NOVA

University of Newcastle Research Online

nova.newcastle.edu.au

Title: Factors that influence the professional resilience of occupational therapists in mental health practice

Running title: Professional resilience of occupational therapists

Dr Samantha Ashby PhD, M.App.Sci(OT), Bsc(Hons), DipCOT (UK)

Prof Susan Ryan

Prof Mel Gray

Dr Carole James

Corresponding Author: Samantha Ashby, School of Health Sciences, University of Newcastle, Callaghan, NSW 2308. Email: Samantha.ashby@newcastle.edu.au

Abstract

Background/aim: Mental health practice can create challenging environments for occupational therapists. This paper explores the dynamic processes involved in the development and maintenance of professional resilience of experienced mental health occupational therapy practitioners. It presents the PRIOrity model that summarises the dynamic relationship between professional resilience, professional identity and occupation-based practice.

Methods: A narrative inquiry methodology with two phases of interviews was used to collect the data from nine experienced mental health practitioners. Narrative thematic analysis was used to interpret the data.

Results: Professional resilience was linked to: (i) professional identity which tended to be negatively influenced in contexts dominated by biomedical models and psychological theories; (ii) expectations on occupational therapists to work outside their professional domains and use generic knowledge; and (iii) lack of validation of occupation-focused practice. Professional resilience was sustained by strategies that maintained participants' professional identity. These strategies included seeking 'good' supervision, establishing support networks and finding a job that allowed a match between valued knowledge and opportunities to use it in practice.

Conclusion: For occupational therapists professional resilience is sustained and enhanced by a strong professional identity and the valuing of an occupational perspective of health. Strategies that encourage reflection on the theoretical knowledge underpinning practice can sustain resilience. These include, supervision, in-service meetings, and informal socialisation.

Further research is required into the role discipline specific theories play in sustaining professional values and identity. The development of strategies to enhance occupational therapists' professional resilience may assist in the retention of occupational therapists in the mental health workforce.

Keywords

Introduction

Occupational therapists play a key role in mental health teams across Australia (Ceramidas, 2010). While mental health practice provides practitioners with opportunities to apply creative skills and focus on occupational issues, it also creates challenges to professional identity (Scanlon, Still, Stewart, & Croaker, 2010). The challenges that can occur in mental health practice often result in retention and recruitment issues for the occupational therapy workforce (Rodger et al., 2009; Scanlon et al., 2010). One way of dealing with these challenges is the development and maintenance of professional resilience.

An exploration of occupational therapists' professional resilience is timely given that professional resilience is a quality that enables practitioners "to bounce back from adversity, persevere through difficult times, and return to a state of internal equilibrium or a state of healthy being" (Edward, 2005, p. 142). This quality arises from professional self-care and is thought to be essential for practitioners who work in the health and human services industry (Fink-Samnick, 2009). Professional self-care involves practitioners adopting strategies which reduce vulnerability and assist in the response to occupational stressors and life challenges, while maintaining the professional values that ensure career sustainability (Fink-Samnick, 2009). Professional resilience is a concept not previously explored in the occupational therapy literature. Given the challenges of mental health practice which result in retention and recruitment issues for the occupational therapy workforce it is appropriate to consider this issue (Rodger et al., 2009; Scanlon et al., 2010).

In the occupational therapy workforce, the cumulative effect of tensions in mental health workplaces can result in difficulty retaining staff. In Australia, this leads to a workforce where the majority of practitioners in clinical positions are under the age of 30 years (Ceramidas, 2010; Scanlon et al., 2010). In turn, a lack of experienced practitioners reduces those available to mentor and supervise graduates and provide positive professional education placement experiences which are known to assist recruitment into mental health (Rodger et al., 2009).

For occupational therapists in mental health practice, challenges often arise from the shift towards working in interprofessional teams. This is associated with an expectation that team members work outside their professional domain (Rosen & Callaly, 2005). This along with the adoption of case management models of service delivery can cause a blurring of professional roles (Nolan & Hewison, 2008; Xyrichis & Ream, 2008). In addition, case management models create competing demands for occupational therapists' time and makes balancing generic and discipline-specific work difficult (Lloyd, King, & Ryan, 2007).

The challenges for practitioners who are in the minority in mental health teams are increased due to professional isolation (Xyrichis & Ream, 2008). These challenges are exacerbated when colleagues from other disciplines conduct supervision when they may not understand, or share, an occupational perspective (Scanlon et al., 2010). Occupational therapists also express a frustration with a perceived lack of respect from other disciplines

for their occupational perspective of health and occupation-based practice (Hayes, Bull, Hargreaves, & Shakespeare, 2008; Rodger et al., 2009; Scanlon et al., 2010). Thus, many of the tensions in mental health practice stem from challenges to professional identity.

