The use of validated work stress and resilience assessment tools: A mixed method study of their applicability and understanding in the OT workplace

Introduction

Occupation Therapy (OT) is a dual physical and mental health trained profession, that takes an holistic approach to enabling a person to overcome complex and dynamic challenges thorough participation and engagement in activities of daily living that matter to them. The current *NHS Long Term Plan* foregrounds key OT principles of person and occupation-centred practice to encourage the population to manage their own well-being (NHS England, 2019).

The most recent Royal College of Occupational Therapists (RCOT) workforce survey (RCOT, 2023) highlights OT as 'under huge pressure' due to the specific challenges of increased demand at a time of workforce shortages. The increased demand is occurring from increases in both the number and complexity of demand for services.

Resilience has been identified as a key strategy to manage work-related stress, attrition and long-term well-being of staff in healthcare and workplace sustainability (Roundy et al., 2023). However, it should be noted at this point that is no one universally accepted definition of resilience, it is a contested concept. Variation in perspectives, could be problematic for organisations. Therefore, it could be argued that resilience as a definition may not applied uniformly in the NHS, which makes it challenging to objectively measure outcomes of any intervention or training in relation to this construct (Ollis *et al,* 2022).

This study aims to provide evidence to inform OT leadership and management practices in relation to resilience. The key aims of the research are:

1. To analyse the applicability of validated work stress and resilience assessment tools to the OT workplace.
2. To explore OT's understanding and experiences of the meaning of work stress and resilience, and their use of validated work stress and resilience assessment tools

3. To inform current OT leadership and management approaches to work stress and resilience.

Literature Review

The OT workforce is ‘under huge pressure’ due to the specific challenges of increased demand at a time of workforce shortages, which contributes to these workplace stresses. These workforce pressures are reflected in studies showing reduced satisfaction, attrition and subsequent stress and burnout in the OT workforce (Mertala et al., 2022), as well as limited professional identity and role satisfaction (Walder et al., 2022). Additionally, OT is a physical, cognitively and psychologically demanding role, which has been observed as leading to workplace fatigue and emotional exhaustion, which are known associated characteristics of burnout (Brown et al., 2017). This very likely has an effect on quality of patient care, service delivery and meeting professional practice standards (Care Quality Commission, 2022). The growing and ageing population of the UK (Department of Health and Social Care, 2023) suggest that these pressures will remain as an ongoing challenge, and likely exacerbated by the financial pressures with the NHS.

There have been variety of supporting clinical guidelines, quality standards, strategies and models to facilitate workforce well-being in the NHS (NICE 2022). The report by Lord Darzi is the most recent example of the need for strategies to manage workplace stress (DHSC, 2024). The evidence is that there is no universal approach to workplace well-being, with varied implementation of macro drivers at a local level, as organisations take different stances in their people and well-being strategies (NHS Employers, 2022). This can include restorative supervision, stress-management including stress risk assessments, counselling, Schwartz rounds, resilience training and mindfulness (Trust withheld, 2022). Many of the leadership approaches and management strategies appear to have elements of workforce resilience attributes embedded within them, also appearing dependent upon clinician’s self-awareness of workplace stressors. For example, the most recent well-being model does not specify resilience but does promote well-being conversations, appearing to have many characteristics linked to resilience promotion (NHSE, 2021). Despite

this prominence, the NHS does not appear to have a systematic approach to resilience, meaning that the variation in delivery within NHS organisations could be vast dependent upon on an organisations' specific perspective on resilience. The significance of this was highlighted during discussion with lead researcher's organisation's external resilience training provider. It was clear that the trainer and researcher had differing views on what resilience meant to them, which could influence the delivery and outcomes both positively and negatively. This is of concern as a generalist approach with differing levels of self-efficacy, emotional regulation, all having different professional and personal values could then impact upon professional identity and integrity going forward. This may limit the beneficial outcomes to team members participating in the resilience training. This is surprising considering the emotive and personal nature of the construct (Richard, 2020).

