An exploration of work-related stress and support structures experienced by occupational therapists working at a physical rehabilitation unit

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DECLARATION

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ABSTRACT

Introduction: Work-related stress is experienced in most working environments but can be particularly high in health-care environments. Support structures can help to alleviate the burden of work-related stress, but whether or not these structures are in place and adequate needs exploration.

Aim: To explore and describe the work-related stress experienced by occupational therapists working at a physical rehabilitation unit and to determine whether the current support structures are addressing the work-related stress that they experience.

Methods: This study was qualitative in nature. A phenomenological approach was used. Seven occupational therapists employed at the study setting were interviewed using semi-structured methods. Data was collected, transcribed and analysed by the researcher, and themes and sub-themes were extracted.

Findings: All of the participants were experiencing quite high levels of work-related stress, mainly due to the nature of the work environment and challenges related to management and supervision. Other causes of stress were problems related to caseload, the role of the occupational therapist (OT) in the team, issues related to their colleagues and qualitative versus quantitative care delivery. The study also revealed that the participants were not satisfied with the support structures that were in place and had recommendations as to how the support structures could be improved to reduce work-related stress.

Conclusion: The findings of the study confirmed the need for more effective support structures. Participants were quite vocal about the amount of stress and the lack of support they were experiencing – to the extent that they had to find alternative means of support. It was felt that management should show more awareness through acknowledging the therapists' experiences, and that the organisation should put better support structures in place.

Recommendations: Individual counselling, team building and group therapy sessions were recommended, as was decreasing the extent of responsibilities over-and-above the core job requirements or having smaller caseloads or more staff.

Among the many suggestions regarding managerial improvements were that managers should be more aware of the staff, help with the patients and be more empathetic. Improved communications through all levels of the Centre and a more representative measure of performance was also suggested.

Keywords:

occupational therapist

physical rehabilitation centre

rehabilitation

support structure

work-related stress

ABSTRAK

Inleiding: Alhoewel werksverwante stress in die meeste werksomgewings voorkom is dit besonder hoog in die gesondheidsorg omgewing. Ondersteuningsstrukture kan help om die druk van werksverwante stres te verlig. Die beskikbaarheid en toereikendheid van ondersteuningsstrukture moet ondersoek word.

Doel: Om die werksverwante stres wat arbeidsterapeute werksaam by 'n fisiese rehabilitasie eenheid ondervind te ondersoek en te beskryf, asook om vas te stel of die bestaande ondersteuningsstrukture hul werksverwante stres aanspreek.

Metode: Die studie was kwalitatief van aard. 'n Fenomenologiese benadering is gevolg. Data is ingesamel deur semi-gestruktureerde onderhoude, met sewe arbeidsterapeute, indiens van die Wes-Kaapse Rehabilitasie Sentrum. Die navorser het alle data ingesamel, getranskribeer en geanaliseer. Temas en sub-temas is ge-identifiseer tydens tematiese analise.

Bevindinge: Alle deelnemers het hoë vlakke van werksverwante stres beskryf. Volgens deelnemers was dit grootliks te wyte aan die aard van die werksomgewing, sowel as uitdagings met betrekking tot bestuur en toesighouding. Ander oorsake van stres het die werkslading, die rol van die arbeidsterapeut in die span, inter kollegeale spanning en 'n kwalitatiewe benadering tot pasiënt sorg ingesluit. Deelnemers was nie tevrede met die ondersteuningsstrukture wat in plek was tydens die study nie.

Gevolgtrekking: Die studie bevindings het die noodsaaklikheid van ondersteuningsstrukture beklemtoon. Die deelnemers was besonder uitgesproke oor die hoeveelheid stres en die tekort aan ondersteuning wat hulle ervaar het. Hulle moes meestal self sorg dat hulle die nodige ondersteuning kry. Deelnemers was van mening dat bestuurders meer begrip kan toon vir die omstandighede waaronder terapeute gewerk het en dat die organisasie ondersteuningsstrukture moet inisieër.

Aanbevelings: Deelnemers het individuele beradingsessies, spanbou en groep terapiesessies aanbeveel. Voorts het hulle aanbeveel dat verantwoordelikhede wat nie deel van hulle kern rol is nie verminder word en dat die pasiënt lading van terapeute verlaag word. Terapeute het klem gelê op aanbevelings wat betrekking het op bestuurders soos dat bestuurders empatie sal hê met terapeute, 'n groter

bewustheid van terapeute se posisie aan die dag sal lê en dat hule 'n klein kliniese lading sal dra. Verbeterde kommunikasie op alle vlakke van die instansie en 'n meer verteenwoordigende metode om prestasie te meet is ook aanbeveel.

Kernwoorde:

arbeidsterapeut

fisiese rehabilitasie sentrum

ondersteuningstrukture

rehabilitasie

werksverwante stres

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DEFINITION OF KEY CONCEPTS

Occupational therapist: A health professional who provides the service of occupational therapy.

Occupational therapy: *"*Occupational therapy is a client-centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement." (WFOT 2012)

Rehabilitation: "… a goal-directed process to reduce the impact of disability and facilitate full participation in society by enabling people with disability to reach optimum mental, physical, sensory and/or social functional levels at various times in their lifespan. The rehabilitation process has levels or stages with specific outcomes for participation throughout the lifespan." (DoH, 2013)

Specialist rehabilitation centre*:* "A specialised rehabilitation hospital caters for clients with severe disabling conditions and requires the services of rehabilitation personnel with specialist skills. The multi-disciplinary team at this level is able to assess for and prescribe and issue assistive devices. Clients at this level undergo intensive rehabilitation to regain as many functional abilities and skills as possible to be able to go back and integrate into communities." (DoH, 2013)

Support structure: A system that provides assistance and help.

Work-related stress: "Stress is the negative feature of the work environment that impinges on the individual…" – *Balogun, Titiloye, Balogun, Oyeyemi & Katz 2002, page 131*

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CHAPTER 1

Background to the study

1.1   Introduction

This chapter highlights the reasons and motivation for embarking on the research. It provides the reader with a background to the study and explains the problem that led to the study, which is entitled 'An exploration of work-related stress and support structures experienced by occupational therapists working at a physical rehabilitation unit'. The aims and objectives of the study are presented and finally the significance of the study is described.

1.2   Study background

The occurrence of stress is not unusual and everybody is susceptible to it in some or other form at various points in their lives. There are many causes of stress, such as financial burdens or relationship difficulties that may manifest in various ways. These manifestations may include anxiety, memory loss or compromised immune systems (Kumar, Rinwa, Kaur & Machawal 2012). According to Balogun *et al.* (2002 p. 131), stress is "a constant phenomenon in today's society… particularly prevalent in the work setting". It is also stated that "stress is the negative feature of the work environment" (Balogun *et al* 2002 p. 131).

Work-related stress has a cyclic consequence in that the presence of stress not only has a negative effect on the employee but also affects the work environment. In turn, a poor working environment will lead to more stress experienced by the employee. Therefore it's important that employees learn to manage their stress and that work environments provide adequate support to reduce stressful situations (Allan & Ledwith 1998; Bassett & Lloyd 2001; Brown & Pranger 1992; Flett, Biggs & Alpass 1995). As Allan and Ledwith state (1998 p. 350): "Stress is an organisational issue and requires organisational responses."

Health professionals are particularly at risk of experiencing workplace stress due to the nature of their work. They interact intensely and closely with their patients (Balogun *et al* 2002; Donohoe, Nawawi, Wilker, Schindler & Jette 1993; Edwards & Dirette 2010; Rogers &

Dodson 1988). These patients have often undergone trauma and are dealing with their own loss and stress. Loss could be in terms of limited functionality as a result of the trauma, or of family members or friends who have died because of the trauma. It is even more stressful for patients who are undergoing rehabilitation after incurring permanent impairments due to health conditions/traumas such as strokes or spinal cord injuries.

Part of the role of the occupational therapist in the physical rehabilitation team is to focus on the functional, everyday tasks that the patient is required to relearn. This can be highly stressful for patients, dealing with activities that they were able to do with ease prior to their traumatic incident. Another role of the OT is cognitive rehabilitation. This includes retraining patients who are experiencing cognitive fallout such as memory loss, disorientation and motor planning problems, to name just a few areas. Patients experience many frustrations and these can be transferred onto the therapists, thus causing additional stress for the OT.

1.3   Motivation for the study

Working as a health professional, particularly in the field of physical rehabilitation, I experience the benefits of working with people – the joy and sense of accomplishment when the patients achieve their desired goals. But I am also aware of the negative consequences of work associated with physical rehabilitation and by the end of my third year of working in this environment I had personally experienced the consequences of work-related stress. For some time I felt depleted of all energy and compassion. Luckily that low-point was short-lived, and once my head was above water again I realised that I was not the only therapist who had been sinking. During this patch and even after, I found myself questioning if it was purely the caring nature of the profession or whether there was also something else contributing to increased levels of stress in the workplace. I reflected on the type and amount of support I received during this time and began to realise that the issue was a lot bigger than just the emotions I was experiencing, that it was a common occurrence amongst my colleagues and something that required further attention.

On starting to read about the occurrence and management of stress experienced by health professionals working in the field of physical rehabilitation, I identified a gap in the body of knowledge regarding the influence of support structures on the work-related stress experienced by occupational therapists at physical rehabilitation centres. Most of the previous research has focused predominantly on burnout rather than work-related stress (Balogun *et al* 2002; Brown & Pranger 1992; Devereux, Hastings, Noone, Firth & Totsika

2009; Donohoe *et al* 1993; Edwards & Dirette 2010; Gupta, Paterson, Lysaght & Von Zweck 2012). A description of the distinction between work-related stress and burnout is provided by Balogun, Titiloye, Balogun, Oyeyemi and Katz (2002 p. 131): "Stress is the negative feature of the work environment that impinges on the individual… Unabated work-related stress can predispose individuals to burnout. Burnout occurs when a person has reached a state of mental and physical exhaustion combined with a sense of frustration and personal failure."

Few studies focussed solely on occupational therapists and the effects, causes and impact of support structures on work-related stress in this group (Brown & Pranger 1992; Poulsen, Meredith, Khan, Henderson, Castrisos & Khan 2014; Pranger & Brown 1992; Sweeney, Nicholls & Kline 1991; Wressle and Samuelsson 2014), i.e. even though this group of professionals has a high possibility of developing work-related stress due to the variety of stress factors that they experience at work. A study conducted in Canada ranked occupational therapy as the seventh-most stressed-out profession (Gupta *et al* 2012). According to Balogun *et al*. (2002, p.132), "…occupational therapists are prime candidates for burnout." However, finding articles that focussed on occupational therapists who worked in the field of physical rehabilitation was almost impossible. The majority of the articles used a variety of rehabilitation workers including either physical therapists (Balogun *et al* 2002; Donohoe *et al* 1993; Flett *et al* 1995; Harris, Cumming & Campbell 2006; Kowalski, Driller, Ernstmann, Alich, Karbach, Ommen, Schulz-Nieswandt & Pfaff 2010; Mutkins, Brown & Thorsteinsson 2011) or psychiatric occupational therapists (Brown & Pranger 1992; Devereux *et al* 2009; Pranger & Brown 1992). Thus it seemed there was a need for more specific research involving occupational therapists in a physical rehabilitation setting.

The majority of studies done on work-related stress were quantitative in nature and aimed to quantify stress (Alan & Ledwith 1998; Flett *et al* 1995; Harris *et al* 2006; Leonard & Corr 1998; Obasohan & Ayodele 2014), burnout (Balogun *et al* 2002; Brown & Pranger 1992; Donohoe *et al* 1993; Du Plessis, Visagie & Mji 2014; Edwards & Dirette 2010; Kraeger & Walker 1993; Painter, Akroyd, Elliot & Adams 2003; Poulsen *et al* 2014) or support structures (Devereux *et al* 2009; Mutkins *et al* 2011). A few studies used a mixed method design (Gupta *et al* 2012; Smith, Kleijn, Trijsburg & Hutschemaekers 2007) and included interviews to provide a more detailed, personal approach. I identified three systematic reviews (Bassett & Lloyd 2001; Lloyd & King 2001; Wood & Killion 2007) that were insightful in highlighting various aspects of the study question. One study was purely qualitative (Sweeney, Nichols & Cormack 1993). A dedicated, qualitative study using only occupational therapists with a specific focus on the support structures in a physical rehabilitation setting in

a developing country has yet to be done. Exploration of whether these support structures are fulfilling their role and reducing work-related stress, provides a starting point and begins to fill the apparent gap of knowledge.

1.4   Study problem

Currently there is insufficient information available regarding the work-related stress experienced by occupational therapists working at physical rehabilitation units. It is questionable whether the support structures to manage stress in a rehabilitation unit in the Western Cape province of South Africa are adequate to address the work-related stress experienced by occupational therapists working in this environment.

1.5   Study aim

To explore and describe the work-related stress experienced by occupational therapists working at a physical rehabilitation unit and to determine whether current support structures are addressing this stress.

1.6   Study objectives

- Describe the occupational therapists' work environment and work experience
- Describe the work-related stress experienced by study participants
- Identify the causes of the work-related stress according to participants
- Identify existing support structures according to participants
- Describe whether the support structures are adequate according to participants
- Identify further support structures that occupational therapists would require

1.7   Significance of the study

This study provided a platform for a small sample of occupational therapists to share their concerns about work-related stress and available support services. Although the process

was by no means therapeutic, it might have been beneficial insofar as a sympathetic ear can be a coping mechanism in helping to alleviate the burdens experienced in the workplace (Balogun *et al* 2002; Bassett & Lloyd 2001; Devereux *et al* 2009).

The study provided information on the causes of work-related stress, current support structures and suggestions for further support. It is hoped that the managers at the study unit will consider implementing the suggested support structures. It is further hoped that this type of study will bring awareness to a larger population and that the Western Cape Department of Health will also be able to utilise some of the suggestions from this study in their other institutions, consequently benefitting more occupational therapists as well as allied health professionals.

On an academic level, this study added to the gap of knowledge that was described in 1.3. Research in the field of occupational therapy is slowly becoming popular and more literature is becoming available. This study should promote the profession and provide further knowledge and research options.

1.8   Summary

Occupational therapists who work at physical rehabilitation units are susceptible to work-related stress due to the nature and intensity of their work. I experienced work-related stress myself and observed it in my colleagues. The presence of support structures is assumed to reduce the levels of stress in our work environment, however, the precise nature of the support structures and how beneficial they are is unknown. So it was that this study evolved to explore the influence of support structures on the work-related stress experienced by occupational therapists working in a physical rehabilitation unit.

1.9   Layout of the document

The study is represented through six chapters in this dissertation. **Chapter 1** gives the background to the study, introducing the study and the motivation. The study problem, aim and objectives as well as the significance of the study are all discussed in Chapter 1.

The Literature Review in **Chapter 2** focuses on two main aspects: firstly, work-related stress, and secondly, health professionals. Work-related stress is defined and the various causes

are highlighted. The consequence of prolonged work-related stress is explored as is how to manage this stress to prevent the consequences. Aspects relating to the health professionals are discussed, such as their years of experience, role and attitude in the team, as well as the role confusion.

Chapter 3 presents the methodology of the study. This covers the study design, the setting, the population and sampling, the data collection instrument, the pilot study, identifying participants and collecting data, data analysis and ethical considerations.

The findings of the study are presented in **Chapter 4** and discussed In **Chapter 5**. And finally, in **Chapter 6**, conclusions are drawn and recommendations are made.

CHAPTER 2

Literature review

2.1 Introduction

In order to identify literature relevant to the study the following search engines were used: Pubmed, OT seeker and Google Scholar. The terms that were searched were: Occupational Therapy, therapist; stress; work-related stress; rehabilitation centre and support structures. I initially limited the search to South Africa but then realised that there would not be sufficient literature and included international studies. I also made use of the reference lists in the articles I found to search for further relevant literature. As there was very little research found with those terms, I ended up not excluding many articles and actually including those that spoke about burnout and had other study settings such as psychiatric institutions.