A focus on the occupational perspective of health brings its own challenges for practitioners. Challenges to professional identity often occur when practitioners adopt what Fortune (2000) termed 'occupational therapy paradigm-dependent practice' - where the main focus and therapeutic interventions are aimed at enabling people to engage in their chosen and necessary occupations. These challenges are exacerbated if practitioners find it difficult to provide a rationale why they use occupation as a therapeutic medium (Fortune & Fitzgerald, 2009). Occupational therapy practice is often difficult to explain because paradigm-dependent practice requires practitioners to draw on, and articulate diverse forms of knowledge such as theoretical, factual, personal, and service-user knowledge (Trevithick, 2008). These forms of knowledge allow an understanding of the dynamic interaction between people, their occupations, and their environments and guide practical actions (Kinsella & Whiteford, 2009).

In occupational therapy one form of theoretical knowledge used in practice are the discipline-based theories known as occupation-focused models. These include the Canadian Model of Occupational Performance and Engagement (Canadian Association of Occupational Therapists, 2002; Townsend & Polatajko, 2007), the Model of Human Occupation (Kielhofner, 2008) and Occupation Performance Model (Australia) (Chapparo & Ranka, 1997). These discipline-based theories are included in entry-level curricula as they offer a theoretical basis for practice by providing explanations about the process and practice of occupational therapy (Ashby & Chandler, 2010; Duncan, 2006). In addition, their use in practice is posited to support professional identity as they provide occupational therapists with discipline-specific theoretical knowledge to underpin and describe their practice (Haglund, Ekbaldh, Thorell, & Hallberg, 2000). However, little is known about their role in guiding practical actions and in the development and the maintenance of professional identity or professional resilience.

Aims of the Study

This paper presents one element of a larger study that sought to understand the theoretical knowledge valued and used by occupational therapists in mental health practice. It presents the strategies that sustain professional resilience in mental health practice and introduces the PRIOrity model. This model represents the dynamic process involved in the development and maintenance of professional resilience, professional identity and occupation-based practice.

Methods

Recruitment of Participants

Formal ethical approval for the study was granted from the local Area Health Human Ethics Committee and the University's Human Ethics Research Committee.

In this study, purposeful sampling was used to recruit participants. On receipt of approval from the two ethics committees, the first author sought the assistance from the Professional Leader in Mental Health Occupational Therapy to identify appropriate occupational therapists. The inclusion criteria for recruitment were: Occupational therapists with more than two years' experience in mental health and who had worked in more than one workplace. The rationale for these criteria was to identify practitioners who had consolidated and developed theoretical and skills-based knowledge for mental health occupational therapy practice (Hodgetts, Hollis, Triska, & Dennis, 2007). It was hoped that experience in more than one workplace would allow participants to compare and contrast the influence of different workplaces on what theoretical knowledge was valued and used.

Eighteen occupational therapists met the inclusion criteria. The Professional Leader then provided a list of their names and contact workplace email addresses of those who met the criteria for the study to the first author. All of these practitioners were sent an information statement about the research. Of these 18 practitioners, 10 expressed their willingness to participate in the study, however one person later withdrew because of extended leave. A condition of the ethical approval was that the researchers were unable to ask the remaining practitioners their reasons for not participating. However responses were also received from three practitioners who noted that they were due to take maternity leave during the study timeframes, and two others who felt part-time work made participation difficult. Prior to data collection written informed consent to participate in the study was obtained.

Data Collection

The data collected for the larger study were gathered in two rounds of interviews. These interviews involved asking participants for explanations of, and stories about, their professional journeys. Preliminary analysis of data from the first interview formed the basis of the second interview. The interviewing techniques and questioning style employed were strongly influenced by a single narrative interview question and were based upon a biographical-narrative style (Wengraf, 2001) designed to elicit stories from participants. Hence, the interview was supportive and non-evaluative. Questions were designed to obtain descriptions of the participants' professional journeys and to explore influences on how theoretical knowledge was used and valued in practice and if different workplace conditions had impacted upon this. The intention of these interviews was to provide a forum that encouraged and invited participants' personalised understanding of the topic under study (Holloway & Freshwater, 2007).

Stage one interviews.

In the first interview, each participant was asked to describe the story of their professional journey and the knowledge used and valued in practice; and to describe what factors influenced how this knowledge was used and valued in different jobs. The interviews were approximately 120-160 minutes. They were audio recorded and verbatim transcripts prepared. Each participant chose or was allocated a pseudonym to maintain anonymity. After the interview, a copy of the transcript was sent to each participant. Participants were asked to reflect on the content prior to the second interview. The data analysis and interpretation began at this stage. The coding of the first round interview led to emerging themes. These themes were discussed and explored further in the stage two interviews.

Stage two: In-depth interview.