Additionally, although there is significant literature regarding resilience in healthcare, particularly post-pandemic, there are differing perspectives regarding the notion, with no single universally accepted definition (Zanatta et al., 2020). Discussion and disagreement relate resilience to be either a 'relatively stable character trait', meaning dependent on the characteristics of the individual, or 'a developmental state which is not static, fixed, or immutable' contextual based, meaning dynamic and situation specific and influenced by the interaction between the physical, social and environmental context (Ollis et al., 2022:650). For the purposes of this research, resilience is conceptualised more in line with the former. This means that resilience requires an individual to have specific personality traits to be able to accept resilience for it to work. For resilience to prosper, the individual would need to accept resilience as a reality. However, as individuals are relational and need to accept resilience, values can differ and misalign with resilience, which creates complexity and is perhaps why it is a contested construct. The effectiveness of resilience could also be influenced by the organisation, their personal or professional values, or indeed how much an organisation's culture promotes resilience as an objective reality. This is a positivist conceptualisation of resilience as an objective reality, despite this being a contested concept (Masten and Obradovic, 2006; Ashby, 2013; Cade, 2023; Vivolo *et al*, 2024).

There appears to be very little research relating to OT and the promotion of resilience, with much of the focus in literature conducted with medics and nursing. Two recently conducted specific OT studies in relation to resilience were identified (Ashby et al., 2024; Popova et al., 2023) but neither study was conducted in the UK, have a much wider target audience and significant variation in research methods. Therefore, limited conclusions could be drawn, as the findings may not be representative of the UK based OT population, with potential variation in organisational policies, approaches and culture influencing generalisability.

Method

Study participants and sampling

The setting for the study was an acute and community NHS organisation set within a rural county in the UK within which the lead researcher is employed. The study population was 66 HCPC registered OTs the across acute and community services. A non-purposive, convenience sampling approach was taken. The study was not open to non-registered members of this OT service. This meant that all respondents were known to the interviewer, as a service manager. This approach may impact the studies generalisability as outcomes may not be representative of the wider OT population.

The lead researcher requested access from the organisation to invite staff to take part in the research, which was granted. The lead researcher sent out an email invite to the study population to take part in the research. Participants who responded to the email regarding their interest in taking part in the study were then sent in reply, including information to enable them to have informed consent to take part in the study.

The research utilising a mixed method approach. This comprised of a self-administered, almost wholly structured questionnaire with the 3 standardised work stress assessment tools, and a semi-structured interview. These two

methods of data collection have been utilised to optimise validity and provide detail of perspective, with the use of triangulation (Noble and Heale, 2019).

Structured questionnaire

The structured questionnaire was divided into two parts. The first part requested information on participants' demographic and work history, and also included an open question asking participants their understanding of resilience. The second part included for completion 3 standardised work stress assessment tools: the Brief Resilience Scale (BRS), the Work Resilience Scale (ReWoS-24), and the Work Stress Screener (WoSS-13). These scales were free and accessible to the researcher, with relevant permissions for use sought and received.). A review of these scales reflected varying standards, inconsistencies and limited evidence bases of the measures available across different populations (Näswall et al., 2019), which was the rationale for including all three.

The BRS is utilised to gain an understanding of respondent's perceptions of their ability to 'bounce back' (Smith et al., 2008). McKay et al. (2021) identified the scales as having validity and reliability for use by clinicians for the measure of resilience. The WOSS-13 and ReWoS-24 work in conjunction to measure experiences of stress and resilience in the workplace, at an individual and team level. This provides insight into 2 main different types of work stress, namely *benign* work stress and *malignant* work stress. Elfeddali et al. (2022: 231) provide a clear distinction between these 2 types of stress, with benign work stress defined as experiencing stress as 'a challenging circumstance inviting total focus on a task, that can result in active engagement and meeting the challenges that one faces at work… a kind of stress which can result in reward'. This is in contrast to 'malignant' work stress, which they define as stress that 'can be associated with burnout, depressive and anxiety symptoms, physical symptoms, and decreased work productivity or sickness absence' (p.231).

The questionnaire access and time frame for completion was over a three-month period, as from experience this was required to optimise respondent

numbers due to the nature of participant's workloads. Use of the self-administered questionnaire enabled flexibility to participants and efficiency for the researcher. It was viewed as the least invasive to the participant to complete the questionnaire at the most convenient time for them, increasing likelihood of response. Information was provided on the average completion time when tested by the researcher, as studies indicate participants are unlikely to spend lengthy amounts of time completing online surveys to minimise non-response rates (West et al., 2023).

Semi-structured interviews

Participants who completed questionnaires were given the option to participate in a subsequent online semi-structured interview. Data from the online questionnaire supported the development of indicative questions for the semi-structured interviews. Utilising this method enable a deeper understanding and more complete answer to the research questions (McKenna et al., 2021).