Members of occupational groups who engage compassionately with people, such as health professionals, are likely to experience work-related stress and to be negatively affected by the experience (Edwards and Dirette 2010; Rees and Smith 1991; Ruotsalainen, Serra, Marine & Verbeek 2008). Jobs that carry the most stress are those which have a variety of stress factors and where the employee feels they have little influence over their situation and minimal support (Devereux *et al* 2009; Marine, Ruotsalainen, Serra & Verbeek 2006), or when health professionals lack confidence in the treatment they provide (Tyler & Cushway 1998), or when the requirements of the job surpass their abilities to do the job both physically and emotionally (Mutkins *et al* 2011). Prolonged work stress can result in burnout and have a negative effect not only on the health professional but also on the workplace and the patient (Lloyd & King 2001; Marine *et al* 2006). In addition to burnout, other disorders that could develop due to work-related stress include hypertension, peptic ulcers, depression and asthma (Mino, Babazono, Tsuda & Yasuda 2006).

This review of published literature provides the reader with an overview. The chapter looks at the three main components of this study. Firstly, it aims to explore work-related stress, what it is, how it relates to burnout and what causes/leads to this mental and physical state. Secondly, literature is explored to describe the strategies and coping mechanisms that have been seen to aid in reducing work-related stress. And finally, this review looks at the health professional and specifically the OT.

2.2   Work-related stress

2.2.1   DEFINITION

Leonard and Corr (1998 p. 257) state simply that "stress is a general term used in everyday language and implies that the person is experiencing some kind of pressure and having difficulty coping". In order to cope with a stressful situation, a person needs skills to either get out of or influence the situation so that they function better or learn to handle the stress (Van Der Colff & Rothmann 2009). Rees and Smith (1991) agree with this comment but add that the use of coping strategies can also affect the degree of stress experienced by the person, as some people make better use of coping strategies and are thus less affected by stress. Stress is further dependent on a person's history, characteristics, temperament, capabilities and awareness of the situation. Furthermore, the availability of moderators that the therapist can use to deal with the stress factors can help alleviate stress (Edwards & Burnard 2003). According to Sweeney *et al* (1991 p.287): "Stress is an individual perception." If the perceived needs of the work environment outweigh the perceived ability to address these, they will result in the employee experiencing stress (Tyler & Cushway 1998).

It is important to note that stress and burnout are not synonymous. Stress can be utilised in a positive manner, bringing about a sense of urgency and an ability to deal with the task at hand. Whereas with burnout, all hope is lost and there is a sense of inability to complete tasks (Espeland 2006). However, prolonged exposure to work-related stress can result in burnout that impacts hugely on one's work performance (Edwards & Dirette 2010; Pranger & Brown 1992; Wood & Killion 2007).

2.2.2   CAUSES / RISK FACTORS

The research reviewed identified a number of causes/risk factors leading to the work-related stress experienced by health professionals, including occupational therapists and physiotherapists, social workers and nurses. The health professionals in these studies worked in a variety of environments, from community centres and old age homes to mental health institutions and physical rehabilitation centres. From these studies, roughly eight main risk areas that can lead to work-related stress where identified. These are, in no particular order of importance: caseload size; management/supervisor/organisational cause; patient contact; working environment; resources and demands; rewards and recognition; poor professional value; and lack of self- esteem.

Caseload Size

Therapists treating a high number of patients are reported to experience more stress (Balogun *et al* 2002; Harris *et al* 2006; Lloyd, McKenna & King 2005; Moore, Cruickshank & Haas 2006a). The more patients one treats, the more stories and tragedies one is exposed to. There is constant decision-making involved in prioritising patients. Du Plessis (2012) found in a study done with 49 South African therapists, employed at rehabilitation hospitals in the private sector, that most therapists complained about time being an issue, given the added administrative tasks associated with high patient-to-therapist ratios. Similarly, Wressle and Samuelsson (2014) found in a study involving Swedish occupational therapists (n = 476) that lack of time was one of the variables causing the most stress, and Poulsen *et al* (2014) found that in a group of Australian occupational therapists (n = 951) work overload was significantly associated with the presence of burnout. In addition, high caseloads can cause a high staff turnover (Balogun *et al* 2002; Du Plessis 2012; Moore, Cruickshank & Haas 2006a; Tourangeau, Widger, Cranley, Bookey-Basset & Pachis 2009) and consequently can have further negative impact on the remaining staff with too many patients per therapist (Du Plessis 2012; Harris *et al* 2006). In the study by Tourangeau *et al* (2009), more than one third of their 162 participants were planning on leaving their current position due to being overworked. These participants were multidisciplinary health care professionals working at long-term facilities in Ontario, Canada.

Management/Supervisor/Organisational Causes

Managers have an important role to play in preventing work-related stress and various aspects of management have been found to increase stress in the workplace. These include:

- Lack of support from supervisors (Balogun *et al* 2002; Du Plessis 2012; Lloyd *et al* 2005)
- Not ensuring an adequate number of staff (Sweeney *et al* 1991)
- Not providing mentorship and supervision (Sweeney *et al* 1991)
- Not acknowledging good performance (Sweeney *et al* 1991)
- Increased pressure from managers for staff to perform within the time constraints (Balogun *et al* 2002; Du Plessis 2012; Harries *et al* 2006)
- Inflexibility regarding administrative tasks (Balogun *et al* 2002; Du Plessis 2012; Harries *et al* 2006)
- Managers' expectations and requirements (Lloyd & King 2001)

- Managers who are too rigid and lack understanding increase the risk of employees experiencing stress at work (Du Plessis 2012)
- Discrimination (Obasohan & Ayodele 2014)

In addition to managerial challenges, the nature of the job and poorly structured organisations, a lack of prospects for career advancement and poorly managed conflict between staff members can increase tension and stress in the workplace (Lloyd *et al 2005;* Lloyd & King 2001).

Patient Contact

Constant exposure to patients who have been traumatised, have a long-term illness, or who have a fatal illness, is likely to result in stress (Smith *et al* 2007; Sweeney *et al* 1993a). Pranger and Brown (1992) received a 70% response rate from the 91 OT personnel who worked in psychiatric facilities in Ontario, and they describe how the relationship that is formed with the patient as well as how often the therapist sees the patient, whether the patient improves and the residual disability experienced by the patient can influence the amount of stress experienced by the health professional.

Working Environment

The work environment can cause work-related stress (Edwards & Dirette 2010). The health care work environment is highly stressful and constantly changing, placing heavy demands on therapists (Balogun *et al* 2002; Flett *et al* 1995; Harris *et al* 2006). Balogun *et al* (2002) states that if a workplace has large emotional and physical stress factors, such as policies and procedures and working standards, therapists are likely to suffer from burnout if unable to cope with the work-related stress. Work environments influence the quality of care an organisation provides (Tourangeau *et al* 2009). Although outdated literature, Schuster, Nelson, Quisling (1984 p. 302) have a pertinent point in "…that the type of facility in which a person works may affect the potential for experiencing symptoms of burnout".

Flett and colleagues (1995 p. 124) describe the responsibilities of rehabilitation therapists as follows: "To focus on community-based planning and service delivery, to acknowledge the rights and responsibilities of consumers, to maintain high standards of service quality and customer satisfaction, and generally function in an environment in which there are too many clients, not enough time, and not enough resources." Work in a physical rehabilitation centre is not only emotionally taxing but also physically demanding (Du Plessis 2012). In addition, the nature of a physical rehabilitation centre is that patients receive treatment over a long

period of time (Donohoe *et al* 1993) during which the physical and psychological effects of the injury are likely to become more evident. What contributes to the emotional stress is that patients do not always improve, resulting in the therapist despairing and feeling helpless (Du Plessis 2012).

The Gupta *et al* (2012) study had both quantitative and qualitative elements. Sixty five occupational therapists from Ontario participated first in an online survey and then in interviews for qualitative data. The findings showed that therapists complained of exhaustion when treating long-term clients who progressed poorly. Furthermore, the interaction with patients at a rehabilitation centre can be seen as quite monotonous, with little change in conditions (Du Plessis 2012).

Resources and Demands

Another cause of stress is when the demands made on the therapist from the workplace exceed the available resources to deal with these demands – as can be found with high caseloads, insufficient staff and a lack of equipment (Du Plessis 2012; Harris *et al* 2006; Lloyd *et al* 2005; Sweeney *et al* 1993b; Wressle & Samuelsson 2014).

Rewards and Recognition

Due to the nature of the helping profession and the type of patients that occupational therapists often treat, rewards from and recognition by the patient may be missing (Sweeney *et al* 1993a). This has been an ongoing cause of work-related stress identified as early as 1984 by Schuster *et al* in their American study involving 160 physio therapists randomly selected from a nationwide sample. A lack of positive recognition from supervisors can result in decreased self-worth and increased stress levels. Moreover, Wilkins (2007) and Balogun *et al* (2002) highlighted that the poor financial value of the profession – as seen in the low salaries and poor opportunities for climbing the career ladder – also contributes to increased stress. Similarly, Du Plessis (2012) found that salaries are not on par with market-values, and Poulsen *et al* (2014) too found low satisfaction with income to be a cause of burnout. Thus therapists might well feel under-valued and under-recognised in their work environment.

Poor Professional Value and Lack of Self-Esteem

As highlighted in literature, occupational therapists have a tendency to perceive their profession as having lower worth than other professions. Moore, Cruickshank & Haas 2006a

identified this challenge while studying a group of 14 occupational therapists in Sydney, Australia. Exacerbating the situation is that occupational therapists work closely with other health professionals and often the boundaries blur and responsibilities overlap, as found by Sweeney *et al* (1993a) in their study involving 30 interviewee participants and 310 postal survey participants who were all occupational therapists working in various environments in the Bath District of England. Besides the blurred boundaries, there is also a lack of understanding and acceptance on the part of other health professionals that can cause added stress (Moore *et al* 2006a). Balogun *et al* (2002) describe how role conflict can cause stress, and if managers fail to clarify the role responsibility, a lack of certainty and lower value in the profession follow, increasing the level of stress (Balogun *et al* 2002; Harris *et al* 2006; Lloyd *et al* 2005). If the therapist's self-worth is low, inevitably this will have a negative impact on their stress levels.

According to Espeland (2006), being overly focused on performing excellently may actually result in substandard work. This can also result in negative feedback and self-criticism, which ultimately lowers a therapist's confidence and self-esteem, which in turn causes increased stress and anxiety. Flett, Biggs and Alpass (1995) cited Ganster and Schaurbroeck (1991), who said that individuals with low-self-esteem are more susceptible to their surroundings and are thus more prone to developing a negative response to work-related stress. Self-esteem may in a sense be viewed as a moderator for stress.

Other Causes

Sweeney *et al* (1991) conducted a pilot study with 156 occupational therapists working in various scenarios in South West England to validate an instrument that measures work-related stress. From this study they found that stress was not only caused by the more predictable sources but also from the "…less obvious sources, such as being poorly prepared for the job and needing stimulation in the work" (1991 p. 286). A negative relationship at work – with colleagues, supervisors or patients – that results in conflict, is another cause of work-related stress (Du Plessis 2012; Lloyd *et al* 2005).

2.2.3. CONSEQUENCES OF WORK-RELATED STRESS

As mentioned previously, prolonged stress can result in burnout. This can have a negative impact on the workplace in that not only is work performance substandard and the incidence of accidents more common, but absenteeism increases. Therapists are more prone to leaving their jobs; the quality of service diminishes and therapists become unhappy, dissatisfied and lose hope in their performance (Chao, Jou, Cing-Chu Liao, & Kuo, 2015;

Edwards & Dirette 2010; Flett *et al* 1995; Van der Colff & Rothmann 2009). Patients get treated half-heartedly and do not receive the best care. Therapists' personal relationships can also start to take strain as they rely on family and friends for support or experience symptoms of burnout. Therefore is it critical that one acknowledges that "stress is an issue of concern for occupational therapists" (Wressle & Öberg, 1998, p.468). Stress should not be ignored but brought to the attention of therapists and managers in order for change to be facilitated.

2.2.4 MANAGEMENT OF WORK-RELATED STRESS

Fundamental to a good work environment is the management of work-related stress. If one uses strategies to prevent stress at work, you'll have a good working experience (Ruotsalainen *et al* 2008). According to Devereux *et al* (2009 p. 368), coping strategies, both practical ("changing the situation") and emotional ("manage emotional distress"), are necessary in dealing with work stress factors and reducing the chances of burnout. Gupta *et al* (2012 p. 92) summarises various methods to reduce the likelihood of burnout through managing work-related stress. These include: "Setting boundaries and balancing needs of home and work, utilizing time management strategies to maximize productivity, seeking support from formal and informal social networks, setting goals and priorities, physical self-care, and turning down tasks." Both organisational and social support play a role in moderating work stress factors and decreasing the risk of burnout (Mutkins *et al* 2011). According to Balogun *et al* (2002 p. 138): "… social support in an organizational setting is a relatively powerful coping strategy in counteracting burnout."

Interestingly, Schuster *et al* (1984) notes that therapists who are possibly showing symptoms of burnout may be using avoidance strategies as coping mechanisms. It is vital that staff learn to use positive coping strategies as these lead to a sense of worth, whereas maladaptive coping mechanises such as avoidance can result in burnout (Devereux *et al* 2009).

The Role of the Supervisor/Manager

According to Tourangeau *et al* (2009 p. 173) a crucial element of a successful work environment "… is the nature and effectiveness of leadership, management and supervision". Support from supervisors is critical in reducing work-related stress and preventing burnout (Balogun *et al* 2002; Du Plessis 2012; Edwards & Burnard 2003; Lloyd & King 2001; McGilton, McGillis Hall, Wodchis & Petroz 2007; Tourangeau *et al* 2009). Staff

members who feel supported at work are more likely to handle the stresses that the work environment produces (Schuster *et al* 1984; Mutkins *et al* 2011).

According to Mutkins *et al* (2011), who explored the role of the supervisor in a study involving 80 participants who worked directly with intellectually disabled clients in the Australian states of New South Wales, Queensland and Victoria, supervisors can start to reduce stress simply by acknowledging that the workplace is stressful. Supervisors should be encouraged to develop social support strategies within the workplace, such as effective communication strategies, and an awareness of the needs of the employee, even on a personal level.

McGilton *et al* (2007) explored work-related stress amongst 222 nurse aids employed at 10 long-term care facilities in Ontario, Canada, and found that a positive relationship between supervisor and employee can reduce the effects of work-related stress and increase the job performance. Supervisors should acknowledge and praise good performance immediately. More formal reviews should also take place to monitor performance and feedback from managers must be given in a constructive manner (Sweeney *et al* 1993b). Good performance can be assisted through clear guidelines stipulated in a job description, which should be agreed upon and should include the policies and procedures that the therapist needs to follow. The benefit and importance of a thorough orientation and induction programme is also highlighted by Sweeney *et al* (1993b). If staff are fully adjusted to their new work environment it reduces the potential for stressful situations. Regular staff development in the form of journal clubs and training provide an opportunity for learning and supervision, ensuring that staff feel supported and encouraged by their supervisors.

In addition, supervisors must be easily accessible and approachable to members of staff. This includes regular meetings to discuss any problems that arise (Moore *et al* 2006b; Sweeney *et al* 1993b). Employees should be able to approach their managers without feeling a sense of reluctance or distress. The authors also state the importance of managers being advocates for their staff. Employees who were most satisfied were those who had confidence that their managers were advocating for their needs with other departments and higher management. In addition, supervisors should ensure that the work environment is secure enough that employees are able to share varying opinions with their supervisors (Van der Colff & Rothmann 2009).