The second interview with each participant sought to clarify and further develop information gathered in the first interview and took place after data coding of the first interview. To begin participants reviewed the timeline of their professional journey and commented on their personal reflections. They recounted any changes that had occurred since their previous interview. The interview was an opportunity to use member checking with participants asked to comment on the accuracy and comprehensiveness of the themes identified from the analysis of the first interviews. The participants were asked to consider the various explanations posited by the researcher. This second interview took between 90 to 160 minutes to complete.

Data Analysis and Interpretation

The data analysis began with the completion of the first interview. A computer-assisted data analysis package – N*Vivo9 (QSR) was used for data coding and to assist with analysis and interpretation (Bazeley, 2007). The analysis considered the influence of the participants' professional journeys on their use of different forms of theoretical knowledge (Holloway & Freshwater, 2007). The analysis of the narrative focused on what was 'told' or reports of events and experiences rather than on aspects of 'the telling' (Mischler, 1986).

Results

Description of Participants

To preserve the anonymity of the nine participants only generic demographic information is included in this paper. As noted in the methodology each person chose or was allocated a pseudonym and this is used to assign ownership of the quotations used in the findings. At the time of the study, the participants who had volunteered for the study worked in a range of work places. These included specialised services for child and adolescence, acute in-patient mental health units, community mental health teams, a specialised psychotherapy unit and community based rehabilitation services. Although the criteria had stated a minimum of two years' experience the mean number of years worked in mental health

practice was 14.3 years, with a range of 5 – 35 years. As a group their collective post-graduation experience was 129 years, and they had worked in over 58 work places.

Of the nine participants two were male. Each participant held a Bachelor of Applied Science in Occupational Therapy, or a Bachelor of Occupational Therapy from an Australian University but did not have post-graduate qualifications in occupational therapy. Three of the participants had worked overseas since graduation.

In each interview the participants referred to "protective factors" in descriptions of episodes when situations had negated the use of paradigm-specific discipline based knowledge and occupation based practice. It led to the exploration of the literature on professional resilience (Fink-Samnick, 2009; McGee, 2006). It became clear that one of the main influences on the use of valued theoretical knowledge was the theme of professional resilience. Subthemes were identified that appeared to support or maintain professional resilience. As part of the member checking process participants were asked if they agreed with the initial analysis and interpretation of all the data. The identification of professional resilience as a theme resonated with all the participants. Table 1 presents the subthemes that emerged from the data interpretation as strategies associated with professional resilience

PSEUDONYM	YEARS IN MENTAL HEALTH	NUMBER OF WORKPLACES
Liam	5	2
Bronwyn	8	5
Anna	11	4
Megan	13	> 10
Sarah	14	> 10
Diana	14	> 10
Alex	17	4
Eliza	17	> 10
Maria	30	3
Total	**129 years mean 14.3**	**<58**

The challenges experienced by the participants were often towards professional values and identity. However, it is important to note that while all the participants' stories described the challenges they had faced in mental health practice, they all found the work satisfying. These challenges required each participant to develop professional resilience. In turn, professional resilience was sustained by a strong professional identity. As Alex noted:

> The medication is the most important thing without that everything falls down but I've seen some really unwell people continue to live in the community, but I haven't seen well people without *living skills* survive very long in the community

All participants identified that professional identity was sustained by a central belief in the efficacy of occupation and its role in improving subjective wellbeing. This was essential for

retention in the workforce. However, the certainty with which this belief was held fluctuated during professional journeys, dependent on workplace experiences.

The Use of Discipline-Based Theories and Concepts

The use of an occupation-focused model appeared to sustain participants' professional resilience. The opportunities to use these valued discipline-based theories and concepts were often dependent on a service's delivery method. The ways in which participants' applied occupation-focused models and occupational therapy concepts to guide occupation-based practice varied. For the majority of participants, occupation-focused models allowed the conceptualisation of service user's needs and the means to address occupational issues at each stage of the occupational therapy process. Often they provided a conceptual framework to carry out assessments and a structure and language to describe occupational issues and the complexity of occupational issues to colleagues.

Occupation-focused models assisted practitioners to explain the intrinsic goals of their use of occupation in diverse practice settings. This was necessary in occupational therapy where there was no "one size fits all program." Participants identified the challenge that other disciplines frequently did not appreciate or understand the intrinsic goals or the complexity of interventions. When they saw occupational therapy programs that used going on a walk, attending a BBQ, or completing a craft activity, they did not understand the assessments and interventions that were conducted "in vivo" during these activities.

Occupation-focused models provided conceptual frameworks and a language to explain practice. Liam described how he strategically used language from the Model of Human Occupation (Kielhofner, 2008) to describe issues and goals more clearly to his team. Eliza and Sarah reported that language from these models helped to explain to managers and colleagues descriptions of interventions that moved away from simple descriptions of the activity used to more attention to the occupational intent of the activity.