Four pilot interviews using outcomes of the screening questionnaire were undertaken. Piloting the interview enabled sense checking to ensure participant comprehension and reduce ambiguity in relation to use of language (Clark et al., 2021), as well as analyse and mitigate the potential of interviewer effects.

All interviews were using MS Teams, with the exception of one which was completed face to face upon choice and convenience of the participant. The use of the MS team's online platform recognises this has been a norm in OT since the Covid-19 pandemic, and so there were no concerns that this would influence the context (Self, 2021). Digital recordings were transcribed with any participant, team or geographical identifiable data removed to maintain confidentiality. 20 respondents agreed to participate in a semi-structured interview. Interviews continued until data saturation was evident to the researcher (Clark et al., 2021). 15 interviews were completed and transcribed.

Data Analysis

The data collected from the structured questionnaire was subject to descriptive data analysis. Nominal data has been converted into interval data to present correlations found in variables.

The interviews were analysed utilising Braun and Clarke's 6-stage structured framework for thematic analysis (TA) (Braun and Clarke, 2021). TA was utilised to provide transparency and flexibility in demonstrating emergence of themes, to support interpretation of findings.

Ethics

Prior to commencing the research, Health Research Authority checklist was completed. This confirmed the NHS Research Ethics Committee approval was not required for this study. Upon ethical approval for the research, participants were provided with a Participant Information Sheet (PIS) and Privacy Statement, which detailed the full research process, to confirm their participation in the research.

The lead researcher had the dual role as both investigator for the researcher and manager to research participants. This meant that the lead researcher knew all the participants prior to their participation in the study. The research team identified that researching participants from within the same service that you manage could raise ethical issues and challenges (Clark *et al*, 2021). A particular issue identified in this research was maintaining a non-biased stance to ensure that what was said in the interviews or from the responses provided in the questionnaires was not tainted by what was known outside of the research process about either participants or the wider context. The research team identified pilot testing the research as a way to mitigate this possibility, as it enabled the lead researcher to reflect on identify where potential issues could occur, and also enabled discussion as a research team to on these issues. Additionally, in order to further mitigate the risk of bias that could occur, the researchers identified the following as specific ways to limit this:

- making it clear at several points in the PIS that participation was wholly voluntary and not mandatory, and not in any way linked to their employment;
- the researcher using their university email address rather than their work email address for correspondence with research participants, and sending correspondence to participants to their preferred email address;
- sending a single email to staff advising them about the research, and not sending any follow up or 'chasing' emails in relation to the participation in the research, unless participants chose to participate;
- stating clearly in the PIS that information provided in the research process would remain confidential throughout the process;
- stating clearly in the PIS that there would be anonymity in relation to the identification of raw data material / content of questionnaires and interviews that would identify them specifically;
- stating clearly in the PIS and during the interviews that the lead researcher was under no obligation and would not discuss their individual contribution within the organisation, and that information provided would not have any implications to them working within the organisation;
- providing participants with the right to withdraw from the study at any time, either via contacting the researcher or via the researcher's supervisor if they did not wish to or feel comfortable to contact the researcher in relation to this matter.

Findings

Self-completed online questionnaire

Respondent characteristics

A total of 36 people out of a possible 66 participants showed an interest in the study, a response rate at 54% which is higher than the average online survey response rate of 44.1% (Wu *et al*., 2022).

Table 1 displays the breakdown of respondent characteristics from the questionnaire. 94% of respondents were female and 6% were male, reflective of the profession’s female imbalance.

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Table 1. Cross Tabulation of Respondents Characteristics from Online questionnaire

Age Range	Average Sickness Episode	Average Number of Hours Worked	Average Number of Clinical Years in Practice
25 - 30	2.14	34.3	12.5
31 - 39	1.84	29.4	7.5
40 - 49	2.12	25.9	7.7
50 - 59	2.64	33.9	6.95
60 - 69	2.5	30	17

This indicates respondents aged 25-30 and 50-59 work a higher number of hours on average comparatively. Those working the least hours on average per week are aged between 31-49. However, those aged 50-59 have a higher average sickness rate, with the least clinical experience. The average number of clinical years in practice suggests several mature students entering professional practice.

The questionnaire included an open question asking participants 'What does resilience mean to you – how would you describe / define this?' All respondents reflected variation in the meaning of resilience, mostly attributable to negative experiences. This supports the argument of resilience as a contested construct, as discussed previously. However, there is communality in indicating resilience as individual, experiential and developing over time, with the view that resilience can be enabled rather than taught.