It is critical for organisations to acknowledge that stress reduction is not only an individual problem but that it requires an organisational response as well. Sweeney *et al* (1993a, p. 140) refers to a lack of stress reduction policy by management as "professional

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irresponsibility", and Van der Colff and Rothmann (2009) also state that organisations should take responsibility in providing support.

Tourangeau *et al* (2009) conclude from their study that, as the recognition of the importance of effective supervisors and leaders grows, these individuals need to acquire and use their skills in order to assist and support their staff effectively. Supervisors need to be trained and equipped to identify stress warning signs in their staff and, with the correct skills, be able to assist employees who experience stress (McGilton *et al* 2007; Wood & Killion 2007). Work-related stress can be easily reduced with quality supervision (Leonard & Corr 1998).

Smaller Caseload

According to Tyler and Cushway (1998, p. 105): "Workload is the main contributor to an appraisal that the job is demanding." Not only would a more appropriate caseload size reduce stress levels, but managers ensuring that the workload is evenly distributed – allowing for more accommodating working hours and ensuring that breaks are taken – will also contribute to the reduction of work-related stress (Wood & Killion 2007). In a recent study conducted with rehabilitation therapists in South Africa, smaller caseloads or more staff were recommended to help control stress (Du Plessis 2012).

Peer Support

Peer support provides a beneficial, constructive coping strategy (Balogun *et al* 2002; Allan & Ledwith 1998). Discussing and sharing with people who can relate to a problem, people such as colleagues, can reduce stress. In fact colleagues are potentially the best source of support. Stress is reduced if professionals feel that they are in a work environment where they are free to debrief, partake in uplifting conversation and explore ideas with colleagues, supervisors and clients. (Donohoe *et al* 1993; Schlenz, Guthrie & Dudgeon 1995).

Group Support / Team Building

In addition to peer support, group support or team building can also be used to alleviate stress. This method doesn't involve an individual employee choosing a colleague to confide in, but rather it is an organisational responsibility involving the whole team of therapists. According to Allan and Ledwith (1998), the use of group support helps to lift the burden of stress experienced at the workplace. Sweeney *et al* (1993a) underline the need for staff support groups that allow staff to debrief and express their feelings of stress and emotional

burden in a constructive and caring manner. Du Plessis (2012) supports the notion that team building will aid in the relieving of negative stress.

Counselling and Debriefing

Counselling allows employees to discuss doubts and worries with a professional who is equipped to guide the process of dealing with these concerns. The benefit of counselling sessions to deal with stress includes improved self-esteem, fewer worries and less susceptibility to depression (Flett *et al* 1995). Walvoord (2006) suggests that healthcare professionals should debrief after being exposed to emotional situations.

Learning Coping Skills

It is advisable that occupational therapists equip themselves with skills that will assist them in coping and managing their stress levels. These skills include time management and learning how to prioritise tasks as well as setting boundaries (Sweeney *et al* 1993a). Also crucial are communication skills, learning to recognise self-worth and how to deal with the stress. It is crucial for therapists to take responsibility for their emotions and stress levels, ensuring that they habitually check their stress levels so as to prevent burnout (Sweeney *et al* 1993a). It is also advisable that employees learn more than one type of coping mechanism so that they are equipped to deal with any kind of stress (Van der Colff & Rothmann 2009).

Time-Outs and Non-Patient Contact Time

Occupational therapists should ensure that they make use of the breaks allocated to them. Regular 'time-outs' from patient contact should be imperative (Du Plessis 2012). They should be allowed to leave the work premises so as to experience being away from the stressful causes when it is time-out (Sweeney *et al* 1993a). Sweeney *et al* (1993a) go on to discuss the importance of scheduling non-patient time into one's day so as to ensure a break from patient contact. And when therapists leave the workplace, it is advisable that there be some task or activity to disconnect the therapist from the workplace. This could include an exercise class or social activity.

Giving Employees Responsibility

Allowing therapists to make decisions in the workplace influences job satisfaction and stress levels (Harris *et al* 2006; Tourangeau *et al* 2009). If therapists have little control in the workplace and high demands are placed on them, especially when it comes to treatment

time, their health may be negatively affected, possibly resulting in exhaustion (Donohoe *et al* 1993). Furthermore, ensuring that the job is challenging and interesting, with opportunities for staff development, can reduce the likelihood of burnout.

Personal Support Structures

Support outside of the workplace was described as valuable in a study conducted by Mutkins *et al* (2011). These support structures play a significant role in reducing psychological distress in the workplace, especially emotional exhaustion.

Stress Management Strategies

In a study by Mino *et al* (2006), 58 precision-machinery workers were randomly divided into two groups – one a control group and the other a group that underwent stress-management sessions. It was found that with the assistance of an effective stress-management programme, depression in the workplace was reduced. Similarly, after conducting a systematic review, Ruotsalainen *et al* (2008) too found that stress management strategies can improve the health of those in the caring profession. A stress management programme includes various strategies that health professionals can use to help decrease the stress and cope with the working environment (Edwards & Burnard 2003).

2.3 Health professionals and work-related stress

This review cannot emphasise enough the fact that health professionals are highly susceptible to feeling that their work is extremely stressful (Wilkins 2007). But the importance of a well-functioning health system is critical for any country as it has huge economic implications (Van der Colff & Rothmann 2009). The following section highlights some of the areas of consideration for individual health professionals and how they are affected by work-related stress. These include age and years of experience, their roles and attitude, role confusion and how this affects the therapist's self-esteem and confidence. As there isn't that much literature specifically focusing on occupational therapists, it is important that therapists refer to the other allied health professions that involve occupational therapists.

Years of Experience and Age

In a study conducted by Harris et al (2006), 139 allied health professionals working in a variety of job settings were asked to complete an online survey. They found that as experience increases, so do perceived levels of stress. This could be due to more responsibility being placed on the professional or to administrative tasks being added to the job requirements. Brown and Pranger (1992) mentioned an increased risk of experiencing work-related stress if therapists are older as they may lack recent training. These older therapists may have become 'institutionalised' and be scared of change.

However, findings from other studies disagree. Mutkins *et al* (2011) found that years of experience and burnout are uncorrelated. In the study by Kowalski *et al* (2010), where 175 health professionals working with people with intellectual and physical disabilities were surveyed using the German version of the Maslach Burnout Inventory-General Survey, and in the study by Poulsen *et al* (2014), it was shown that the occurrence of burnout was higher in younger employees. Sweeney, Nichols and Kline (1993), and Tyler and Cushway (1998), describe how age reduces the chance of burnout and ascribe this to the clinicians having a greater belief in themselves, being more experienced in client treatment and having a greater say in organisational and work requirements.

Therapists who have remained in the same position for many years may feel like they deserve recognition and rewards, such as a raise or promotion (Sweeney *et al* 1993a). If therapists feel they are not paid what they are worth, they might become bitter and resentful – feelings that increase stress (Brown & Pranger 1992).

Role and Attitude of the Therapist

Simply put, the role of the occupational therapists is to help patients achieve their goals. If patients are able to achieve their goals, it may leave the therapist with a great sense of accomplishment and satisfaction (Moore *et al* 2006a). If they are unable to assist their patients, the therapists may feel that they are unable to fulfill their role and start to become stressed. The managers interviewed by Du Plessis (2012) found that therapists, who were motivated but had high expectations which at times they were unable to achieve, were candidates for burnout.

Role Confusion

Many occupational therapists struggle to define their role or to explain and justify what they do (Edwards & Dirette 2010). In this study, 126 occupational therapists from various environments completed the standardised questionnaires and it was found that the inability to define their role can increase their stress level. To the contrary, however, Wressle and Samuelsson (2014) found that professional identity and being clear about their roles did not have a big impact on the stress experienced by the Swedish occupational therapists focused on. Edwards and Dirette (2010) further explain how occupational therapists often 'gap fill', addressing the needs of the client that are not handled by other health professionals. Thus the distinctive role of the OT is overlooked. Therapists who are acknowledged by patients as providing a unique treatment, presented with less stress symptoms. If occupational therapists are unable to define their own role, other professionals might also struggle to understand the occupational therapists' role and consequently might disregard the profession (Rees & Smith 1991).

Self-Esteem and Confidence

Lloyd and King (2001) found that occupational therapists are renowned for a lack of confidence in their practice. Feelings of incompetence when treating patients are a major cause of stress. As mentioned above (linked with role confusion), a blurred professional identity and low recognition can add to stress levels. A participant in the Gupta *et al* (2012) study revealed a sense of feeling disrespected by other team members and needing to constantly justify occupational therapy interventions. In the study conducted by Lloyd and King (2001), little prestige and little recognition from colleagues were also identified as causes of stress.

Protected from Stress?

Lloyd and King (2001) mentioned that the creative characteristics of the job and the achievement gained by treating clients might protect occupational therapists from work-related stress. Similarly, Rogers and Dodson (1988) mention that the creative nature of the OT profession, as well as the client needing to be actively involved in treatment, may prevent emotional exhaustion. Smith *et al* (2007) concur that some therapists who have been working with traumatised clients may experience a sense of accomplishment if they have the right support. Other factors that might help to protect against work-related stress are the individual's personality, their previous experiences and the coping strategies they have developed (Lloyd & King 2001).

2.4 Impact of context and health care policy on job stress

The majority of studies referred to in this literature review were performed in resourced settings (Poullsen et al, 2014; Du Plessis, 2012; Gupta *et a,* 2012; Mutkins *et al,* 2011). Although the articles provide little contextual background one can expect these settings to have fewer challenges with regard to lack of human resources, size of caseloads and health reform.

The struggle to find South African literature that was relevant to the study might be indicative that this topic is something that is not commonly addressed in South Africa, even though factors such as high caseloads, a shortage of service providers, management challenges and a protracted health transition process (Naledi, Barron & Schneider, 2011), which have been associated with increased job stress, is common in South Africa. Of the South African studies Van Der Colff & Rothmann (2009) focused on the experiences of registered nurses. Du Plessis (2012) explored burnout amongst therapy staff, but contextually even this study differs from the current in that Du Plessis explored burnout amongst therapists working in private rehabilitation hospitals. A setting which at the time of that study operated much more like rehabilitation settings in developed countries than according to the philosophy of primary health care.

Health care to South Africans should be provided according to the philosophy of primary health care (Naledi et al 2011). Thus rehabilitation, along with the other pillars of health care, should be provided through the district health system, initiated at primary level of care in people's communities, and be supported by a referral system. The current study setting, a specialised rehabilitation hospital, is at the opposite end of the referral spectrum from points of primary care delivery (DoH, 2013). Due to resource constraints and other barriers neither rehabilitation at primary level in communities, nor referral services provided at specialised rehabilitation centers manage to address the burden adequately. Specialised rehabilitation settings such as the study setting are often at capacity with long wait lists and only patients with good prognosis are considered for admission. Similarly rehabilitation services at community level suffer from a lack of human and other resources (Rhoda, Mpofu & De Weerdt, 2009). Health care services in South Africa are currently undergoing a re-engineering to ensure that rehabilitation and other health care services are accessible to all people (DoH, 2013; Naledi et al 2011). Focus areas of this process which might be relevant to this study include leadership and management as well as human resources. One hopes that improved management and the development of human resources will better equip occupational therapists and other service providers of rehabilitation services in the public

sector of South Africa to perform their roles and thus reduce job stress. However, these aspects will have to be studied in future.

2.5 Summary

This chapter describes work-related stress. Although commonly linked to burnout, the two concepts are not one in the same. Work-related stress is the pressure that someone experiences from their work environment. Should this not be addressed or managed, it can develop into burnout. Work-related stress, according to the literature reviewed, has seven main causes which, in no particular order of importance, are as follows: caseload size; management/supervisor/organisational cause; patient contact; working environment; resources and demands; rewards and recognition; poor professional value and the lack of self-esteem. Other consequences (apart from burnout) of prolonged work-related stress are discussed. Thereafter, the management and reduction of work-related stress is discussed, including: the role of the supervisor/manager; a smaller caseload; peer support; group support/team building; counselling and debriefing; learning coping skills; time-outs and non-patient contact time; giving employees responsibility; personal support structures and stress management strategies. Finally, the health professional is discussed, focusing mainly on the OT as regards the years of experience, the role and attitude of the therapist, role confusion, self-esteem and confidence, as well as therapists being protected from stress.

CHAPTER 3

Methodology of the study

3.1 Introduction

Chapter 3 outlines the methods used in the study. It explains the choice of a qualitative design, introduces the reader to the facility where the research took place and addresses the study environment and the study population. Furthermore, the instruments used and the purpose and findings of the pilot study are presented. Data collection and analyses strategies are explained, and finally the methods to ensure rigor and trustworthiness and ethical considerations are expounded on.

3.2 Study design

The study used a qualitative design. Qualitative research has its basis in social science and strives to elicit information in terms of people's feelings, attitudes and behaviours through exploring their experiences (Joubert & Ehrlich 2007). It also encompasses how individuals understand their roles, the emotions linked to these roles as well as what causes behaviours. As the research aims to explore and describe the feelings about support structures and how these influence the occupational therapists' levels of stress, the qualitative paradigm was deemed most appropriate.

Specifically, within the qualitative paradigm, the phenomenological approach was used. Phenomenology explores the experiences of informants (Smith, Flowers & Larkin 2009). The researcher aims to inquire into the everyday lives of occupational therapists with an explicit focus on how they handle their work-related stress and what support structures they make use of to decrease the stress.

3.3 Study setting

The study was performed in the Western Cape Province of South Africa, specifically the city of Cape Town. The facility is a specialised rehabilitation centre for people with physical

disabilities. It is the only government-subsidised, specialised in-patient rehabilitation unit in the province.

The centre has 240 beds available for in-patients and an out-patient department where patients are seen on a daily basis. The services are provided by approximately 200 staff members including doctors, nurses and allied health professionals. Patients are mainly from the Western Cape, but some come from other provinces such as the Eastern Cape, Gauteng and Northern Cape. Every year, approximately 700 patients are treated as in-patients, with the number of admissions having increased steadily over the last five years and patients tending to stay at the centre for between three and twelve weeks, depending on their condition.

The rehabilitation centre offers specialised services such as seating clinics; however patients mainly have neurological conditions such as cerebrovascular accidents or spinal cord injuries. Treatment is provided by a multi-disciplinary team including doctors, nursing staff, social workers, speech therapists, physiotherapists and occupational therapists working according to multi-disciplinary teamwork principles. Additional staff members who are available to the patients include a psychologist, dietician and biokinetisist. Each patient that is admitted to the facility is assigned their own physiotherapist, OT and social worker. These health professionals work closely together with each other, the patient and the patient's family and form a functional team to achieve the client's goals.

At the time of the study, 10 permanent occupational therapists and one part-time OT were employed at rehabilitation centre. In addition there were three occupational therapy technicians and two OT chiefs.

3.4   Study population and sampling

The study population consisted of all the occupational therapists working at the study setting in April 2013 (both those in permanent and part-time employment). Due to this being a research assignment, there was a need to keep the study small. Being an OT, I decided to focus on occupational therapists while fully aware that other health care professionals working at the rehabilitation centre might also experience work-related stress and that their experiences might have enhanced the findings.

3.4.1 INCLUSION CRITERIA

- Participants must be able to give informed consent to the researcher and be willing and able to be interviewed.
- Participants must have worked clinically and full-time at the study setting for at least six months before commencement of the study in order that that they would have sufficient experience of working with people with physical disabilities at this setting.
- Participants working both in the inpatient and outpatient area will be included so long as they work full-time.

3.4.2 EXCLUSION CRITERIA

- Therapists who have not worked at the study setting for at least six months before data collection for the study began were excluded from the study.
- Therapists, whose responsibility is primarily managerial and administrative, such as the chief occupational therapists, were excluded from the study. The reason for this exclusion is that roles and responsibilities of managers are different to those whose main responsibility is patient care and I wanted to focus on those therapists whose main focus was patient care and not necessarily responsible to implement support structures.
- Occupational therapy technicians were excluded from the study.