Becoming Professionally Bilingual.

As noted above many participants acknowledged that some colleagues did not understand the therapeutic use of occupation. This resulted in the need for repeated explanations in an effort to enlighten colleagues. Participants noted they had consciously not allowed this to negate their identity and employed strategies to deal with this situation. Sarah named one of these strategies as "being bilingual." The central skill involved in being bilingual was described in varying ways, but centred on the necessity to find effective ways to explain occupation-based practice. Sarah explained that she described her interventions in the language for her psychology colleagues, with living skills explained as adaptive behaviours "in vivo." This provided a "shorthand" explanation that allowed the other person to understand occupational therapy from an alternate disciplinary perspective.

Coping with the Pressure to Adopt Other Forms of Theoretical Knowledge

All participants had developed strategies to deal with the pressure from others, within and external to the profession for the adoption of techniques and approaches derived from psychological theories rather than valued occupational therapy knowledge. This was described as dealing with "a barrage" of new knowledge. This new knowledge included practical techniques drawn from psychological theories such as Dialetical Behavioural Therapy, Acceptance and Commitment Therapy and Cognitive-Behavioural Therapy.

The participants reflected that the most vulnerable time that this barrage occurred was during the transition to practice, when the majority of participants (7/9) had first jobs in acute psychiatric inpatient units. This transition and pressure to gain new knowledge competed with the need to consolidate occupational therapy skills and practice knowledge and "learn how to be an occupational therapist." While greater generic bio-medical knowledge was also required, participants did not consider this as a negative because it enhanced occupation-based practice. The perceived threat from the adoption of the psychological therapies previously mentioned was that it negated the time for occupation-based practice. As noted by Bronwyn this could lead to a "dissolving" of occupation-based practice into something unrecognisable as occupational therapy.

A major pressure was that colleagues viewed the psychological therapies as more evidence-based and validated forms of therapy. In addition, therapies such as cognitive-behavioural, were perceived to provide more structured therapy skills and techniques. Thus, these were easier to explain than occupation-based treatment techniques. The pressure to conform to these expectations was confronting, as it appeared to invalidate occupational therapy knowledge. As participant Liam suggested it appeared that "occupational therapy knowledge was not enough." Although some participants were able to argue that their occupational therapy knowledge "was enough", others said it was difficult to advocate for, or justify occupation-based practice. Eliza described how this was particularly difficult when practitioners stepped into a job where the previous occupational therapist had focused on psychological theories as it led to team expectations to "be the same and offer the same service…and to live up to expectations." This increased the pressure to develop practice skills based upon psychological theories and impacted on professional identity as the participant had to defend the profession and use occupation based practice interventions. Many reported that at times this had resulted in the explicit use of psychological theories in practice with occupation-focused knowledge used tacitly to interpret the service user's occupational issues. As participant Bronwyn described, while she used psychological theories in her practice:

> I always see things from an occupational perspective, that's what I focus on… What am I doing that's different from what other professions can do and how can people benefit from that? In my mind I go back to the MOHO…I guess that's the underpinning theory in my mind.

On reflection, participant Sarah felt that at times her use of psychological theories had resulted in her "losing sight" of the service-user's occupational goals and her own professional goals: "We dilute our skills because we're actually trying to do our job and a range of other people's jobs at the same time."

While it was identified that the development of a professional "tool box" was important it was the balance of occupation-focus with other borrowed therapies that influenced professional identity and long-term resilience.

Professional Socialisation

In the transition from education into practice Sarah remembered, "It's like another world." In this phase and throughout their careers participants recognised the importance of informal and formal professional support networks. The leaders of the mental health occupational therapy service in this region had recognised the importance of professional socialisation. Overtime, this resulted in monthly in-service meetings for all mental health occupational therapists, and the development of a social committee that organised informal events. Informal networks were developed during these meetings and in the social events, which followed these meetings. Liam described that these networks acted as a "protective factor." The engagement in professional socialisation was regarded as another strategy that maintained professional resilience. All participants described the efforts they had made to develop these networks.

While important for all, rural or professionally isolated participants noted that these meetings served an important function in the maintenance of professional identity. It countered the professional isolation caused by work as a sole occupational therapist within a team, service, or for those geographically isolated. Informal and formal opportunities for professional socialisation allowed participants to cope with working in difficult situations. These occasions provided participants with opportunities to "vent" about their lack of validation, seek problem-solving solutions, and maintain their desire to "continue to fight" and advocate for their occupational perspectives.

These formal networks had led to the development of other informal social networks and a feeling of solidarity within the profession. Participants noted that it was regular professional socialisation, which contributed to their retention in the Area Health's mental health workforce. Socialisation within formal and informal networks was a key protective factor when participants experienced difficult times due to workplace challenges. Networks offered opportunities to meet with other occupational therapists, receive validation for professional practice, and share strategies to cope with difficulties experienced in a collegiate environment.