Brief Resilience Scale (BRS)

The BRS was utilised to gain an understanding of respondent's perceptions of their ability to 'bounce back'. Table 2 provides a tabulation of participant's

scores. The overall average BRS score was 3.50, indicating a 'normal' level of individual resilience for most respondents of their ability to 'bounce back'. This is similar to Popova et al.'s (2023) findings, despite their data being gathered during the Covid-19 pandemic. Interestingly 3 respondents had completed resilience training, yet their BRS score reflected 'low' resilience.

Place Table 2 here

Table 2. BRS scores of participants

BRS Score Interpretation	Category	*n*	%
1.00 - 2.99	Low Resilience	8	22.2
3.00 - 4.30	Normal Resilience	21	58.3
4.31 - 5.00	High Resilience	7	19.4

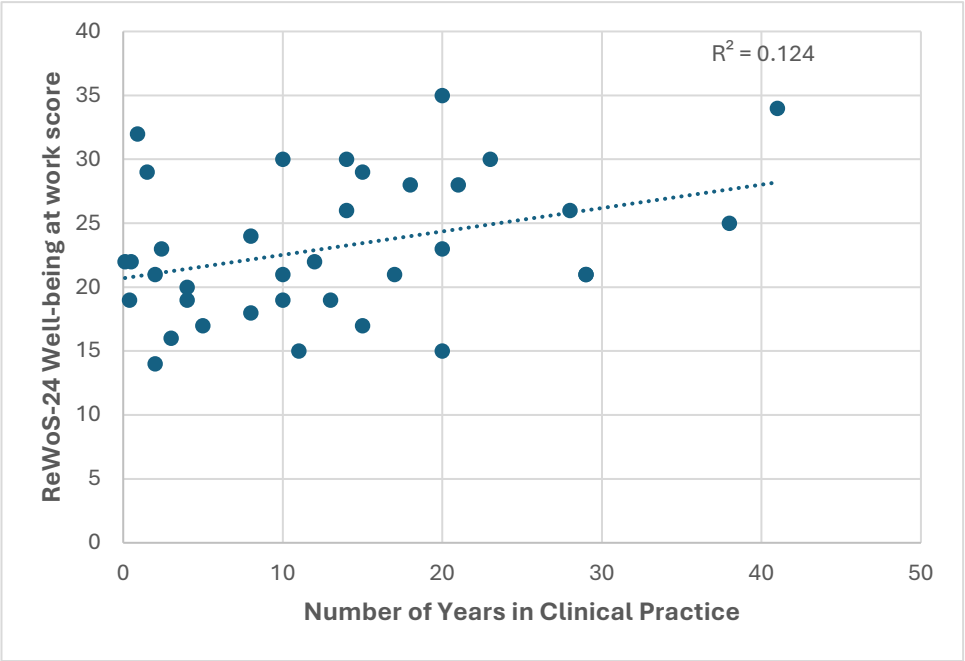
Resilience at Work Scale (ReWoS-24)

Participants expressed a good level of well-being, with over 50% of respondents expressing feeling generally well and healthy for more than half the days in the 2-week period, 39% feeling well rested and 92% feeling able to be flexible, gain perspective and cope with workplaces challenges. 90% of respondents felt a sense of responsibility and perseverance, suggesting a high level of satisfaction.

Findings suggest a weak positive association between those with more experience in practice have an increased level of work-well-being (Graph 1). There appears to be a reduction in average scoring between graduation and 5 years into practice. Graph 1 also shows a reduction in motivational stress (WOSS-A), which is reflected in the reduction of general, work-well-being and job satisfaction. However, the average malignant stress does not change until 6-10 years into practice, where there is a reduction in motivational work stress, general well-being, and an increase in malignant stress. This could be linked to role and demand conflict with external stressors.