3.4.3 SAMPLING AND PARTICIPANTS

According to Smith *et al* (2009), there is no formula for deciding on a sample size in phenomenological research. The researcher strives for richness of data rather than numbers of participants. They do however suggest that a sample size of between three and six participants be considered and that rich data is ensured through going back to participants for further exploration of findings rather than by adding participants.

When I was ready to start data collection in April 2013, there were 11 therapists employed at the rehabilitation centre. One of the therapists had only just started working at the centre and was excluded according to the exclusion criteria, whereas three of the therapists did not respond to the email invitation to participate in the study, leaving a potential sample size of seven. One of the therapists who responded was not very keen to participate and was therefore excluded. However a therapist who had recently resigned from the centre and was willing to participate was included, thus keeping the number of participants for this study at seven – she had worked at the rehabilitation centre for a number of years and I thought her years of experience would benefit the data, and the time frame between her resignation and data collection complied with the inclusion criteria.

The demographic details that were collected for each participant was the gender; age; marital status and whether they had any children; how many years of OT experience they had and how long they had worked at the rehabilitation centre. I also asked about their recreational activities and hobbies mainly to get an idea of what they do when they take time for themselves. Participants demographic information cannot be provided per participant as that might lead to identification of specific participants and breach confidentiality. Thus I provide an overview of these details here. All the participants were women. There ages ranged between twenty-seven and forty. Five of the participants were married and four had children. Most of the participants had five years or more of occupational therapy experience and the average experience working at a specialised rehabilitation centre were four years.

3.5   Data collection instruments

Semi-structured interviews were used to gather information from the participants. This type of interview method makes use of pre-developed questions to help guide the interview but allows for flexibility in clarifying questions (Carter, Lubinsky & Domholdt 2005). It promotes a relaxed interaction which then generates a better description of what was experienced (Smith *et al* 2009). I developed an interview schedule (Appendix 3) that contains guiding questions with the direction of USAID Center for Development Information and Evaluation, 1996. The following aspects were included in the interview schedule:

- Exploration of the work environment and stress at work
- Exploration of current stress levels
- Exploration of stress management strategies
- Exploration of support structures at work

3.6   Pilot study

A pilot study was conducted prior to the commencement of the research proper. The purpose of the pilot study was to practise the data collection process and provide the opportunity to smooth out any difficulties before commencing the study.

The pilot study was performed with one participant, a colleague of mine at the new hospital where I worked. She has worked as an OT for a few years and has dealt with many people suffering from physical disabilities, although not at a rehabilitation centre. She was

approached to participate, agreed, and a time and venue was decided on. The interview was conducted as stipulated, following the interview guide, completing the consent form, noting demographic details and with the interview being recorded.

Not many changes needed to be made to the questions according to the interview guide. The OT participant in the pilot study did however have some helpful suggestions regarding the wording of the questions to make them clearer. I also added one or two words to remind myself of things to do in the interview, such as setting up the cell phone to record the interview and completing the demographic questionnaire.

3.7   Identifying participants and collecting data

Once ethical approval and permission for the study had been granted, potential participants were emailed in March 2013 to gauge their interest in the study. At that time I was still employed at the rehabilitation centre and had access to all their email addresses. The email explained that I had approval and permission to do the study and included the information leaflet (Appendix 1) as an attachment.

When I was ready to start the data collection process (April 2013), a time, date and venue for the interview was set up and confirmed via email with the OTs who had indicated that they were willing to participate. The logistics of each interview was determined by the participant according to what was most convenient for them. Permission to conduct the interviews at the rehabilitation centre was granted by the CEO; however the choice of venue was ultimately decided by the participants – four preferred to be interviewed at their workplace, two at their homes and one where I was staying whilst visiting Cape Town.

On meeting with the participants the study was again explained to them and they were provided with information and consent letters in English – English is the language used by professionals at the rehabilitation centre and all communication is done in English, apart from that with patients if/as required. The majority of therapists at the study setting are English-speaking, as am I. The study participants were encouraged to ask questions about the study which were then answered to ensure clarity. If they indicated that they were still willing to participate, they were then asked to sign the consent form. Once written consent (Appendix 2) was received, I conducted the interviews and recorded them by way of an application on my cellular device.

I used the interview schedule with discretion. Questions were mainly open-ended to elicit a conversation-type interview. I explored the responses that were unclear as well as the new ideas identified in the interview. This type of interview encourages informants to express their feelings, attitudes and behaviours towards the research topic.

Since it was my aim to develop a thorough understanding of the informants' viewpoints, I observed participants' body language and other visual cues during the interviews to gain further insight. I reflected on each interview immediately afterwards and jotted down any observations I thought might be useful. The reflection time also allowed me to offload emotionally and to record my feelings experienced during the interview process. This process was more difficult than initially expected as post-interview I was generally quite drained and exhausted.

After the initial extraction of themes, they were sent to the participant to determine whether the data had been interpreted correctly. All of the participants were satisfied with what themes and sub-themes had been extracted. Nevertheless, a follow-up interview was conducted with two of the participants to explore some of their responses further.

3.8   Data analysis

Data from each participant was first analysed separately, after which patterns across the entire data set were identified. The following guidelines were used whilst analysing the data – guidelines based on Smith *et al* (2009 p. 82 - 106):

Transcription, Reading and Re-reading

I transcribed the audio recordings and immersed myself in these transcripts, going through the data many times to familiarise myself with the information.

Initial Noting

Initial, exploratory comments were made alongside the transcripts as I immersed myself in the data.

Developing Emergent Themes

Themes were extrapolated as the data was reviewed. Common themes emerged from the analysed data across the different participants.

Searching for Connections across Emergent Themes

The connections between the themes were developed and compiled to produce quick, accessible themes that identify the participants' experience.

Moving to the Next Case

The process was repeated for each informant.

Looking for Patterns across the Data Set

Analysis was then made across all the participants to group themes together. These themes are presented in the findings chapter of this document and are linked to the objectives of this study.

It is also crucial that along with data analysis the data should be managed adequately. This was done as follows:

The recordings as well as the transcriptions were saved on a computer hard drive as well as externally. Each participant was assigned a number, corresponding with their interview number, as well as a colour – the transcripts were printed on different colour paper corresponding with the participant's assigned colour and the participants' paper colour codes were also saved on both the hard drive and the external drive. Themes and sub-themes were extracted from the different coloured transcripts and compiled on larger pieces of paper which are in safe keeping together with other master's documentation.

Table 3.1   Summary of Data Analysis Process

1.	Each participant was assigned a number
2.	Interviews were conducted
3.	Data was transcribed, with copies of data kept on computer and external hard drive
4.	Transcribed data, observations and notes were analysed by the researcher
5.	A summary of themes and sub-themes was sent to each participant and confirmation was received that the themes reflected the views of the participant
6.	The themes and sub-themes were written up, using colour-coding in bringing participants' narratives together

3.9   Rigor

Guba's (1981) model of trustworthiness of qualitative research, as cited in Krefting (1991), describes four characteristics of trustworthiness that need to be considered. These are: (a) truth value, (b) applicability, (c) consistency and (d) neutrality. The first aspect to be considered is truth value, which, according to Krefting (1991 p. 215), "… establishes how confident the researcher is with the truth of the findings based on the research design". This explores the credibility of the study. If readers are able to identify with the findings due to the study methods being described clearly and accurately, the credibility of the study is improved. I ensured that there was "prolonged engagement" (Krefting 1991), that is, spending sufficient time submerged in the collected data to fully extract information from the data. There is no clear indication of exactly how long one should spend with the data but I collected and transcribed the data myself, thus engaging with it in quite an in-depth way. I then read through each of the transcripts more than once before beginning to extract the themes and continued to do so until the themes where fully extracted.

Reflexivity is another method to ensure credibility of the study. This ensures that the researcher does not become too involved and remains aware of personal feelings and experiences that may influence the study (Cho and Trent 2006; Krefting 1991). In qualitative research, the researcher cannot be separated from the study (Holloway & Biley 2011). For this reason I documented my thoughts, feelings and ideas as they arose in the interview process.

A number of people participated in the study in order to provide a fuller and richer data set, thus developing a better understanding of the phenomena under study. As seen in the data

collection process, member-checking was used to ensure credibility of the study, which forms part of the transactional approach described by Cho and Trent (2006). The process was continuously discussed with my study supervisor, colleagues and classmates, maintaining the utmost confidentiality in terms of personal particulars. The fact that I am an OT and have worked at the study setting improves the credibility of the study, as I am able to draw from my own experiences and have insight into participants' responses.

The second aspect to be considered is the applicability of the study. According to Krefting (1991, p. 216): "Applicability refers to the degree to which the finding can be applied to other contexts and settings or with other groups…" Qualitative research is specific to a setting, a group of participants, and does not aim to generalise. However, where the context is similar, findings and recommendations might have wider application than just the study setting. In addition, the study methodology and setting was described in detail and, with this information, should other researchers wish to replicate the study or to apply findings and recommendations to other settings, they should be able to do so.

The consistency of the data is the third aspect of trustworthiness to be considered. This implies whether or not the findings will be the same if the study is repeated (Krefting 1991). However, the nature of qualitative research is such that it is subjective and unique – variation is expected and an exact replica of the study is impossible as no two peoples' stories are the same. What is considered though is that the variability is identifiable and that there are extremes and contradictions in the findings. I ensured that all the methods of data collection and analysis as well as the compilation of the findings were as in-depth as possible. This ensured that the research was clear and that another researcher would be able to follow the thought process that I engaged.

Bracketing is another strategy that was used to ensure the validity of the study. This technique attempts to separate the researchers' experiences and belief from that of the participant (Chan, Fung & Chien, 2013). I was aware at all times that my experiences and beliefs would influence my deductions from the participants. I kept mindful of this during the planning of the research, during data collection, analysis and write up. I tried to ask open-ended questions during the interviews, made reflective notes post interviews and as much as possible reduce bias when analysing.

3.10 Ethical Considerations

The following ethical considerations were upheld whilst undertaking the study:

- ***Beneficence and Non-Maleficence.*** At all times I warranted participant's safety and ensured no maltreatment by way of misusing information. Participants were free to leave the study at any time with no consequences. The study may not have had a direct bearing on the participants, but possibly the opportunity to discuss and debrief about support structures at work may be beneficial. All the suggested support systems discussed in the interviews were used as recommendations to the institution. The willingness of the institution to acknowledge the need for various support systems, and how quickly they implement them, will also determine whether participants benefit from the study. Only one of the participants became obviously emotional, whereupon I provided support and allowed her to express her emotions (the interview continued thereafter in accordance with her wish to do so). Prior to commencing the interviews, before informed consent was given, I disclosed the negative effects of the study that were known to be possible. All interviews were terminated if/when emotional saturation was reached, i.e. after I provided the opportunity for last comments and thoughts, thus ending the interview process correctly. As participants did not want to be referred to ICAS,[1] I ensured that they were not emotionally distraught before leaving the interview.

- ***Informed Consent.*** Participants were asked to sign a consent form (Appendix 2) after having read an information leaflet (Appendix 1). This consent form clearly states that participants will be participating voluntarily. It also outlines that participants are able to withdraw from the study at any point without any negative consequences. The participants had the opportunity to ask questions or voice concerns that may have arisen after reading the information leaflet, and I strived to answer these questions to their satisfaction before the consent form was signed. This ensured that participants knew the purpose, benefits and risks of the study and were willing to participate. Participants were aware that interviews would be recorded and that certain extracts of their narratives would be used verbatim.

- ***Anonymity.*** Participants' particulars remain confidential. I am the only one with access to details and the only one who is able to identify participants. I didn't disclose to anyone who was participating in the study. However, the participants all work in the same

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[1] ICAS: Independent Counselling and Advisory Services

environment and if they wished to share their own engagement with the study they were free to do so. Narrative examples were used in disseminating findings, and therefore participants shared their experiences with the public but anonymously.

- ***Autonomy.*** Study participants are to at all times be respected as individuals (Joubert & Ehrlich 2007). One of the aspects of a qualitative study is the rich variety of data that comes from participants being autonomous. Thus I strived to allow participants to be self-autonomous at all times, as I held the information that I was gathering from them in high regard. I allowed participants the right to their own ideas and decisions without influencing them in any manner. I strived to be non-judgemental throughout the project and at no point was any of the information regarding the study withheld from the participants.

- ***Justice.*** Ensuring justice Includes being fair to all participants and treating each participant equally (Joubert & Ehrlich 2007). All participants received the same information before, during and after the research unless the information was specific to one informant.

- ***Ethics Approval.*** The research only commenced once ethics approval had been given by the Research Ethics Committee of the University of Stellenbosch: Research Ethics No. S12/11/295.

- ***Permission.*** The Western Cape Department of Health and the facility gave their permission for the data collection before it started. Permission to perform interviews on the premises was granted by the CEO.

- ***Security.*** All information and data is kept on my computer, which is only accessible using a password known only to me. Backup of the data and information is stored on an external hard drive, with this external hard drive as well as the original recordings being kept safe and secure.

3.11 Summary

This study used a qualitative design with a phenomenological approach. The setting for the study was a specialised physical rehabilitation centre in Cape Town for people with physical disabilities. Seven occupational therapists were interviewed, with the selection dependent in

part on when and how long they had worked at the centre. Semi-structured interviews were used and the researcher performed all of the interviews. Prior to starting the research, a pilot study was conducted to ensure that the interview process would run smoothly. Whilst interviews were being conducted they were recorded and the data was then transcribed verbatim by the researcher. Thereafter the researcher analysed the data thoroughly, extracting themes and sub-themes which were cross-checked by the participants. Confidentiality and ethical considerations were upheld at all times.

CHAPTER 4

Findings of the study

4.1 Introduction

In this chapter the findings of the study are presented according to the objectives of the study. Firstly, themes related to the work environment and experiences will be described, as will the stress that is experienced. Next, the causes of the work-related stress according to the occupational therapists will be explored. Then follows a presentation about the support structures that are currently in place and whether these are perceived as adequate by the therapists. And lastly there are the therapists' recommendations regarding support structures.

Table 4.1 summarises the main themes and sub-themes that were identified from the data – see overleaf.

Table 4.1   Summary of themes and sub-themes

Themes	Sub-themes
Work environment and working experience	o Requirements of the job o Organisational attitude o Nature of rehabilitation o The role of the occupational therapist as regards in-patient rehabilitation service provision o Recognition of occupational therapy o Blurred responsibilities
Work-related stress	No sub-themes
Causes of work-related stress	o Nature of the work o Challenges related to management o Problems related to caseload o Role of the occupational therapist in the team o Colleagues o Qualitative versus quantitative care delivery
Existing support structures	o Colleagues o Family and friends o ICAS o Team building
Adequacy of existing support structures	No sub-themes
Potential support structures suggested by the participants	o Counselling o Team building and group therapy o Management o Decreasing extra responsibilities o Smaller caseload or more staff o Improved communication levels

4.2   Work environment and work experience

4.2.1   REQUIREMENTS OF THE JOB

The work environment was described as very demanding and intense. The requirements of the job included managing a large caseload of patients, supervising students, attending and facilitating training and events, as well as administrative duties. The administrative duties included progress notes, medical insurance reports, referrals and follow-ups, plus liaising with families, schools and employers.