Professional socialisation also assisted in recruitment of occupational therapists. Many participants acknowledged that their choice to apply for jobs and remain in employment in the health region in this study was influenced during placement experiences. They had witnessed the supportive community, where experienced therapists would share knowledge and offer support.

Professional Supervision.

While professional supervision was seen a form of professional socialisation its role differed. Although professional supervision with an occupational therapist also diminished professional isolation, it was regarded as a more focused time and opportunity to share occupational therapy ideas with someone with a shared philosophy. Supervision allowed time for reflective practice and to explore professional reasoning, personal resilience, and existing support networks. The reflective processes involved in sharing of experiential knowledge and adoption of shared strategies helped in the maintenance of professional identity. It was one means to discuss strategies for explaining occupational therapy goals to colleagues. Supervision also enabled identification of the direction for continuing education opportunities to develop clinical skills.

Professional supervision with an occupational therapy colleague was considered more effective than generic supervision with a person from a different profession. Supervision with an occupational therapist was most effective if the supervisor supported and encouraged a debate about the efficacy of occupation in the workplace. A lack of debate in supervision with other occupational therapists had led Diana to describe how issues that negatively impacted on her professional identity were unheard and thus not dealt with. Supervision was considered effective if it provided the opportunity to discuss the challenges that arose from working in interprofessional teams when role blurring could occur and allowed reflection on the link between occupation-focused models and professional identity:

> I'm not working in an OT role…but I'm using these [occupation-focused models] as tools. And I guess that's what we've worked with a lot in supervision is, you're using an OT model regardless of what you do because that's how you're, that's how you develop your clinical reasoning; is with the OT model that you spent four years learning, that you've been practising for x-amount of years now. (Bronwyn)

"Knowing When It's Time to Go."

Practitioners' movement between jobs acted as a means to sustain professional resilience. The study findings highlighted the need for professional self-care while battling against, what often appeared to be, insurmountable barriers to occupation-based practice. Perhaps in response to these barriers career mobility was considered part of the social norm for occupational therapists. As participant Sarah stated, "It is 'normal' for OTs [sic] to move around a lot." Participants reflected that career longevity had been extended by "knowing when it's time to go" - when to quit a job. The decision to leave a job was usually only reached when the participants had faced insurmountable challenges in workplaces. They were unable to change the negative features of a job, which included sustained lack of opportunity to deliver what Fortune (2000) described as "paradigm-dependent" practice –

when it was difficult to remain occupationally-focused in practice. These challenges arose from a poor match between professional values and ability to apply an occupational perspective of health, and their practice. Frequently, this occurred more in work places dominated by a bio-medical model of intervention that focused on symptom reduction. This made voicing an occupational perspective a challenge. Participants used metaphors of war in describing these daily "battles" to validate practice. This dissonance between values and practice was most frequently described in the context of acute inpatient settings. As noted previously this was the first job for seven of the participants and this acted as a "stepping stone to other jobs" in the community.

Discussion

This paper builds on previous studies that have identified the many challenges faced by occupational therapists in mental health practice (Fortune & Fitzgerald, 2009; Scanlon et al., 2010)and also links with literature that discusses the issues of recruitment and retention in the mental health workforce. However, it is important to note that the experienced practitioners involved in the study had 129 years of collective experience. They had found ways of living with these challenges because they found the work satisfying. The discussion provides some insights and understanding of the professional self-care strategies that occupational therapists adopt and develop to maintain professional resilience in mental health practice.

The findings from this study indicate the presence of a strong connection between the maintenance of professional resilience through professional self-care and professional identity. These connections are presented in Figure 1, which draws together the findings from this study and is presented as the PRIOrity model (Ashby, 2012). The model represents the dynamic relationship that was found between professional resilience, professional identity and occupation-based practice.

Figure 1: The PRIOrity (Professional Resilience, Identity, Occupation) model in which occupation based practice is supported by, and impacts on professional resilience

The PRIOrity model also presents how professional resilience supports, and leads to the maintenance of professional identity and occupation-based practice. This indicates that while professional resilience supports occupation–based practice this link is not automatic because it is also influenced by professional identity. In turn, professional identity appears to be associated with the value placed on occupational perspectives of health, and factors such as the prevailing discourses and service strategies in a practitioner's workplace.