Place Graph 1 Here

Graph 1. Correlation between well-being at work and years in clinical practice

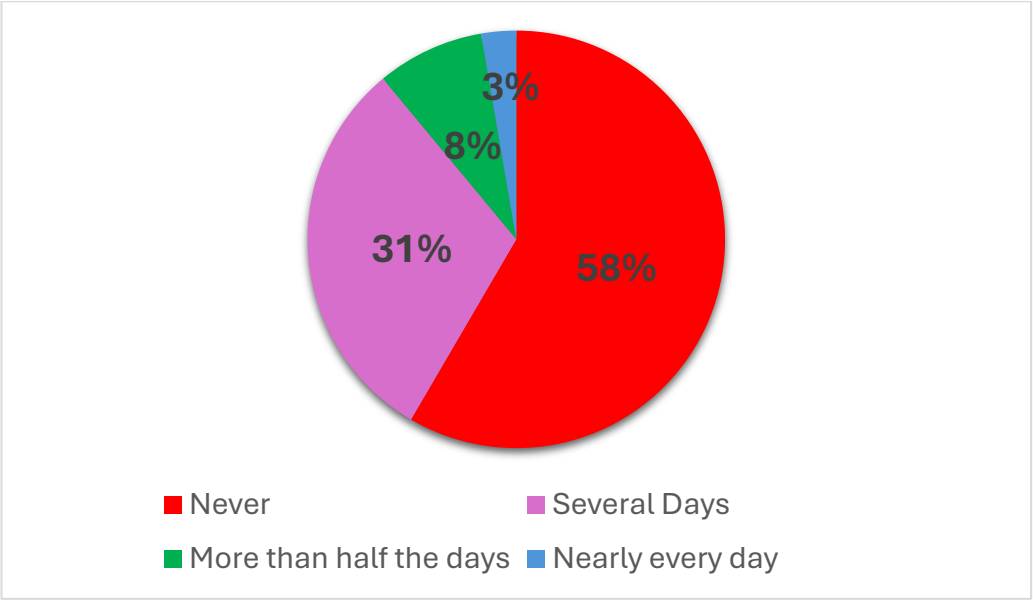


Work Stress Screener (WOSS-13)

53% of participants felt positively challenged and 47.2% felt committed to work nearly every day. Only 19% of participants indicate a high benign stress, all of whom have high or normal individual ReWoS-24. Most participants expressed never experiencing low job satisfaction, with only 3% expressing low job satisfaction every day, as shown in Graph 2.

Place Graph 2 here

Graph 2. Participants' experiences of low job satisfaction



The general findings from the questionnaire imply respondents having a 'normal' level of resilience at both individual and team level. Overall, the type of stress demonstrated was benign with little malignant stress. There is individual and team workplace resilience, suggesting the OTs have positive motivations, commitment to their work with what appears to be limited harmful stress. This suggests the OTs experiencing positive motivations and commitment to their work with what appears to be limited harmful stress.

Semi-structured interviews

From the semi-structured interviews, 2 key themes relevant to that discussed were evident: a) the prevalence of malignant stress as opposed to benign stress; and b) the importance of leaders and managers to facilitating resilience. These are discussed below.

a) The prevalence of malignant stress as opposed to benign stress

Participants differed in their perspective from the standardised tools' focus of resilience as a positive motivator and, and described it more negatively as relating to the ability to cope, rather than having positive association:

> *Stresses I think can also be a very positive and motivating factor. But I think we associate it very negatively in the workplace*.
>
> (P123)

Maybe some of the words used from a personal perspective would automatically instigate certain feelings, you're only going to get a certain result from using the word work-related stress.

(P112)

Also in contrast to the questionnaires, participants' expressed workload pressures of limited time and space, suggestive of malignant rather than benign stress:

Busy, not got time to do what needs to do to manage stress

(P109)

Lack of time to sit down and reflect, carve out time to give validation in what I do

(P130)

Natural culture of failure, don't want to be seen to as not resilient, (…) lack of normalisation of getting support early

(P101)

Everyone's busy. That's not an answer when you're down and low, that's the last thing you want to hear.

(P105)

In particular, feeling undervalued and not respected was identified as affecting participants' resilience in a malignant way:

Forming those trusted relationships, not feeling that you're sitting on the edge of your seat or walking on egg shells and it's actually developing those relationships with your peers that actually helps your resilience (…) vitally important to how we support each other(…)

(P103)

It made me feel undervalued. For me personally, that's my big zapper, I would say with resilience, if I feel undervalued and not respected, my resilience goes (…)

(P118)

Participants in particular identified the influence of system initiatives that drive productivity, create increased demands and constraint practice as affecting their role clarity, and subsequently impacting on their resilience:

> *Purposeful blindness to resilience with enormous pressures and impact of service standard expectations, real OT becomes less and less*
>
> (P103)

> *Impact of medical model expectations and influence of this*
>
> (P118)