> *"Um, I work at a high intensity rehab facility. Where we see in-patients, um, at least three times a week. [The therapist is referring to providing treatment to the same patient]. At the moment my caseload is about 19 to 20 patients. And we also supervise students, so we also involved with being a part of the training… also attending training, um, also helping with other events that might be happening at the facility… Notes and reports and follow-ups in the community that you need to organise. And contacting employees, and contacting schools and family members."* (OT 04 p. 2)

> *"Like I say, some of them [referring to patients] are really challenging, and we've got the report that requires a lot of admin, and we've got students, you know… That adds up too, because you need to give them supervision in the gym."*
> (OT 07 p. 4)

4.2.2   ORGANISATIONAL ATTITUDE

The organisational attitude was generally one of excellence:

> *"…but also, you are told that you work at this very, um, good hospital and it's got this aura and people think it's the best place ever, and then you also feel that with that comes the responsibility to have that level of care all the time for the patients."* (OT 08, p. 10)

> *"I think there's a lot of things that are expected of you at work that's not, um, expected of people in other settings necessarily, and I think there's a lot of, um, pressure on you to perform and be on a certain standard."* (OT 08, p. 3)

The participants felt that the environment attracts dedicated professionals. Colleagues described each other as devoted and self-reflective of their professional practice and behaviour.

"… it's wonderful working with a group of people who are all dedicated and highly-skilled and professional and who look at themselves… constantly reflecting on their practice and seeing shortcomings and striving to improve." (OT 06 p. 1)

But the overall attitude of excellence can add to the pressure experienced by staff:

"… we've got high expectations of therapists working here… you do need to be quite emotionally strong when you do work here." (OT 04 p. 9)

4.2.3   NATURE OF REHABILITATION

Therapists felt that they were more involved in the lives of their patients than what therapists in acute settings might be. A strong therapist-patient relationship develops over the four to eight weeks that therapists generally spent with each of the patients. Also, it is easy for patients to access therapists in their offices or the gymnasium at any time during working hours.

"I think it's the length of time we spend with the patients… The relationship we build up with them. The boundaries are blurred in rehab." (OT 06 p. 8)

"So ja, I think we're incredibly accessible to our clients." (OT 03 p. 14)

Thus they might walk the extra mile for patients:

"Ja, I think it's about a rehab setting. I think it's about, um, we are so tuned in with community integration and having the client out there that if a family member comes unannounced on a Friday, and you know that this client came from an acute hospital, and was in hospital for three months, hasn't been home yet, this is your chance for him to go home and just experience his family and just have that contact with them. And you still think maybe you should do the training, get them out for the weekend because you are so in tune with this client. Whereas acute, sometimes if it's out-patients if they come late, then 'sorry, your appointment was at 10, let me give you another date', they don't even worry that the client drove one hour from Robertson to be here today. When someone comes from George and you have to, unannounced, and you have to make do, because you know that this client family just spent R800 to get here…" (OT 08 p. 12)

"And I often feel because we are in a rehab setting and not an acute setting, you're too nice to people when they, um, come outside of appointment times and

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you still manage to slot them in even though you don't have a slot for them. And you are thinking about the person and you are so focused on the person that you are not saying 'well you should have been here by 9 o'clock' and you're not 'sorry, come again'. We never do that. We always make a time. Ja so…"
(OT 08 p. 12)

4.2.4 ROLE OF THE OCCUPATIONAL THERAPIST IN REHABILITATION SERVICE DELIVERY

Therapists describe how working in a rehabilitation setting brings out the full potential of an OT. However, it was highlighted that the environment can result in increasing stress because in this setting the OT needs to address many aspects of the person's life.

"… if you really want to understand the value of being an OT or being appreciated as an OT in terms of how much you can contribute, you must come work in a physical rehab setting, because that is really where your role really gets the time to blossom, you are able to contribute in so many areas of someone's occupation." (OT 08 p. 10)

"…because there is so many areas that we can contribute towards, so you have to make time to do all the self-care with the client, do all the household tasks and manage to phone their work and manage to arrange for a work assessment if needed… And I often feel that that contributes a lot to the stress that we are experiencing." (OT 08 p. 10)

"…with working in rehab and being so involved with care of the patient from the moment that they step out of the acute hospital till when they go home, I think there's a lot more, how can I say this, a lot more, you just put more in, because you want them at a certain level when they have to go home. So your personality must be of such a nature that you almost a perfectionist in terms of this is what you want for that patient so you are going to work towards that." (OT 08 p. 10)

4.2.5 RECOGNITION OF OCCUPATIONAL THERAPY

Another aspect that affected therapist's working experience was their concern that occupational therapy and the OT's role were not always recognised. They felt they were losing the core crux of what it means to be an OT and because of that their experience included needing to prove the worth of the OT profession.

"I just feel working as an OT in a rehab centre, because there is a lot of overlap… sometimes I felt like I'm losing my OT, you know, because physios could do activities. There's a whole lot of things that they were praised for and at the end of the day when the clients give feedback they will say 'thank you to the physio that I was able to walk'… When I look at that, that was very disappointing and that is why now maybe I'm not objective enough in terms of looking at my role as an OT in rehab when I'm here now, because this is OT. I cannot. No one can argue with me about that. Because I felt that I always have to… I don't know what or how to put it across. You need to prove what you do as an OT is outstanding. Because when you, especially other, I'm gonna say physio, they felt like they are doing everything… It was very disappointing or depressing and almost felt like maybe this OT… Did I choose the right career? What, what, what value do I have in this rehab? You know as much as I've learnt a lot but from an OT, pure OT stuff, I've felt like, hmm." (OT 2-07, p. 10)

4.2.6   BLURRED RESPONSIBILITIES

One therapist describes how responsibilities within each hierarchy at work are constantly being shifted and passed down to a lower level.

"[Facility name] had the structure that was neat and perfect… It was actually a very simple, neat structure, and yet it didn't work because nobody in their different levels took the responsibility that was theirs to take. It kept getting passed down, I felt. I shouldn't have to decide what the policy is on, be on a committee to decide what policies are on braces. The doctor must decide that. You tell me." (OT 06 p. 4)

4.3   Work-related stress

Therapists experienced high levels of work-related stress. The majority of therapists said they think their stress levels are about eight out of ten, with ten being the highest severity of stress. They described their work as follows:

"Work in a very high-paced work, very stressful…" (OT 09 p. 2)

"Gosh. Hectic. (Laughs). Generally it feels very hectic." (OT 03 p. 2)

"… it can be very intense, very busy at times." (OT 05 p. 4)

"At the moment work is tiring." (OT 08 p. 3)

"Um, I do feel a bit overwhelmed with work at the moment…" (OT 04 p. 2)

And they expanded on the stress they were experiencing:

"Towards the end it was constant. I don't think was a… and it was… it wasn't just, it wasn't just management stress, it was stress about worrying about your client, what treatment you were going to be doing, are you giving the best service. Just ya, I think it got to a point where I was just taking too much home." (OT 06 p. 5)

"… something that was at work was stressing me to a point that I couldn't actually appreciate what I had in my life." (OT 06 p. 5)

"Hmmm, at the moment I'm feeling that something is missing. That I would like to maybe let my life take another course or, I don't know. Something, I'm searching for something, I'm just not sure what it is. And I feel it's mostly work-related. In my private life I'm quite happy and my social life, I'm quite happy. But, I feel in terms of eight hours a day, five times a week that I spend at work that I'm not completely satisfied with that." (OT 08 p. 2)

"… I feel the pressure is a bit on and the stress is a little bit more. Um, I've sort of, um, become numb to the type of stress. It's okay to dream about patient things that you have to do the next day. It's okay to come home and think 'agh, I haven't done this thing', and make a list at home. Um, bring patient notes home because there's just not time at work. So it's sort of become a norm that, all these patients they stay with you." (OT 08 p. 5)

"I've never reached the point where I have to get up in the morning for work and I really, really don't want to. I think once I've reached that point, I think that's the point for me where, okay, I must go see someone now. Um, I have gone through periods of just feeling I go to work and then I'm there and I'm thinking I don't want to be here, I really hate being here. And then I start working on my patients and then I'm okay again. Then I move on. Um, then you just reach a point of saturation where you just don't care anymore. You don't care what people think of you, you just do your job, you are ugly with people that you're not normally ugly with because you're just so over things that you can't worry about other people's feelings. Just so numb to caring about your colleagues and people around you. If you upset me I'm going to tell you now to your face and move on. Which I also don't think is a good thing. You also reach a point of 'what's the use of complaining because nothing is going to be done'. It's been like this for the four years I've been there. It's never going to change. You sort of see that the system is failing but there is nothing that you can do about it. Um, its things that will never change unless there is staff turnover, unless there is a change in the job evaluation, um, so you sort of feel like… I just carry on, I do my job, I get paid, I satisfy my clients, ya." (OT 08 p. 14)

4.4   Causes of work-related stress

Table 4.2 summaries the causes of the work-related stress that were identified by the seven therapists who were interviewed.

Table 4.2   Themes and sub-themes related to causes of work-related stress

Themes	Sub-themes
Nature of the work	No sub-themes
Challenges related to management	o Lack of support o Lack of awareness of the problem o Lack of sensitivity o Lack of communication o Lack of mentorship o Lack of recognition and appreciation o Lack of engagement with therapists as individuals
Problems related to caseload	o Size of caseload o Type of patient o Not all patients require OT
Role of occupational therapist in the team	No sub-themes
Personal factors	o Lack of assertiveness o Commitment to the job
Colleagues	No sub-themes
Qualitative versus quantitative care	No sub-themes

4.4.1   NATURE OF THE WORK

The therapists felt that the job requirements (as described under 4.2.1) and the nature of rehabilitation work (as described under 4.2.3) created stress.

4.4.2 CHALLENGES RELATED TO MANAGEMENT

Lack of support

The majority of the participants interviewed felt that there was a lack of support from managers and supervisors:

"I think sometimes, um, when you go with problems to your supervisor, um, I feel sometimes like you don't always get feedback about your problem, or they quite reluctant to let you in on what's happening. So that I find quite frustrating sometimes. Um. Also, um, or when you have, when you've got a problem and you do go to them and you do speak to them about what's bothering you, um, it just feels to me that they not always listening what you're saying." (OT 04 p. 3)

"Apart from my managers not listening to me, (laughs), um, I think, I think there were a few things that I did wrong as well like, um, not, like sometimes I think I talked too much about things. So when you're talking about it you, you make it more real, I don't know, almost. And then because you're talking to people feeling something similar you can kind of drag each other down. I think that, but at the same time, if I had been able to say to [manager], um, these are my issues and that something would be done about them, I wouldn't have needed, um, to get to that. And it was stuff, ugh. I didn't think that we were complaining about things that couldn't be changed. So, we can't afford to have more OTs working at [facility name], so your caseload is going to stay your caseload. I understood that. You're still going to have 18 to 20 to 24 patients. It's still going to be that, it's not going to get any less. I need to work more effectively and efficiently, groups or whatever. Fine. I can do that. Um, but there is some things that do need to be addressed, like, is there somebody in the team that is not working, how is that addressed?… if there is somebody going through a rough patch, how do you support them? You need input… and that was never there." (OT 06 p. 6)

"You are telling your supervisor that you're stressed out and yet nothing gets done. Nothing goes up to top management to tell them that this is not working." (OT 08 p. 6)

"I find that difficult because if you do speak to them [referring to management] about things it feels like things don't really change so it feels like the same things keep popping up. And I think they [referring to management] are aware of the

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problems but it's almost like they don't really know how to do something about it.
Or even if they do speak to the person about it I'm not sure in which way or in
which manner they do it. But it almost feels like you do speak to them about stuff
but nothing changes. So it's not… Should you speak to them about it, will it really
make a difference, I'm not sure?" (OT 2-04 p. 1)

"I think um what stresses me out… I think for me, is just that lack of support from
our supervisors." (OT 09 p. 3)

Lack of awareness of the problem

Therapists felt that managers were unaware of what was happening at ground level and had
forgotten what it felt like to treat patients:

"Um, I don't think top management spends a lot of time thinking about the
experience, um, of their staff." (OT 03 p. 6)

"I think they have forgotten what it's like to treat one patient, let alone 16."
(OT 03 p. 6)

"I just feel a lack of support at the moment. Not just support but understanding
from our middle management what, like, the pressure that we're under at the
moment. It's like they just, they will say that like, it's a usual thing for [facility
name] to be understaffed. So, um, just continue and do what you can do. And
that's fine, we continue and do just what we can do, but I don't feel like there is a
good understanding of the pressure. Um, that you have with meeting with families
still, having to give feedback, knowing you don't have all the time, all the time you
would have wanted to spend with that client." (OT 04 p. 4)

Lack of sensitivity

Some of the information points towards a certain lack of caring or sensitivity amongst
supervisors and staff at top management level:

"I also think things like [top management] saying to us that we needed to either
go on medication or leave if we couldn't cope… I would have marched into her
office after that and said basically… I didn't want to stand in front of my staff and
say that, cos you still have a responsibility to your juniors as well as to the top. It's
a difficult position to be in. I'd hate to be in it. But I would say 'you do not say

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things like that to my staff, cos that's just rubbish. You know. Those are not the two options. Something else needs to be done. And I never felt that the people in management had that confidence to actually say you're out of line [to top management]." (OT 06 p. 15)

"So people have resorted to not… They don't feel like it's worth it to tell your supervisor that 'I'm stressed out, can you please make the load lighter, can you please not admit medical aid clients, can you please sort out problems with other colleagues'. But they not giving that support, they not really listening to you. Ja, um, sometimes I feel that you go, you go into a, a meeting with your supervisor, and you tell them how you're feeling and then half of the, um, meeting she's telling you how she's also going through the same thing. Almost making it about her and not about you." (OT 08 p. 6)

Lack of Communication

Communication between various levels of staff was lacking according to participants:

"Um ja, I think communication is the reason for a lot of errors that we see going on." (OT 03 p. 8)

"Probably my biggest bug would be a lack of communication. On all levels. I think from top to bottom." (OT 03 p. 7)

"The communication between the therapists and the ward and middle manager and top management is not there." (OT 08 p. 6)

"Um, and I don't think there's a very good platform to hear it from us either." (OT 03 p. 6)

Lack of mentorship

Therapists felt that mentorship within the occupational therapy department was missing:

"… but I feel in terms of OT input and that mentorship from, from your supervisor, I feel like that is not there." (OT 09 p. 4)

"Also having, um, people that you can learn from. I do feel like there is a bit of a lack of mentorship in the OT department." (OT 04 p. 3)

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"I guess it's a good thing in a way that you learn on your feet, but in another way there is no one. It is difficult to find, for me, um, someone to sound off of. Um, in, especially in this discipline. It's difficult to, there's no one to go and, ja, really bounce ideas off or collaborate ideas, that's sort of been there." (OT 05 p. 5)

"And I don't feel that in our OT department we have the necessary role models to look up about, um, the patient that you're struggling with, and then you resort to asking your physios and the physios' mentors, and then you're thinking 'but am I really doing OT then, if I'm asking a physio for help'. So ja, I feel that there isn't any role models that we can look up to in our department." (OT 08 p. 7)

Lack of recognition and appreciation

Therapists expressed the feeling that there was a lack of appreciation from their supervisors and that attention was more focussed on the errors that sometimes occurred.

