapists as these contribute to professional resilience [22]. Shin et al. [5] also identified the role of supervision in mitigating occupational stressors and reducing burnout and argued for 'structural and organizational changes to counter consequences and promote a productive and thriving occupational therapy workforce.' Although the importance of supervision as a professional resilience strategy was confirmed by the current study, it is important to emphasise that not all supervision was regarded as effective as over 30% of practitioners did not consider it to be a professional resilience strategy. Also of concern was that over 20% of practitioners in the study reported never receiving supervision. The perception of the effectiveness of supervision as a professional resilience strategy was diminished if practitioners had negative experiences of supervision focused only on the managerial aspect of Proctor's three-function interactive model of supervision with formative (educational) and restorative (pastoral support) omitted. While effective supervision should include time for reflection-on-practice [32] workplaces have shifted away from supportive and educational supervision due to increased service pressures which reduces "the restorative aspect which involves supporting personal wellbeing" (p. 2). The number of practitioners not utilising supervision may be problematic as professional socialisation and professional supervision support the maintenance of professional identity, assist practitioners to learn and reflect, and build cohesive teams [33].

The results indicate that policies and national guidelines are transformative for ensuring supervision is accessed by practitioners. In several countries registration agencies stipulate the minimum number of hours spent annually in supervision. The mandatory nature of registration means that supervision is then prioritised by employers and practitioners. Indeed, there was a strong association between country of practice and whether practitioners had professional supervision. Practitioners from countries with practice guidelines and registration requirements for supervision such as Australia [34] and New Zealand [35] had higher rates of supervision compared to Canada and the US [36] where supervision is recommended but not mandatory.

Mentoring was accessed by 59.3% of respondents and unlike professional supervision had no association with country. The use of mentoring as a strategy to support professional resilience provided an informal and enjoyable event for encouragement and support, and cherished opportunities to debrief. Doyle, Gafni Lachter [37] argue that the advantage of mentoring is that it provides practitioners with a perspective from outside of their organisation and is a source of advice on longer term career planning. As a form of professional socialisation it provides validation and support for those not receiving effective supervision, or who work as sole therapists [22]. Rather than use mentoring and supervision as ongoing restorative strategies some experienced practitioners appear to access them when it is perceived as a need rather than a regular means of maintaining their professional resilience. This is problematic as Shin et al. [5] identified that supervision reduces burnout. More research is required into what factors contribute to effective mentoring and supervision as a professional resilience strategy.

# Limitations

It is acknowledged that this is an exploratory international study as the sample size was 489 and that participant responses were shaped by health and social care policies within country. While online surveys allow recruitment of the greatest number of participants a limitation was that made it impossible to predict the total sample size. It is also acknowledged that convenience sampling using social media may have resulted in sampling bias. While the authors accessed members of national professional associations who did not require formal membership, or payments this did limit recruitment. It is also acknowledged that although practitioners from 29 countries responded participation was limited because the survey tool was only available in English due to costs of translating. This limits the representation of non-English speaking practitioners. In addition, the small response sizes from some countries limited the statistical analysis able to be performed due to inadequate numbers for analysis of variance (ANOVA). These limitations mean that the findings are skewed to reflect practice issues in English speaking countries.

## Conclusion

The study provides a greater understanding of the strategies used by experienced occupational therapists to foster and maintain their professional resilience. While health and social care workplaces inherently include occupational stressors, implementation of professional resilience strategies at service-level practitioner-level strategies and education-level may assist in mitigating stressors and strengthen professional resilience. For employers losing experienced occupational therapists creates instability in the work force, creates costs in recruitment for organizations and lead to a lack of experienced practitioners to supervise graduates. The targeted reduction of stressors by employers combined with the promotion of effective workplace professional resilience strategies may assist in sustaining workforce retention.

Employer-level strategies can include responsive management, promotion of occupational therapy, provision of breaks and vacations, access to education and professional development, and prioritisation of professional supervision. Practitioner-level strategies include setting clear workload boundaries, fostering professional identity through socialisation, extending knowledge of how to assertively argue for occupation-based practices, improving time management strategies, to maintain occupation-based personal paradigms seeking effective supervisors who support reflective practice, and by accessing mentors who can provide support and advice on occupation-based practice development.

At an educational-level, entry-level and post-graduate curricula can provide practitioners with foundational skills for the development of professional identity and curation of professional resilience strategies. National professional associations for occupational therapists can also foster training and educational options which nourish professional resilience by expanding knowledge on how to sustain professional identify through occupation-based practices.

## Declarations

**Declaration of interest:** The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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## Table

Table 2 is available in the Supplementary Files section.

## Appendix A

Appendix A is not available with this version.

## Figures

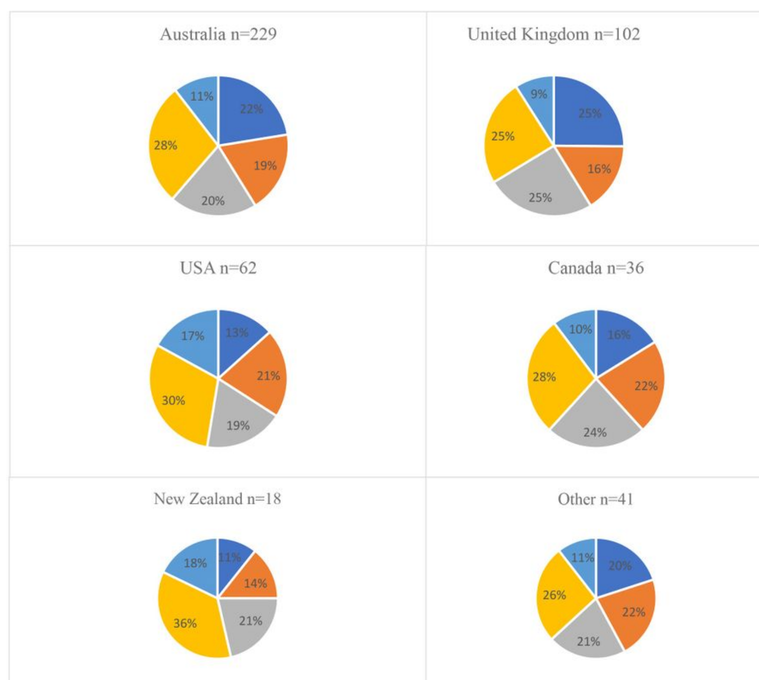


**Figure 1**

Occupational Stressors by Country

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Table2.docx