> *It's a tricky climate because OT'S want to rehabilitate, they want to do more than they are constrained to do within settings. These days, most people want to do more than that. Most people want to do more than patch up, ship out, give people care.*
>
> (P103)

> *Initiatives that are being rolled out they all seem to come at the same time. (…) it's often a very intense drive rather than trying to embed these concepts into practice all year or as a normal sort of way of working. We have these really highly intense and pressured week or two or month. (…) And that itself is again not a healthy way to work. And I think people do become less resilient and less able to work productively in these things.*

A possible reason for this divergence was identified within a consensus of concern from participants that answers to the questionnaire may have been different depending upon the period chosen, with fluctuations experienced in both professional practice and personal life. Participants indicated that a period of between 3 to 12 months could provide more realistic perspective of team's resilience and work-stress levels.

b) The importance of leaders and managers to facilitating resilience

Although, self-awareness and early identification difficulties with resilience is not straightforward, 14/15 participants acknowledged concerns with resilience were identified too late, indicating the existence of constraints of time and education to enable meaningful communication to be proactive rather than reactive:

> *Having that awareness and knowledge of what we can do in the workplace to boost somebody's resilience, because often people aren't able to identify that themselves.*
>
> (P123)

Newly qualified participants reporting being conceptually taught workplace resilience but not how to practically apply it in practice:

> *It's kind of basic what we would do, what we understand about resilience. I don't think they gave us any kind of strategies. (…) they we were talking how we are coping, but not actually what to do.*
>
> (P139)

Most participants reflected meaningful communication with their supervisor or peers as a pre-requisite, highlighting the need of understanding and assurance of role and purpose. There was an emphasis on the facilitation by leaders and managers is pivotal at both individual and team level to enable recognition and build awareness of individual and team resilience:

> *Role clarity and purpose, need meaning.*
>
> (P112)

> *If a team doesn't have a manager that is supportive. And a good communicator (…). As good as the rest of the team might be, I think you need to have somebody to pull everything together (…) we as a team have regular team meetings and so that communication's really clear.*
>
> (P109)

Recognition comes from your immediate manager; keeps you going, makes you believe you are valued.

(P125)

We always say how important is for us to build up that rapport. I do think that kind of management is a big part of that. Keeping everyone together. Being the glue I guess. For the team. And just keeping everyone, you know if there's a shared kind of commitment to our to our roles (…). Finding different ways of doing things if things aren't working a certain way and adapting to different situations.

(P109)

Supervision is really key and that's kind of well-established in my workplace, and I think that's really key way of supporting resilience. (…) team cohesion and efforts by managers to promote kind of team bonding (…), good team spirit, I think that's really important.

(P108)

However, some participants in leadership roles recognised they did not feel equipped with the appropriate skills or time to effectively manage variation in support required. It could be argued that high demand, reduced self-awareness and self-efficacy could influence the supervisor's own resilience, leaving a challenging balance with the feeling of requiring more proactivity, rather than current reactivity:

(…)we try our best and I try not to cancel supervisions or I try not to not pick the phone up if someone's phoning. But could we guide it better through some strategic tools (…) We'll put informal plans in place. But if they don't know themselves or they don't know what makes them tick or they haven't got that clarity or what's important to them, that understanding. Are you on a bit of a dead end to nowhere.

(P110)

When I get to know people, then it's a bit easier for me to see. (…) I'm sure there are probably some traits that if I was better trained resilience

myself or had a greater awareness, then maybe I might be able to pick up on some of those things a bit earlier

(P123)

The findings from the interviews are in contrast to the questionnaire in 2 significant ways. Firstly, participants did not articulate experiences of benign stress as indicated in the questionnaires, but in contrast indicating malignant stress as more prevalent. Secondly, participants identified the importance of leaders and managers to enabling team resilience. However, the ability of managers to facilitate this was not evident.

Discussion and Recommendations

The findings from the data highlight 3 key but interrelated issues for OT managers and leaders in relation to the current use of work stress assessment tools to promote resilience in the workplace.

1. The contrast between positive focus of standardised resilience scales and the negative understandings of OTs

The scales used in this research are likely to be used by leaders and managers to assess the level of resilience in their workforce. The key focus of the tools is on positive resilience, and the questions in them are geared towards this positivity. However, participants in this study attributed resilience with negative experiences, rather than positive. This could mean that the tools are measuring resilience in a different way to that from how participants relate to it. If this is the case, it limits the utility of the tools to measure resilience. Interview outcomes further demonstrate a lack of role understanding and reduced recognition of autonomous practice, appearing to influence self-efficacy levels, linked to fostering resilience (Brown et al., 2017). Where participant's experience system drivers due to higher demand, such as patient flow models, designed to improve quality of patient care, this was felt to reduce value and integrity of roles. This provides further evidence that limited resources and system constraints influence team and individual stress and resilience (Bushby et al., 2015).