"Just because I choose to do this kind of service, doesn't mean I don't want to be recognised. Um, I think that recognition is lacking in internal structures. Um, sort of the general feeling I get from management is that they like to highlight concerns or errors in how we go about executing our jobs. We very rarely get told thank you for doing a good job or an acknowledgement of, um, when we do right rather than when we doing wrong. So lots of emails about, you know, stats that are overdue, or, um, BMT [the bed management team] is unhappy with how full we keeping the hospital over the weekends for example. Which I think the finger often get pointed at the wrong person. The wrong people. Um, it's not my job to keep heads on the pillow. Um, it's not my job to keep stats up to standard. Um, if I'm, you know, especially if I'm pushing my hardest every single day to get as much as I can done. If clinicom [computer system for patient administration] is down for example, then clinicom is down, there is nothing I can do about it. My stats are late. My patients… medical aid patient is discharged and my stats is incomplete because computer clinicom is not working so… Sometimes it would be nice just… Those sort of issues have to be addressed by management, that's understandable, but it would be nice to be, if it was countered with positive reinforcement as well." (OT 03 p. 9)

"My work ethic is good. I'm professional. I believe strongly in what OT is. I want to learn more. I come back and look at my books, go back on the internet. But that

isn't enough. That wasn't ever enough. No, we weren't ever thanked or praised." (OT 06 p. 14)

"… No, we were never good enough. We were never good enough. And then when you leave, you realise, damn, I'm good. (Laughs)." (OT 06 p. 13)

"… But there's nothing given to the staff. It's all about the patient and us giving to the patients, which I totally get but then it should be something that the facility caters for, then there must be an officer just manning all the special events because there's not time to be busy with clients and do all these extra things. Even with our one staff party that we get at the end of the year, we must organise it, it's not organised for us. So you sort of feel like okay, well if, if someone is not going to organise it for us, why, why should we be doing it, then just give us our R30 or R40 whatever it is, I'll go buy my McDonald's and I'll eat it with my people who I want to eat it with. So it's extra work for you to just have a staff party which I feel the admin people can organise for us, um, or the facility can organise for us. There's nothing being organised for the people working there." (OT 08 p. 15)

"They'll [referring to patients] say thank you, um, sometimes even like one of your OT colleagues might say thank you, so it's usually the people you work with, sometimes even students, if you teach them something or show them something they didn't know they will thank you, but not really from top management. And the thing is, like, if they do thank you it feels like it's at the end of your SPMS [staff performance measurement scale] thank you for your hard work. I'm like, after three months giving me one thank you in general? I don't know but I like to get like a specific thank you about something specific. Like 'Thank you, you handled that so well' or 'you did this so well' so no, ja, top management and middle management I don't like the way they thank us just generally about things. Doesn't feel like it's sincere." (OT 2-04 p. 4)

"Except for the SPMS sessions, no. I don't remember. Ja. In terms of initiating initiative coming from her [referring to manager] in that sense [referring to feeling appreciated or thanked], just out of the blue, I don't remember… to be quite honest I cannot recall [a time of] 'Can we sit and I just want to see how you're doing?' Except for the SPMS which is very formal and documented… I don't remember. Even a letter or something. I don't know. No I don't remember. If that R30 at the end of the, is it R30? That they give you for Christmas? If that's what it's meant for, maybe. But I cannot recall anything." (OT 2-07 p.7)

Therapists also felt that they could receive more appreciation from the patients that they treated:

> *"Um, I feel like there's a lack of gratitude, um, from, I'm not just talking now about internal structures, I mean even from patients. It can be even quite a burden to bear offering a free service. I think it's part and parcel of, of government services because it's free, um, I think because clients aren't paying for the service it's, um, don't know. Ja, I think in the two years that I've worked now at [facility name] I received very, probably, I can count on the two hands how many 'thank you's' I've received…"* (OT 03 p. 9)

Lack of engagement with therapists as individuals

Some of the therapists felt that top management were unaware of their staff or wouldn't be able to recognise them. This has a negative effect on the therapists worth and self-image.

> *"I actually wonder if any of them liked us. I don't think any of them looked at us and thought oh we are good therapists. Or that we are nice people."*
> (OT 06 p. 14)

> *"Ja, if she [top management] sees my name on paper and she has to put a face to my name she won't know. Which is really bad for me because we are not a big institution. There might be a lot of therapists, yes, but I feel like as a head of institution you should be able to identify who's working for you."* (OT 08 p. 9)

4.4.3   PROBLEMS RELATED TO CASELOAD

Size of the caseload

The patient-to-therapist ratio was an area of concern for all therapists, as they felt that there were too many patients per therapist. Furthermore, if staff were off sick or on leave, this added to the burden of stress as it increased the caseload.

> "*And when one goes there's always someone new coming, um, so there's just this constant load of people all the time and it never stops."* (OT 08 p. 11)

> *"Agh. We are short-staffed at the moment, so it's a bit of, a lot of patients to see. Um, some of the colleagues have been off sick last week, from like the physio department also. So then you feel that patients they would see, you're now*

seeing, um, and patients weren't handed over to other therapists, physiotherapists, so then you feel like you need to give everything to that client." (OT 04 p. 4)

"Um, I do feel that we are short staffed even now, if we are full complement." (OT 09 p. 4)

"And it's so stressful when you go on leave because you rush, because you have to have a handover for your patients that you have to give to your colleague and then, even if you are on leave, sometimes you forget to do something and then you get phoned or messaged, um, 'I have this client here, what am I supposed to do with this client. I have to fill in this letter, discharge letter for you, what do I have to write.' So you still like, still in work mode because you're still getting phoned or asked about clients." (OT 08 p. 12)

"When you are home and you are on leave, you still think about your colleague having to handle all your patients. Um, because it's still expected for those clients to be seen because they never go away… even if you go on leave, it doesn't stop for your colleagues, you feel bad for your colleagues. You feel that you're not even allowed to take sick leave because 'what's going to happen to my patients when I'm sick'. So you end up going on leave or going on sick leave and coming back and having double the load that you had before. So you end up going to work sick still because you just worried that these things aren't going to get done." (OT 08 p. 11)

Type of patient

The type of patient that gets seen at the physical rehabilitation centre was mentioned as a reason for causing stress. These are patients who have undergone immense life-changing trauma.

"Well, the kind of clients we had. (Laughs). That was stressful." (OT 06 p. 6)

"What we handle is, um, are these huge significant occurrences in a person's life." (OT 03 p. 6)

"… um, so a lot of stuff is quite heavy stories. Quite heavy." (OT 03 p. 12)

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"… I think the job in itself, innately as an OT, and who we are and what we take on of the client is in itself stressful because I do think we take on more of the… It's a more invested relationship, if I can call it that. Which is in itself stressful… To then have to deal with that underneath or on top of all the other stuff is, um, also in itself is completely difficult. I think because it's such an acute story… and the client is still dealing with all the emotional aspects of it, obviously you not, you're gonna be now professional but you do, you do get affected more by that, um, and then, I think the ability to then mange that or whatever. Ja, I think people get chipped away at lot easier…" (OT 05 p. 17)

The need to assist the patient to regain function and be able to perform functional activities creates further stress:

"I think there's quite a lot of pressure on us to get the patient functional. Because they [physiotherapists] can get the patient stronger and they [physiotherapists] might get the patient walking, but that doesn't mean anything if you can't do something with it. So I do feel sometimes there is a lot of pressure on us to get the patient independent with washing and dressing. Or even with, um, regards to return to work… I think there is quite a lot of pressure on us to get the patient independent." (OT 04 p. 4)

"Mmm, I feel like there is quite a lot of pressure on us, um, to achieve those goals, because I mean walking without doing something while you're walking or functionally, is useless actually. Um, but I think… mmm. I think, I'm not sure if this is the right way to say it… I can, I can relate to that, and I can think that yes it might be true, and also, not just saying we've got more admin but it feels like there are things to follow-up about. Like following up about school, following up about work. Um, which is not necessarily part of the physio's work to do, and I think we also tend to be the people usually that makes contact easier with family when we need to organise like training or so on. So I feel in a way there is things that's more, comes down to the OT to organise or to do. And I feel like there is quite a lot of pressure on us to get them functional. But I do feel also you can't have OT without the physio. So we do need to be a team. But I can see a lot of the things sometimes the OT's responsibility in the team." (OT 2-04 p. 3)

Issues related to treating medical insurance patients also impacted on the stress experienced. Medical insurance companies require progress reports every second week as well as written motivations for assistive devices.

"… the medical aid patients also stresses you out because then it's, you're motivating for devices, and devices take a long time to come and that obviously stress you out." (OT 09 p. 4)

"… stressors about having medical aid clients and knowing that they are paying for the service more than your other patients and not being able to see them every day and really give them the quality input that they actually pay for. So that stresses one out a bit." (OT 08 p. 5)

Not all patients require OT

Some therapists also felt that not every patient needed to be seen by an OT:

"… sort of goes back to the structure at [facility name]. I think another thing that contributes to unrealistic, what creates that unrealistic sort of feeling… if I was top management I would say not every client is appropriate for OT, for example." (OT 03 p. 5)

"Again, deciding, prioritising who needs the service of OT and not being afraid to distinguish between physio and OT. Sometimes a client just does not need OT…" (OT 03 p. 15)

4.4.4 ROLE OF THE OCCUPATIONAL THERAPIST IN THE TEAM

Many of the therapists felt like the profession of occupational therapy was undervalued:

"... I generally think OTs are undervalued as profession, as a discipline. I think we're the underdogs. Um, so I think we're, you often have to fight for your place, for your voice. So that has an OT on a whole different level as a profession, but as a therapist here I don't think so, I think we're expected to keep quiet and get on with it." (OT 05 p. 15)

"… maybe you acknowledge that, yoh, I have done a lot for this client, and between OTs we do often say to each other that, yoh, we really do a lot within the rehab setting, and we, really, we are the main person contributing to this person going back into their community and being integrated. But it's never acknowledged by other occupations within our setting and it's, um, I sometimes still feel that, um, within this setting the nurses and the social workers still feel that the physio has a much bigger role within the setting and I don't really know

why. And it's sometimes as if people see that we doing everyday things with the client, so it can't be that difficult to do, which is not the case." (OT 08 p. 10)

4.4.5   PERSONAL FACTORS

Lack of assertiveness

Therapists felt that being unable to say "no" for extra responsibilities caused added stress:

"… 'no, actually I'd prefer not to'. We don't say that. If someone goes 'this needs to be done'. We'll go 'ok'. You get the job done. You keep quiet and get the job done. But to what extent and which point do you go, do you allow yourself to go 'you know what, no. I can't any more'. We don't do that." (OT 05 p. 11)

Commitment to the job

From the interviews, it seemed like the attitude and work ethic of the occupational therapists was of a high standard:

"… when that happens [referring to notes not up-to-date] to me it stresses me out, like I can't manage my time, I'm not managing with my workload and all of that." (OT 07 p. 4)

"… for me to be able to function at work I feel like I must be able to do everything I am required to do. Once I feel something else is lacking, then I don't feel like I'm a… ja. So. (Becomes tearful)… So I feel like I'm not adequate or something, I'm not up to standard, or something is wrong with me… Because all the time I keep on checking, have I done a, b and c. I've got a to-do list and this, but how does it get to this. I know for somebody else, this is minor, my notes are not up to date for a month. I've spoken to some people, they say 'no, yours is better, it's two, three weeks, mine is like a month' or 'the patient is gone and I still, I must go to my diary and write my notes' and so that's how I feel." (OT 07 p. 5)

"… for me, it's about the stigma about not being able to cope and that's a sign of weakness for me. So I'd rather fight within myself and get this sorted and pray about it and talk to family members." (OT 08 p. 14)

"You don't want to go and run every time because I've seen that it's perceived in a different way if you always run to your supervisors. I've got that experience.

There were people that did that and, maybe, and then it is perceived in a different way" (OT 2 07 p. 5)

The "different way" being that you're unable to cope with the workload or feel that you aren't such a good therapist or don't have the skills, when in fact you do have the skills and you're just wanting to receive some support or being asked to cope with too much.

4.4.6   COLLEAGUES

As in any working environment, different personalities are evident and reason for tension and stress.

"… sometimes things frustrating you is also your colleagues." (OT 04 p. 6)

Carrying the slack for colleagues who are not pulling their weight, adds to the stress experienced:

"Um, I think a lot of the times you have to, um, make up for the things that your colleagues don't do. Um, so cover up things that they can't get to, that actually is, um, maybe physio and OT responsibility but I feel that at the end of the day you see it's not being done and the time of this patient is almost up, almost being discharged, so just jump in and get the thing done. Um so it's about covering up for people like that. It's about trying to also, um, promote your profession and show people that OT is valuable, but it feels as though sometimes others who work with you in the same profession, net om jou profesie 'n bietjie te uplift en vir mense te wys dat OT is valuable actually maar dit voel somstyds as of die ander wat saam met jou in die selfde profesie is, they just don't give a damn about if people think we are just basket weavers or just happy to give of their responsibility as an OT to someone else in their profession. And ja, so I feel that a lot of the times there's maybe one or two in the OT department that wants to really do a good job and really uplift your department and have that standard of care as an OT that you want, that you feel that you should be giving your patients. And then you have to cover up for the rest that's not doing their part."
(OT 08 p. 5)

4.4.7   QUALITATIVE VERSUS QUANTITATIVE CARE

Participants felt that as occupational therapists they had a qualitative outlook to care, however they were often forced to work quantifiably.

"… if I now use a comparative, say for instance physio, um, they're a lot more, um, quantitative as a profession, if I can use that. You know, they look more at quantitative things, and so when you come from a sort of qualitative point of view, but I know this person, it's not, you cannot say 'but the result was 11, that's why I know. I know my client, I've done this'. Um. People don't get that, I don't think. So it's difficult to find your place, so I think as an OT you then have to make up for that and you have to learn some quantitative stuff along the way which I don't think was necessarily taught at varsity. So I've had to learn it so I can fight my fight and fight from both angles, which is difficult because now on top of everything you're doing here, you've now got to learn qualitative, ja quantitative stuff, and you're fighting the fight." (OT 05 p. 15)

"I think government can take some ownership for that as well. I mean government pushes service delivery and I think that's what contributes to that sort of panic. I've got a quota to fill. It all comes down to like heads on the pillow, or stats, or amount of treatment time or... It's all accounted for in numbers. Um, whereas what we do is more qualitative. We're about improving quality of life so, you know, I should be able to justify saying it might take me an hour with my patient this week to actually get what I need them to get, and with patient number two I need nine hours. Whereas I'm supposed to be giving five hours and five hours with those two clients. Maybe I'm wasting four hours on one client that could be given to another." (OT 03 p. 15)

"Um, I think with the whole, I think it's an expectation from higher up… because, um, at the end of the day, um, Jennifer, I think what they are looking, and this is, like true, is numbers basically… the only way that they can track or see what I'm doing on a daily basis is looking at my stats. And if they see my stats is low, they automatically assume that I haven't been working, but it's all the other things that go with my work… the structures or management expect you to push for numbers, I feel like." (OT 09 p. 5)

4.5 Existing support structures

Table 4.3 outlines the support structures that were currently available to and being used by the participants.

Table 4.3   Sub-themes under support structures being used by participants

Support provided by the institution	Individual support structures
ICAS	Colleagues
Team building	Family and friends

4.5.1   SUPPORT PROVIDED BY THE INSTITUTION

Independent Counselling and Advisory Services (ICAS)

Therapists were aware of the ICAS programme but none of them had used it and most of them were unaware of how to access the programme.