The findings build on previous research that has identified the challenges faced by occupational therapists in mental health practice (Scanlon et al., 2010). It is proposed that these challenges can be better understood by reference to Foucault's (1980) concept of dominant discourses. The concept of dominant discourses provides a useful perspective from which to understand the pressures reported by occupational therapists on professional identity. It allows for an understanding that tensions in mental health practice are inevitable for members of those professions, such as occupational therapists, that have discourses that differ from the psychological and bio-medical theories of wellness which dominant many mental health workplaces. The recognition of the existence of these dominant discourses allows for the preparation and planning of strategies that can sustain occupational therapists' professional resilience. It is important that these strategies are in place to reduce the pressures that occur in the transition from graduation to employment. From this study, it appears that this transition is one that can threaten professional identity and resilience. During this transition, practitioners appear to benefit from the role modelling and mentoring that occurs during professional socialisation. This is especially true when first job experiences are in bio-medically dominated acute inpatient units.

Within the occupational therapy profession retention of staff in the mental health workforce is an identified issue (Scanlon et al., 2010). The findings from this study demonstrate the important role that occupational therapy leaders can play in the establishment of formal and informal networks, which assist in the retention of staff. These networks act as protective factors in the maintenance of professional resilience as they create and maintain professional collegiality. They appear to assist experienced occupational therapists to live with the tensions created by prevailing discourses. The utilisation of these strategies can counter the tensions created when occupational therapists are faced with the competing discourses of psychological and bio-medical theories of wellness dominant in many mental health workplaces.

The ability to explain and articulate an occupational perspective and the use of occupation to enable occupation to others appeared to be an important strategy in the maintenance of professional resilience. This strategy accepts that other professionals with differing professional philosophies will always find it difficult to understand occupation-paradigm specific practice. In addition, becoming professionally bilingual assists practitioners to explain how occupation is being used. The ability to explain occupation-based practice supports professional identity.

The findings indicate that professional identity is underpinned by the value practitioners place on an occupational perspective. This in turn determines the extent to which practical actions are occupation-based and "paradigm specific." It appears that a strong professional identity is crucial as it assists practitioners to resist the pressure to adopt, rather than adapt forms of theoretical knowledge and therapies borrowed from other disciplines and therefore to keep practical actions orientated to occupational issues. This reinforces the need for occupation-focused curricula (Whiteford & Wilcock, 2001).

An increased awareness of the factors underpinning professional resilience can assist educators to develop entry-level curricula that are explicit in making graduates aware of the discourses that exist in mental health, and how to maintain professional self-care. In addition, it appears important that entry-level curricula prepare graduates with greater assertiveness skills to ensure they have the expertise to negotiate and advocate for the use of occupation. One means of developing the ability to advocate for, and articulate occupation-based practice, and development of "professionally bilingual" skills could be through interprofessional education (Turpin & Iwama, 2011). Further implications for practice include future competencies standards, such as those designed for occupational therapists who work in mental health (OT Australia, 1999), to include the need to nurture professional resilience through the ability to advocate for, and demonstrate the use of occupation-based practice

While the awkward alliance between rehabilitation and occupation has been explored by Friedland (1998) the findings from this paper suggest that it may be timely to further explore how the use of psychological therapies is presented in occupational therapy literature and practice. While the role that psychological therapies can play in a "professional tool-box" is recognised it is the ability to balance and adapt these therapies to include occupation, which maintains professional identity and professional resilience. It is the balance that appears

vital in the maintenance of the ontological stability described by Molineux (2011). The findings indicate that this balance is enhanced by the conceptual and explicit use of occupation-focused theoretical knowledge. The use of occupation-focused models appears to assist in the development and maintenance of professional identity and resilience. These discipline-based theories provide practitioners with alternate, explicit structures for assessment and therapy interventions, and implicit or tacit conceptual frameworks to consider occupational issues. They provide practitioners with additional language to describe the complexities involved in occupational therapy interventions (Eklund, 2002). The study reinforced Law and McColl's (1989) findings about the role of entry-level programs as practitioners' source of knowledge about occupation-focused models. The important role played by curricula requires further study of the nexus of education and theory knowledge.

Entrance into the mental health workforce requires occupational therapists to adopt strategies that reinforce and develop professional identity and resilience through professional socialisation which supports McGee's (2006) argument that professional socialisation plays an important role in the maintenance and development of professional resilience. For occupational therapists the opportunities for professional socialisation take many forms, from formal meetings and supervision, to informal social events. As noted by Wilding, Marais-Strydom and Teo (2003) engagement with mentoring schemes also affords guidance and support from a colleague. In addition, social media sites offer professional socialisation. All forms of professional socialisation provides collegiate support, validation and sharing of practice knowledge that can nurture traits of resiliency in self, students and colleagues (McGee, 2006).

This study builds on previous work by Scanlon et al. (2010) as it reinforces the importance of supportive, non-judgemental supervision by a respected occupational therapy colleague. Effective supervision of new graduates appeared to be a key strategy in building professional identity and sustaining professional resilience. It can support graduate's belief in the efficacy of occupation as a therapeutic medium. This is important when new graduates work in clinical settings with a strong biomedical focus on diagnostics and symptom reduction. In addition, professional supervision allows for case based supervision and time for reflection on the role played by theoretical knowledge in practice. There is also opportunity to discuss how to balance discipline specific duties, theories and concepts with therapies derived from psychological theories. Supervision also provides a forum to debate and negotiate professional identity issues and question occupational perspectives and the application and role of discipline specific theories in professional reasoning. For geographically isolated practitioners this professional supervision can occur in a non-traditional manner using information technology.