2. The need for resilience to be measured and monitored in a variety of ways

Linked to this is the need to use a range of different sources to measure resilience. There is clearly a distinct divergence between the quantitative and qualitative findings. The standardised scales tools measured resilience in a quantitative way, and the findings from this indicated a normal, benign levels of stress and resilience. However, the qualitative process detailed the presence of malignant stress and less positive levels of resilience. This mismatch appears to occur for 2 key, linked reasons. The first is a lack of understanding of the conceptualisation of stress and resilience in the standardised questionnaires. This means that what is defined as benign levels of stress individual and team resilience may be viewed as 'normal' from questionnaire outcomes, but interpretation of this could be dependent upon individual understanding of what the terms mean. For example, the Likert scales within the questionnaires appear open to interpretation and could increase ambiguity, drawing into question the overall validity of the data. Elteddatli *et al* (2022:233) specifically outline 'the importance of assessing the characteristics of benign work stress from the perspective of employees themselves' as opposed to using preset characteristics. The use of more specific OT focussed questions, using language known to the OT profession as illustrated by Ashby *et al*. (2024), may have reduced ambiguity.

The second reason is that the qualitative process provided the opportunity for participants to articulate and express their experiences of stress in a more personalised way than the somewhat rose-tinted view delivered by the quantitative outcomes. This enabled participants to consider issues such as the influence that system constraints and demands has upon self-efficacy, resilience and consequent influence upon professional identity and integrity, and the importance of meaningful communication approaches and establishment of team belonging to OTs. This suggests that, as argued by Noble and Heale (2019: 67), the use of mixed methods can offer a more balanced explanation to readers of complex human behaviour through the process of triangulation. In this context, triangulation enabled a truer reflection of the level of relational stress and therefore resilience.

In practice, the implications of utilising only quantitative data could lead to conclusions being drawn that there are no concerns with the current well-being of the OT's and management strategies are adequate. As an OT manager, reliance wholly on the quantitative findings from this study could present optimism, as it implies existing strategies in managing work-related stress and promoting resilience are adequate, and therefore lead to the conclusion that no further action is required. However, qualitative finding provided a different perspective, highlighting the existence of malignant stress and reduction in work resilience. They also demonstrated the influence that system constraints and demands have upon self-efficacy, resilience and consequent influence upon professional identity and integrity. This study further concurs to an extent with international findings of resilience training as being rarely accessed, with a limited awareness of its existence. Schwartz rounds promoted as a key initiative were not identified. Rather OTs appear to utilise their own strategies, un-related to organisational provision. The findings indicate this may be due to various perceived limitations in accessibility and time (Gilbert et al., 2023). In addition, policies such as the stress management in the workplace, appear to lead to reactive outcomes and a transactional approach, with onus placed upon individuals or line managers to facilitate (Sani et al., 2024; Trust withheld, 2022a). This appears to drive negative perceptions of resilience, linked to sickness and feelings of failure (Traynor, 2018), rather than promoting a proactive, individualised and preventative approach (Holland et al., 2018).

3. The importance of leaders and managers to promoting resilience

Restorative supervision and team connectivity appear to be a key strategy for OT's enabling positive motivations. This study provides an OT perspective supportive of restorative supervision, to manage the multi-faceted and emotional demands of the OT role. However, varied understanding of resilience may have implications with the use of restorative supervision practices, with recognition that this approach is dependent upon individual relationships to be effective (RCOT, 2015).

There appears to be high demand upon team leaders with expectations of role modelling healthy behaviours placed in the well-being strategy (Trust withheld, 2024). However, this may not be sustainable as the study identifies feelings of a challenge between balancing system expectations, patient care, individual needs. To an extent a positive variation in OT leadership approaches is reflected when supporting individuals and teams to ensure support and communication is meaningful. Although not specific to OT, studies appear supportive of the combination of compassionate, relational and inclusive leadership styles deemed necessary to build resilience in highly emotive and demanding workspaces, highlighting the requirement of appropriate skills and attributes from leaders and managers to facilitate a supportive climate (Grimes et al., 2022; Stacey et al., 2020).