> *"Say for instance, like, I was really struggling, I could go to ICAS. I wouldn't necessarily access that."* (OT 05 p. 12)

> *"I know everyone has spoken about ICAS but I've never accessed it, I must confess. Um, I don't know why."* (OT 06 p. 11)

> *"… ICAS, but obviously I'm not using that."* (OT 09 p. 5)

> *"We've had ICAS coming in once. But there wasn't any follow up on that…"* (OT 08 p. 11)

Team building

Therapists referred to team-building activities:

> *"… we have our team-building's, there are two team-buildings a year, so one organised by the therapy staff and one organised by the nursing staff. So it's not that often that we do have it and then it's the other issue about on-site versus,*

you know what I mean, off-site. Um, but ja, it's not very, it's not regularly that we
do have. I do feel it's myself ,and obviously you do it, it's a nice time to chill out
but also to work on building relationships, and I do feel useful tool ja."
(OT 09 p. 7)

4.5.2   INDIVIDUAL SUPPORT STRUCTURES

Colleagues

Participants made use of their colleagues for support:

 "So I debrief quite a lot with my colleagues…" (OT 04 p. 8)

"… my colleagues I think, those were the main support systems." (OT 2-07, p. 2)

But it seemed that it was more a case of emotional support, rather than establishing
solutions:

"Um, colleagues yes. In terms of, look everybody is busy, it's not support in terms
of I'll do this or, you know what I mean, it's an emotional, you sort of understand
each other, you can, you get what each other is going through, kind of thing."
(OT 05 p. 9)

And it wasn't always necessarily positive support, because it had the potential to add to their
burdens:

"I think support in terms of your colleagues, your fellow ground workers I think,
that's there. Um, I think often a lot of the stress comes from you handling your
colleagues stress… you are going through the same process as your colleague
and then they come tell you that this is how they feel, they venting and you sort of
take it on. And it's nice because you're feeling someone is listening and someone
understand – they are going through the same thing…" (OT 08 p. 6)

"Ja, I think it's, I don't know if it's a new insight that I've come upon or come to…
But I think we can influence each other to be negative also, so I think it good to
share but I think you need also to be selective about what you're going to share
with your colleagues. Because if they are in a bad spot now complaining about
something else or sharing your experience, it just might pull them down more. So,
um, I think, ja, I think it's good to share but it can definitely put a burden on them

also or influence them negatively. And at the end of the day it's like an evil cycle. It just keeps on going. Everybody keeps on staying negative because you keep on complaining about things, to the same people. Which is not good."
(OT 2 04 p. 1)

Not only were other occupational therapy colleagues utilised, but therapists reported that they also leant on colleagues from the other disciplines:

"I think it's just my OT colleague and then some of physio's colleagues also, specifically in our area. I won't say really my supervisor. I don't feel that."
(OT 04 p. 8)

"… we actually are a very, if I can say, close, not close-knit, but during lunch times then we will do debriefings, or just now and then someone comes into my office or I go in their office, like my other colleagues, like the physios or the social workers, and then we just like sort of like just vent off each. That is also our way of supporting each other. So ja, with my immediate colleagues here in the area."
(OT 09 p. 5)

One of the therapists highlighted the fact that when colleagues gathered after working hours, they automatically spent some time initially debriefing about work:

"… you end up having a social gathering with friends in the same occupation, and then half way through you realise that you've just spent two hours of this social gathering to talk about work. Because there is so much to talk about and there's so much that you just want to get out of your system". (OT 08 p. 11)

Family and friends

Many of the therapists used their husbands or mothers as a support structure:

"I enjoy quite a good, um, support from my husband and from my family."
(OT 04 p. 2)

"… I would spend at least three times [days] out of the five talking to him [referring to husband] about stuff that bothers me at work ja." (OT 04 p. 6)

"I find it just helps talking about it to my family and my friends." (OT 04 p. 8)

> "*How do I handle my stress… I think, I must be honest, I used to gym and ja, but nowadays is just chatting to my family, um, my husband, my mom also, she's also a very spiritual person, obviously participating in daily prayers and asking God to just help me and just, that is my way of coping. And just, the daily interaction with my family especially, like I said, my mom and my husband."*
> (OT 09 p. 5)

The use of a family member as a support structure has a potentially harmful consequence on the relationship.

> "*Um, I think a lot of the time you come home with your stress so you take it out on your partner, family members. You don't want to burden your colleagues any more with your difficulties that you struggle with. So, um, you do, I do feel that you do have to vent about these things. There's sometimes, like I say, you come home and you take it out on your partner…*" (OT 08 p. 11)

Although the therapists did make use of their family to debrief, they were also aware that one could not just debrief with anyone:

> "*And so it sometimes so, that kind of a person [referring to a family member who is a health professional] because you can't talk with just anybody.*"
> (OT 07 p. 11)

> "*Ja, probably say my husband, although (laughs) limited info for him, he's not so keen on the work story. Ja, it would be to him, that I would then speak, but… he can't relate.*" (OT 05 p. 12)

One of the therapists commented that she felt she was lucky to not have children or responsibilities post work:

> "*Ja, and I mean I'm incredibly fortunate because I'm single and I have no children… I don't actually have massive commitments after work. I do have the luxury of space and time for myself that is there to take if I am conscious enough to take it. Which I'm sure is very different for people with children.*" (OT 03, p. 11)

On the other hand, therapists with children seemed to be able to shake off the stress experienced at work quicker than others, as they knew they needed to give their children their attention when they returned home:

"I think I also don't have the luxury, big inverted commas with luxury, of mulling over stuff. I don't, I can't, I can't spend too much time thinking because I have to deal with the boys. I have to deal with whatever they want or need at the time. Um, so I don't have a lot of that, but when that, what I can say is that because you don't have the luxury it can actually sort of manifest or fester in other ways. So you might, you don't have time to think of something, so you're a bit more snappy, you know what I mean?" (OT 05 p. 7)

4.6   Adequacy of existing support structures

Therapists felt that they required more support structures. In answering the question "Do you feel supported at work?", the following answers were given:

"No, not at all. I think support in terms of your colleagues, your fellow ground workers, I think that's there." (OT 08 p. 6)

"… I don't think they [referring to supervisors] realise the magnitude of the situation [situation being lack of support]. Which is scary." (OT 05 p. 9)

One of the therapists was slightly more optimistic about the support she received:

"Um, (laughs), um, it varies. So at times you do feel like there is support from staff and from management, um, but at other times is does feel like you've been thrown in at the deep end and you need to paddle. So ja, it varies…" (OT 2-04 p. 1)

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4.7 Potential support structures suggested by the participants

Participants were quite vocal in discussing various options for support structures that could be implemented at the rehabilitation centre. Table 4.4 shows the potential support structures.

Table 4.4   Themes and sub-themes related to potential support structures

Themes	Sub-themes
Counselling	No sub-themes
Team building and group therapy	No sub-themes
The role of management	o More visible and supportive o Involvement with patients o Appreciation o Awareness of problems o Maintaining confidentiality
Decreasing extra responsibilities	No sub-themes
Smaller caseload or more staff	No sub-themes
Improved communication	No sub-themes

4.7.1 COUNSELLING

One of the options was to have counselling services available for therapists:

"I don't think we realised how much debriefing was needed." (OT 06 p. 19)

"… and if they [referring to management] can't give support to us, to get somebody from outside to come and have debriefing sessions with us. I would feel that is quite important. That would be something that I would want to put in place if I was the manager of this place." (OT 04 p. 5)

"Um, I think ja, even a counsellor would be appropriate, just for a space to, like, debrief because you don't. I don't want it to have to be my family members, or my friends, or boyfriend or… Even your colleagues aren't the most appropriate people to talk to. Um, ja, a person with some sort of counselling skill, um, maybe some knowledge of rehab. Or background in rehab, so it's not completely foreign matter. I think, ja, maybe, and obviously not forced either, on a completely voluntary basis if people want to use the service and then it's there."
(OT 03 p. 12)

"Ja, but I think if we maybe had, maybe a, someone also to come in, and also counselling sessions, then that will also help for some people." (OT 09 p. 7)

Varying ideas were expressed by the therapists about the length of time needed for counselling:

"I would give them probably time, I would, structured time, um, within working hours. Not a lot, let's say one hour a week, um, to speak to a professional."
(OT 03 p. 12)

"I think it would be really nice if they could have like a set time, like once a month, like a session where somebody can come in, you can talk about the things. Debrief a little bit." (OT 2-04 p. 3)

4.7.2   TEAM BUILDING AND GROUP THERAPY

Most of the therapists saw the benefit in having group sessions, whether team-building or therapy, as a means to reduce stress:

"… sort of annual or biannual group activities, I'm sure would also be beneficial for people to feel that sense of, um, what's it called, sort of when you see that people are going through the same thing you're going through." (OT 03 p. 13)

"Um, I do feel there is value in group therapy because sometimes, um, you think you're the only one that goes through this, and just that feeling of… Other people are also experiencing the same thing… That's good, and I think it can work within a setting like this. Um, ja, we not, it's not so openly, um, available as it sounds. It's all up there for me. ICAS. I don't even know who I should contact if I want to contact them." (OT 08 p. 13)

"And then I think other things like just having team-building's, um, regularly, will also work. Obviously it needs to be structured and what you want to get out of it needs to be planned well." (OT 09 p. 6)

"Team building, maybe once a month or once every second month." (OT 09 p. 7)

One of the therapists highlighted that even with the prospects of group therapy, the OTs may still have a negative outlook:

"And so I don't know, if we had someone come in and, you know, do, facilitate groups, how would we actually have felt about that. I think there would have been quite a lot of negativity." (OT 06 p. 12)

"I had thought, probably I don't know if ICAS provides that, but I sort of thought, wouldn't it have been a good idea to actually say, instead of doing stupid team-building stuff, actually get someone from ICAS to do a series of things with the team. I don't know?" (OT 06 p. 19)

4.7.3   THE ROLE OF MANAGEMENT

A number of sub-themes, as presented in Table 4.4, arose under the theme of the role of managers.

More visible and supportive

Therapists emphasised that managers should be visible, accessible and supportive.

"… having that support from your supervisor, um, will actually help a lot."
(OT 09 p. 6)

"I think management needs to be more visible. Hmmm. I think they're managing something they don't see enough of. I can maybe count the number of times on both hands that my immediate supervisor has walked into the gym where I work, in one year. She's hardly there. She doesn't see what we're doing. She doesn't see how we're doing it. For all she knows we could be offering crap services. Um, things need to be monitored on a more qualitative basis rather than quantitative. That's what I mean by visible… the most my supervisor knows about me is my stats. I would guess. On occasion I've had to discuss certain clients with her because I've come to a dead-end or, um, sort of in a SPMS setup. Then we'll

discuss very briefly, very quickly, the type of clients I'm working with. Um, but I don't think management knows what's going on in their own institution. Especially top, top, top management. I haven't even gone there. I've sort of stuck to immediate supervisors because as far as I know, I don't even know what top managements' job description is. I don't know what their key roles are. I don't know where they fit into my sort of job description. Are they linked to me or? They definitely not visible enough though. Although by visible I don't mean, I need to be seeing them, they need to be seeing us. And they not." (OT 03 p. 16)

"Um, I think, I think that management, number one, need to stop and listen… And so the first thing they can do is listen and give people the forum to speak, and I don't think that forum is having everybody together. Because I don't think that's a forum that everyone feels comfortable to speak in. So you only hear from a few people, a view from the same people, so then it's like 'agh, I've heard this before' kind of thing. So I think that is the first thing… instead of trying to counter it with saying something else, to actually just forget about how it was and what you had, you know what I mean, take it for what it is, for that person is experiencing, and acknowledge it. And I think that what they can also do… and then look at exactly what does a therapist goes through on a day to day basis. And I think the therapists here are generally hard-working. And they want what's best for the client. So they not complaining about working hard, they complaining about not working hard on the area where it really matters. They don't have the time or the space to do that." (OT 05 p. 9)

Involvement with patients

Therapists thought it would be helpful if line managers treated a few patients themselves, so that not only were managers aware of the issues around handling patients but that they also helped to decrease the load:

"Maybe having middle management actually involved in treatment of patients. Having like, they have a caseload of at least like, maybe three clients, so that they do stay in touch on what's happening diagnosis-wise, also with clients. Because the type of diagnosis we've been seeing is quite mixed at the moment… So I think it would be good for them to have an understanding of when we're saying a patient is difficult to manage that they actually know what we're talking about. And also to keep them in touch with having meetings with family also, having an expectation from, from the outside. From family members or

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caregivers, about patients. Um, and also just to see also to have a good understanding of the admin like involved with a client. If it be doing a motivation for an assistive device, or doing the medical aid reports for clients. Or just keeping your daily or your weekly soap notes up to date. I think that would be something good." (OT 04 p. 5)

"I feel that yes you can ask your supervisors to help to manage the caseload, to see some of the clients. But sometimes I'm not even sure how good their clinical skills are, because they not, um, there supervisors, they're not working hands-on enough with patients. Um, it is an option for them to assist with seeing patients but at the end of the day, um, ja, I'm not sure if they're [referring to patients] going to be getting the treatment they should be getting from those therapists… Um, but I think ja, having supervisors to help out can maybe assist to relieve the burden slightly." (OT 2-04 p. 2)

"The first thing, as [facility name] is at the moment, I didn't know what the expectations were as far as caseload for our line manager. So [previous manager from a different department] used to see clients, ours don't. The first thing I would do, is actually be spending time in the gym seeing a couple of patients a day, so that one, my staff gets to know me, but two, I need to know what my staff is doing. Um. You need to, there still needs to be the division, I'm the line manager, you are the therapist, but there needs to be more understanding of what you do and what I do." (OT 06 p. 15)

Appreciation

Therapists felt that if managers showed more appreciation for what they do it will make them feel more supported in the workplace. This would include ensuring that the compliments and complaints system at the rehabilitation centre is working effectively and reaching the therapist.

"Isn't it [referring to complimenting the therapist] something that should be done, like maybe once a year, that people [referring to the therapists], they've got individual sessions and this kind of feedback [compliments] you get. It will be nice. Even if there's no monetary or something, but that time, maybe if it's half an hour, that you sit with the head of the institution or the head of therapeutic and then they… [give the therapist positive reinforcement]" (OT 2- 07 p. 8)

"Um, ja, this is now on a totally different level but I do think that people are not appreciated in their job… You're not getting thanked. You're getting thanked when you're doing your job evaluation but you forget it again because it's not continuous, it's not, um, ja, you get no recognition for all the extras you do." (OT 08 p. 8)

"Oh I do feel like now, occasionally, I think it must come more from our supervisors. Um, even if just, like I said, even if she just pop in, not when she comes to fetch something for someone, but just coming in and asking how things going here and not walking past our area, you get what I'm saying, just occasionally well done and keep up with the good work and chatting, just generally, not just about work but just finding out how things going will be much appreciated." (OT 09 p.8)

"And even if something, compliments, things come from outside through her [top management] to say thank you to the people at the bottom who did the job. But that doesn't, that doesn't happen. And even clients that might come afterwards and say to you, 'you know what, I've written a compliment for you and you', we don't even know about the compliments. There's a complaints and compliments box. We don't know about anything that comes in. There isn't a monthly meeting or even an email to say that this month, [therapist name] got two compliments. Even if it, ja, even if it's not sent out to everyone, maybe just to that person that the compliment was addressed to, so you don't even know about half the compliments or complaints that you get, which I think is bad because you do want to know if there is something that you can improve on, and you do want to know if someone really, really appreciated your care which doesn't happen. Ja, so I think they must, they've got these systems in place but it's not getting, it's all up there and, it's to tick a box but then it doesn't get to where it's supposed to be getting." (OT 08 p. 9)

"I think the gratitude that you do get is from your colleagues. And it's from the families of the clients, so that's quite nice. Um, sometimes you get it from the patients that you think won't even say anything, and then that's quite nice to have. Um, but the recognition from the people on top is not there. And I don't, I think that our head of institution won't even be able to know who I am..." (OT 08 p. 9)

More awareness of the problem

Therapists felt that if managers were more aware of the problem and acknowledged the stress experienced by the staff, this in itself would be support for the OTs:

"… Um because I don't, the whole thing is, I don't think that the full extent of the, or the root cause necessarily, if I can put it that way, is known by management. I also think management don't necessarily realise that it's on an institutional level. I think in their mind it might be individual, because some individuals are more vocal than others. Um, I, so I think, so that's why I think, that sort of place, or that forum for, for that just to be able to say your say completely freely, um. That's why I think that's the first step, so they can realise the magnitude of the situation and take in all the factors and then work out almost common themes around one of the problems. And then they would definitely take action." (OT 05 p. 14)

"So that's, I think that's, it would be kind of like, protecting my staff, my therapists, so that they aren't taking on more than they actually should be taking on. Um. And trying to ensure, if there are issues, they are addressed in the appropriate manner using your appropriate structures." (OT 06 p. 15)

Maintaining confidentiality

Therapists also wanted to be able to confide in their managers with confidence – that what was said would remain confidential:

"… the other thing also, is also having that, speaking to the, your supervisor, but in confidence. But I feel like you speak, I feel, I don't feel comfortable, and going to my supervisor and speaking, not to gossip about someone else, but when really concerned about the therapist that's not pulling their weight, you want obviously, because at the end of the day it's affecting the client, and we are providing the service. And if you, I don't feel comfortable going to her and saying that one is not pulling their weight, because I know that person is going to go back and speak to the other person this person is speaking about, and it's going to be a whole, and then it looks almost like you're gossiping about the person. And I know the process is to go to that person directly, but what if that person is still not doing what they supposed to do. What must I do? Get what I'm saying? So, I also feel like had that supervisor known what's going on in the area, they would be able to address it and not me going to the supervisor." (OT 09, p.9)

4.7.4   DECREASING EXTRA RESPONSIBILITIES

A huge area of concern was the additional responsibilities that therapists had to take on in the physical rehabilitation setting. Many stressed that if these extra tasks were reduced, they would feel more supported.