Extending career longevity is a key issue for the Australian occupational therapy mental health workforce (Ceramidas, 2010). The findings from the study demonstrated that for many practitioners knowing when to leave a job, which negates professional identity, or occupation-based practice was important as this extends career longevity. The study indicates that the retention of minority professions in interprofessional teams can be improved through the creation of workplaces where all members feel validated (Nolan &

Hewison, 2008; Payne, 1982). It also showed that strong leadership by occupational therapy professional leads and managers can promote professional resilience through the implementation of supportive strategies that enhance professional socialisation and identity.

Limitations of the study.

While this study explores the nature of professional resilience in occupational therapy this subject requires further research to evaluate its applicability to the wider occupational therapy community. The limitations of this study are the small sample size located in one geographical location. In this location practitioners had the freedom to choose an occupation-focused model and the findings may not be transferable to practitioners who work in services that adopt the explicit use of one occupation-focused models. When considering professional resilience it would also be helpful to discuss this issue with those occupational therapists who have chosen to leave the profession to identify if any additional strategies could have prevented this.

Conclusion

A greater understanding of strategies that support professional resilience could assist occupational therapists live with the tensions experienced in mental health practice. An awareness and adoption of strategies at educational, managerial and practitioner level may combat difficulties faced in the recruitment and retention of occupational therapists in the mental health workforce (Scanlon et al., 2010). Professional resilience in occupational therapy is multifaceted and appears to be connected to a strong professional identity. It is sustained when there are opportunities to use concepts and discipline based theories to engage in occupation-based practice.

By developing services that offer professional supervision, and the development of professional networking appear essential in the maintenance of professional resilience. A greater understanding of the issues that strengthen and challenge professional identity can assist educators and managers to better prepare graduates to transition into practice, and develop strategies to increase retention of experienced practitioners.

References

Ashby, S., & Chandler, B. (2010). An exploratory study of the occupation-focused models included in occupational therapy professional education programmes. *British Journal of Occupational Therapy, 73*(12), 616-624. doi: 10.4276/030802210X12918167234325

Bazeley, P. (2007). *Qualitative Data Analysis with NVivo*. London: Sage Publications Limited.

Canadian Association of Occupational Therapists. (2002). *Enabling occupation: An occupational therapy perspective* (Revised ed.). Ottawa, ON: CAOT Publications ACE.

Ceramidas, D. M. (2010). A case against generalisation of mental health occupational therapy in Australia. *Australian Occupational Therapy Journal, 57*(6), 409-416. doi: 10.1111/j.1440-1630.2010.00876.x

Chapparo, C., & Ranka, J. (1997). *Occupational performance model (Australia): Monograph 1*.

Duncan, E. (Ed.). (2006). *Foundations for practice in occupational therapy* (4th ed.). Philadelphia: Elsevier Churchill Livingstone.

Edward, K.-L. (2005). The phenomenon of resilience in crisis care mental health clinicians. *International Journal of Mental Health Nursing, 14*(2), 142–148. doi: 10.1111/j.1440-0979.2005.00371.x

Eklund, M. (2002). Explicit and implicit methods in psychosocial occupational therapy *Occupational Therapy in Mental Health, 18*(2), 3-15. doi: 10.1300/J004v18n02_02

Fink-Samnick, E. (2009). The professional resilience paradigm: Defining the next dimension of professional self-care. *Professional Case Management, 14*(6), 330-332. doi: 10.1097/NCM.0b013e3181c3d483

Fortune, T. (2000). Occupational therapists: Is our therapy truly occupational or are we merely gap filling gaps? [Opinion but based on 4 interviews with british ots working in adolescent or youth services]. *British Journal of Occupational Therapy, 63*(5), 225-230.

Fortune, T., & Fitzgerald, M., H. (2009). The challenge of interdisciplinary collaboration in acute psychiatry: Impacts on the occupational milieu. *Australian Occupational Therapy Journal 56*(2), 81-88. doi: 10.1111/j.1440-1630.2009.00790.x

Foucault, M. (1980). *Michel Foucault. Power/knowledge: Selected interviews and other writings, 1972-1977.* Brighton, England: Harvester Press.

Friedland, J. (1998). Occupational therapy and rehabilitation: An awkward alliance. *The American Journal of Occupational Therapy, 52*(5), 373-381.