Following these discussion points, the following recommendations are suggested to enable a more relational, compassionate and inclusive approach specific to OT.

- At induction introduce a ‘well-being and getting to know me’ conversation with mentor/supervisor, to raise self-awareness, understanding and ownership of resilience in workplace, to enable early identification of stressors and what this means to individuals.
- Introduction of ‘what does resilience in the workplace mean to you’ workshop for students and newly registered clinician’s, to enable shared understanding of different perspectives of resilience and available support.
- Adjust and agreed updates to supervision documentation and meeting agendas to include well-being conversations as standard, to aid proactivity in capturing any stressor or resilience concerns. And emphasise the requirement for engagement as part of clinical and operational supervision.
- Utilising collaboratively the IGLOE and JD-R models, to illustrate a broad system perspective (Gilbert *et al*, 2024), to raise clinician and organisational awareness of role demands. Also, formulate meaningful communication and a heat map for individuals and teams to support

recognition and perhaps reduce work-stress escalation, to facilitate self-efficacy and professional integrity. This could be utilised in board reports to provide meaningful understanding of service demands and implications upon professional practice and how this relates to provision of quality, safe and effective care to meet governance and clinical safety domains (CQC, 2022).

Study limitations

The authors acknowledge that these findings should be viewed with caution due to limitations in the size, scale and representativeness of the research. In terms of size, according to Yang (2025) there are 50, 000 occupational therapists in the UK, which when applying Krejcie and Morgan's (1970) small sample size determination table, means that the sample size for this research is significantly well below the ideal sample size. The implication of a significantly smaller ideal sample size is that the internal and external validity of the research are limited (Faber and Fonseca, 2014). In specific relation to the internal validity of this research, this means that the issue of whether the positive focus of the tools is the cause of the positive responses that were achieved cannot be stated with a significant degree of confidence. In specific relation to the external validity of this research, this means that the findings cannot be generalised to other contexts outside of this study. In terms of scale, the relationship between the research participants and the researcher could have affected the responses to the questionnaire, either directly through the power differential that exists in the work relationship (Gibson et al, 2014) or indirectly through social desirability bias (Gower et al, 2022). For both of these, the effect could be to skew the responses towards those perceived as favourable to the researcher. The positive responses to experiences stress in the assessment tools in particular convey this possibility, but the less positive responses in the qualitative data mediates this possibility, and suggest a reliability of the data (Flick 2018). In terms of representativeness, the relevant point here is that all the data have been taken from a single OT organisation, when there is a diversity of OT organisations that exist in term of structure, organisation and operation. This is compounded by the non-probability convenience sampling used in the research. This means that the data cannot be said to be representative of OT organisations or individuals as a whole, which limits its external validity and

therefore the generalisability of the research (Alavi et al, 2024). Together, these limitations of size, scale and representativeness are important considerations for the research .

A larger, longitudinal study across a range of settings nationally would be beneficial to facilitate generalisation and gain a broader perspective of OT resilience and workplace well-being. This could provide insight into the variation, influence and effectiveness of strategies and approaches used to promote resilience and manage work-stress.

Conclusion

The OT profession has been identified as a high-risk group in relation to workplace stressors, with an ageing workforce. This study set out to explore the current level of resilience in HCPC registered members of an NHS OT service. Using a mixed method approach, it gained insight into the team's understanding of their work-stressors, resilience and experience in practice. The use of the mixed methods approach was shown to be useful in providing depth and context, showing some divergence between quantitative and qualitative outcomes.

Findings could assist with justifications towards workforce well-being strategies being multi-modal with individualised elements, rather than an exclusively universal approach. This could engage earlier recognition of potential challenges and prevention of escalation in stressors, through leadership approaches to facilitate engagement and responsiveness of an OT service resilience framework.

This study adds a UK based OT perspective to the existing body of international research regarding work-related stress and resilience in healthcare. Findings reflect the varied requirement of relational, compassionate and inclusive leadership approaches that facilitate the management of work-related stress and promotion of resilience in the workplace, in a way that is meaningful for OT.

Key findings

- The mismatch between the positive focus of the tools used to promote resilience and the negative understanding of OTs
- The need for resilience to be measured and monitored in a variety of ways
- The importance of leaders and managers to promoting resilience

What the study has added

The study has identified three key interrelated ways in which leaders and managers can apply and improve the current resilience framework to better meet the needs of the OT workforce.

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