Haglund, L., Ekbaldh, E., Thorell, L.-H., & Hallberg, I. R. (2000). Practice models in Swedish psychiatric occupational therapy. *Scandinavian Journal of Occupational Therapy, 7*(3), 107-113. doi: 10.1080/110381200300006050

Hayes, R., Bull, B., Hargreaves, K., & Shakespeare, K. (2008). A survey of recruitment and retention issues for occupational therapists working clinically in mental health. . [Research article]. *The Australian Occupational Therapy Journal 55*(1), 12-22. doi: 10.1111/j.1440-1630.2006.00615.x

Hodgetts, S., Hollis, V., Triska, O., & Dennis, S. (2007). Occupational therapy students' and graduates' satisfaction with professional education and preparedness for practice. *Canadian Journal of Occupational Therapy, 74*(3), 148-160

Holloway, I., & Freshwater, D. (2007). *Narrative research in nursing*. Oxford: Blackwell Publishing.

Kielhofner, G. (2008). *Model of human occupation: Theory and application* (4th ed.). Baltimore: Lippincott Williams & Wilkins.

Kinsella, E. A., & Whiteford, G. E. (2009). Knowledge generation and utilisation in occupational therapy: Towards epistemic reflexivity. *Australian Occupational Therapy Journal 56*(4), 249–258. doi: 10.1111/j.1440-1630.2007.00726.x

Law, M., & McColl, M. A. (1989). Knowledge and use of theory among occuaptional therapists: A Canadian survey. *The Canadian Journal of Occupational Therapy, 56*(4), 198-204.

Lloyd, C., King, R., & Ryan, L. (2007). The challenge of working in mental health settings: Perceptions of newly graduated occupational therapists. *British Journal of Occupational Therapy, 70*(11), 460-470.

McGee, E. (2006). The healing circle: Resiliency in nurses. *Issues in Mental Health Nursing, 27*(1), 43-57. doi: 10.1080/01612840500312837

Mischler, E. G. (1986). *Research interviewing: context and narrative*. Cambridge, MA: Harvard University Press.

Molineux, M. (2011). Standing firm on shifting sands. *New Zealand Journal of Occupational Therapy, 58*(1), 21-28.

Nolan, E., & Hewison, A. (2008). Teamwork in primary care mental health: A policy analysis. *Journal of Nursing Management, 16*(6), 649-661. doi: 10.1111/j.1365-2934.2007.00766.x

OT Australia. (1999). *Australian Competency Standards for Occupational Therapists in Mental Health*. Fitzroy, Victoria: OT Australia.

Payne, M. (1982). *Working in teams*. Basingstoke: Macmillan.

Rodger, S., Thomas, Y., Holley, S., Springfield, E., Edwards, A., Broadbridge, J., . . . Hawkins, R. (2009). Increasing the occupational therapy mental health workforce through innovative practice education: A pilot project. [research]. *Australian Occupational Therapy Journal 56*(6), 409-417. doi: 10.1111/j.1440-1630.2009.00806.x

Rosen, A., & Callaly, T. (2005). Interdisciplinary teamwork and leadership: Issues for psychiatrists. *Australasian Psychiatry, 13*(3), 234-240. doi: 10.1111/j.1440-1665.2005.02195.x

Scanlon, J., Still, M., Stewart, K., & Croaker, J. (2010). Recruitment and retention issues for occupational therapists in mental health: Balancing the pull and the push. *Australian Occupational Therapy Journal 57*(2), 102-110. doi: 10.1111/j.1440-1630.2009.00814.x

Townsend, E. A., & Polatajko, H. (2007). *Enabling occupation ll: Advancing an occupation vision for health, well-being, and justice through occupation* Ottawa, ON: CAOT Publications ACE.

Trevithick, P. (2008). Revisiting the Knowledge Base of Social Work: A Framework for Practice. *British Journal of Social Work, 38*(6), 1212-1237.

Turpin, M., & Iwama, M. K. (2011). *Using occupational therapy models in practice: A field guide*. Edingnurgh: Churchill Livingstone Elesevier.

Wengraf, T. (2001). *Qualitative research interviewing: Biographical narrative and semi-structured methods*. London: Sage Publications.

Whiteford, G. E., & Wilcock, A. A. (2001). Centralizing occupation in occupationl therapy curricula: Imperative of the new millennium. *Occupational Therapy International, 8*(2), 81-85. doi: 10.1002/oti.134

Wilding, C., Marais-Strydom, E., & Teo, N. (2003). MentorLink: Empowering occupational therapists through mentoring. *The Australian Occupational Therapy Journal 50*(4), 259–261. doi: 10.1046/j.1440-1630.2003.00378.x

Xyrichis, A., & Ream, E. (2008). Teamwork: A concept analysis. *Journal of Advanced Nursing, 61*(2), 232-241. doi: 10.1111/j.1365-2648.2007.04496.x