"I think reducing also your outside responsibilities with committees and so on, cos I feel like that is not my core job. I'm a therapist; I'm here to treat patients. And if I could spend all the time I spend trying to organise other things, just seeing my clients. I think that would be much better. Because I do feel it's important to have these events and promoting people with disabilities but I feel like that can be something that somebody else might do, that they appoint specifically for something like that. I feel like that would also help a lot. Um. Then, ja, I think that would, ja, do a lot at the moment for us." (OT 04 p. 8)

"Mmm, maybe some of the admin things, taken away. I know our clinical progress notes need to be ours. Maybe. I don't know what else can be taken away. Yeah, some of the things. If you can just focus on your patients and your notes, because you need to write SOAP for your patients and just deal with patients issues…" (OT 07 p. 9)

"*Hmmm, I think, if I think about all the extra things that we also, as a therapist and what in terms of our core job, um, what's its task, whatever we need to do, the extra admin things which I feel like is our supervisors responsibly. I think if that is sort of filtered right, and they do what they are supposed to do and we do what we're supposed to do, I think that will also make it much more better. Because to be honest with you, I think sometimes it's just them delegating the work to us, because they, I don't know if they don't have time to do it or they don't feel like doing it, that also makes it difficult or extra for us as therapist. Because I mean at the end of the day, we are paid on a salary level that we're supposed, but we are doing much more, and I feel like that is not being seen by the person."*
(OT 09 p. 8)

"So I think the administrative stuff, that needs to cut down a bit. Um, to give people the space to focus in on a client, because I think also that you're always juggling a ball, there's always 500 things to be done. So I also think people get frustrated because they don't have the time to invest with the client… I don't think everybody knows fully what the resources are that are sort of out there. So you're

always sort of searching and wondering what else for this client. Where else. And you don't necessarily come up with the answer because you've got health and safety reports to do. You know what I mean? That stuff is not necessary…"
(OT 05 p.10)

"Um, small in-service training, yes, I've decided that sometimes that I'm not going to attend it, which, and also like they asked me again last year if I want to participate in the, um, the seating trainings, being the clinical coordinator for the, for it, from [facility name]side. And I decided no. So I've started to be more assertive, to say 'no' to things. So I feel I can manage better with the other things that I need to handle that's more priority than doing that. And like the big training, like the Bobath and the seating things, I think that is compulsory because it improves your skills. And I think you need to be selective also, and choose 'is this really going to improve my skills when I'm treating a patient or working with a client'. And if you don't feel that, then I don't think you should attend it." (OT 2-04 p. 4)

4.7.5   SMALLER CASELOAD OR MORE STAFF

An obvious solution to the problem resulting in more-supported therapists who aren't stressed is a smaller caseload or additional therapists to spread the caseload.

"I think definitely a lighter caseload" (OT 08 p. 7)

"I think to start off with, I think we obviously need to have more staff, to start off with." (OT 09 p. 6)

"I think maybe more staff. I don't know if they've got the resources for that but I think in terms of patient load on the therapist, to add an additional staff member so that the load is less in terms of patients…" (OT 2-07 p. 4)

Therapists also brought up the aspect that possibly not all patients should be seen by the occupational therapists:

"I think what I always found was that working within the facility, um, I could never do what I should have been doing. So, um, I often felt I was doing very superficial stuff anyway. And because that was one of the things that I brought up with management over a period of time, was that, I didn't think that OTs should see patients necessarily from day one. But that maybe we should continue to see

*them four to six weeks post discharge. Um, and that may be we just need one
therapist in each unit who just does that. Because, it's such an unnatural
environment, um, yes, you're getting them up and dressed but you're getting
them up and dressed in a ward. You're getting them to make a sandwich or cook
their breakfast, but you're doing that in a well equipped kitchen with water on tap.
You can only do so much to step up… simulate the environment. The best is to
actually see them in their environment. And so I often felt I was, sort of, going to
fail before I'd even started because of where I was working, because of how it
was."* (OT 06 p. 9)

Another possible solution suggested in terms of the patients was to reduce the admissions of
medical insurance patients, because of the additional administrative work that these patients
require:

*"I mean if you can work without having medical aid patients, that will I think
lessen the burden of work, to be quite honest."* (OT 2-07 p. 6)

4.7.6   IMPROVED COMMUNICATION

A support system that most of the therapists recommended was ensuring that
communication systems are being run effectively. This will ensure better management of
patients and less stress experienced by the therapist:

*"I think there needs to be a better system in terms of communication with the
ward. Um, I think that's our biggest problem at the moment and I think it is
because of, um, shifts that changes, so you are communicating with the day shift
and then it goes over to the night shift and then there's a another day shift again.
So I think the problem there lies, that within those three shifts a lot of
communication occur via a person and then it gets lost within the whole system of
communicating… I do think the communication book is a good way to
communicate but there must be some accountability in terms of, have you really
read the book. Because what's the use if there is this nice system and people
aren't reading everything that is written in there. Because it can't get lost if
everything is in the book. So I think between their shifts they need to up their
communication a bit. Then whatever we are translating to the ward will be better.
I think communication between ground level and supervisors needs to be better,
in terms of your supervisor must also try to, um, read what's going on in the
ground level work, with the ground level people. In terms of, be in the gym and*

check out what's going on. Get involved with patients, ask them about this patient, what are you doing, is this working, can I help you? Um, ja, I think sometimes your supervisor expects because you are beneath them you must come to them. And they not willing to come down to the ground and see what's going on there, because sometimes a picture speaks a thousand words. Just being there when something happens and she's not. Ja, I think she needs to be more in tune with what's going on. Ja, I think if that's better, the mentoring will also be better." (OT 08 p. 7)

"Um, so although the opportunity is there, um, for you, even for me, I have the opportunity to communicate, I often feel it's got to be concise, it's got to be quick, it's got to be to the point, um. I don't know, I don't know how to fix communication errors. (Laughs)." (OT 03 p. 8)

4.8   Summary

This chapter describes the findings of the study. Data gathered showed that the work environment played a crucial role on the stress experienced by the therapists and their working experience. Therapists described their role in the rehabilitation centre and how their responsibilities were often blurred and overlooked. Therapists discussed the stress that they experienced due to the work environment and what the causes were. Most participants listed the same reasons for experiencing work-related stress. These causes were linked to the nature of work, challenges related to management, problems related to caseload, the role of the OT in the team, their colleagues and qualitative versus quantitative care. The findings of the study also highlighted existing support structures that were already in place. Participants leant on their colleagues, family and friends. They also discussed the use of ICAS services as well as team building and the effectiveness of all these support structures. Finally, support structures that the participants would ideally like to see in place were highlighted. These included: counselling, team building and group therapy services, more support from management, decreasing extra responsibilities and especially those that are non-patient related, having more staff or a smaller caseload, and improving the communication amongst all levels within the rehabilitation centre.

CHAPTER 5

Discussion of the study findings

5.1   Introduction

The aim of the study was to explore and describe work-related stress experienced by occupational therapists working at a physical rehabilitation unit and to determine whether current support structures are addressing the work-related stress experienced by the OTs. The findings indicated that stress is present and caused by many factors, including the work environment, clinical and administrative caseload, role uncertainty and managerial challenges. Two formal structures for stress relief were identified, however neither seemed adequate. The findings will be discussed in more depth in this chapter.

5.2   Work environment and demands

The work environment was described as tiring and intense. It seems from the findings as if the specific environment created multifaceted challenges related to the type of patient, the size of the caseload, administrative and other tasks, the constant interaction with various people as well as organisational attitude and the stature of the study setting in South Africa.

According to the study participants, the type of patient being seen at the rehabilitation centre caused increased stress. Sweeney *et al* (1993a) and Du Plessis (2012) described a similar finding and related it to the fact that the patients have usually undergone severe trauma and had incurred life-changing events. Patients might have huge expectations from rehabilitation and the service providers with regard to achieving their pre-morbid status and abilities. Smith *et al* (2007) and Sweeney *et al* (1993a) point out that constant exposure to patients who have been traumatised can result in stress and ultimately burnout. The study participants expressed a sense of carrying the burden of the condition with the patients. They also mentioned that the lack of recognition, not only from managers but from patients as well, caused additional work-related stress.

The OTs emphasised that their caseloads were too large. The ratio of patients to therapist was, on average, 15:1 if no therapists were on leave, and it was felt that this resulted in sub-

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standard services and feelings of stress. High caseloads and lack of time seem to be a common cause of work-related stress and burnout, with many studies having reported as much (Balogun *et al* 2002; Du Plessis 2012; Harris *et al* 2006; Lloyd *et al* 2005; Moore *et al* 2006a; Tyler & Cushway 1998; Wressle & Samuelsson 2014). Better distribution of workload and a more reasonable caseload would assist in supporting staff (Du Plessis 2012; Wood & Killion 2007). According to Sweeney *et al* (1991), it is the responsibility of managers to ensure that there is a sufficient number of staff relative to the patient load. As therapists were feeling overwhelmed by their large caseloads, this could mean that potentially, managers are not taking on their responsibility and motivating for more staff. The study participants did not feel supported by their managers. This feeling might be partly because it did not seem to them that managers were trying to reduce caseloads, either through a change in admission policies or through increasing staff numbers. However, in South Africa, with limited resources and funding, an increase in staffing to reduce caseload size might be an unrealistic expectation.

Reducing caseload size through re-distributing the workload, as therapists have suggested, might be more feasible. They felt that not all patients admitted to the rehabilitation centre required OT, and that some of those who do require OT do not necessarily require OT immediately on admission. Their suggestion is that OT should commence when the patient has developed sufficient control and balance to start participating in the activities of daily living. Thus the OT might be able to make a bigger difference, faster. Suggestions about continuing OT on an out-patient basis were also made. This would allow the OT to see whether the patient has fully reintegrated into the home environment, and to provide treatment in this environment. While a sensible and practical suggestion, since this is the environment in which the patient ultimately has to function, it might increase the time challenges, and therefor increase stress, as home visits are time-consuming.

Ultimately, more liaison with the community therapists should be encouraged so that better continuity of care is instilled. Currently, the number of OTs working at primary level in South African communities is insufficient to provide primary level services to those patients who require OT (Kahonde, Mlenzana & Rhoda 2010). And so this solution, albeit ideal, is not feasible. There are other avenues that can be explored. The first being that if the numbers of OTs are insufficient at both in-patient rehabilitation and primary level, it might be time to overcome the excuse of insufficient financial resources and to motivate for the employment of more OTs. This is especially important in the light of findings by Cawood (2012) that OT had a statistically significant, positive impact on participants' community mobility and self-care activities as monitored by standardised outcome measures as well as in the light of the

Framework and Strategy for disability and rehabilitation services in South Africa 2015 – 2020 being clear on the importance of rehabilitation at primary and specialised level and that this include access to therapists at these two as well as other levels of service delivery (DoH, 2013).

The other avenues were outside the scope of this study and are only mentioned briefly since they might warrant further exploration. The role that home based carers and non-governmental organisations can play in continued rehabilitation post discharge must be explored – as must the possibility of transdisciplinary teamwork in community settings.

In addition to the big caseloads, the study participants had numerous administrative tasks. This was also a common complaint in the study by Du Plessis (2012). Participants suggested the reduction of non-patient related administrative work. They did not want to be burdened with tasks like developing hospital policies such as admission criteria or team-planning documents that were, according to them, the responsibility of managers. One can understand the frustration that can develop in a person who sees his/her essential role as being involved with managing patients but who has to deal with seemingly endless meetings to develop policies. But it is important that the therapists who actually provide the service have a voice in determining policies such as admission criteria. This might be another area where direct supervisors did not fulfil their role as they should have – they should be the ones who explore the therapists views on these issues and then represent them at meetings where polices are developed.

Participants mentioned being overly involved in organising events such as awareness days for different conditions (World Disability Day, Stroke Awareness Day) and end-of-year or team-building functions. They felt this should be the responsibility of a public relations officer. Also, they felt that additional clerical staff could be appointed to assist them with administrative duties such as managing statistics, making appointments and doing routine telephonic patient follow-up. Administrative clerks are cheaper to employ. This would mean that the therapists, who are paid more, would be free to focus on their core business of patient management.

Ensuring that therapists have time-out and non-patient contact time during the day was a strategy highlighted in the literature as a support structure (Du Plessis 2012; Sweeney *et al* 1993a). Time-out and non-patient contact time during the day can be seen as time to do administrative tasks. But these tasks are tedious, and combined with the high caseload can cause unnecessary stress. It might be for this reason that participants in this study did not specifically suggest time-out or non-patient time, but rather a decrease in their administrative

duties. However, non-patient tasks that are not tedious should be considered – tasks such as attending in-service training, having dedicated time to exercise, or debriefing and counselling sessions. These suggestions should be implemented in conjunction with other strategies such as reduced caseloads so that therapists are not participating in supportive strategies while feeling guilty for neglecting their patients.

The type of work demands the ability to interact with many different people from various backgrounds (colleagues, managers, other health professionals, families, students) and with different personalities and expectations on the part of the therapists. These interactions can be stressful and often require patience and skilful negotiation. However, when already under stress, skilful negotiation becomes difficult and an extra burden that depletes energy levels and internal resources. Therapists are expected to follow an interdisciplinary teamwork approach. This necessitates close contact with colleagues who can create interpersonal stress and conflict. Interpersonal stress at work was also identified as a challenge by Du Plessis (2012) and Lloyd *et al* (2005). In an environment where most individuals strive to provide the best service they can, negative feelings might arise towards colleagues who are somehow seen as not producing the same high standard of work – especially where one person feels that she/he is doing extra work because a colleague is not doing what she/he should be doing. On the other hand, peer support from colleagues can be and was a source of stress relief. Participants went to their peers as their first port-of-call when they felt the need to debrief. This might have been because colleagues were easily accessible and because the study participants did not feel they were receiving support from their managers. However, the participants had ambiguous feelings about seeking support from colleagues. They felt they were burdening their colleagues, but also knew their colleagues were the people who could relate to their experiences. Generally, if someone has trained to be a therapist it is because they love interacting with people. Therefore interacting with different groups of people and different personalities should not be a cause of additional stress. This issue might be due to the irritability that developed when other areas not being addressed. In my opinion, this might not be a major concern if concerns such as caseload size and unnecessary administrative tasks were confronted.

The study setting is hailed as a flagship for physical rehabilitation in South Africa and this brings the added stress of having to constantly provide services of excellence. Many discharged patients promote the facility as the best, and this adds to the high expectations placed on the staff. Similarly, Flett, Biggs and Alpass (1995) describe how the responsibilities of the rehabilitation therapists were numerous and included providing high quality service to too many patients with not enough time and too little resources. However,

these expectations were not extensively described in other studies. This may be due to the fact that standards in other environments may already be at a higher level and thus employees at those institutions may not need to strive to bring about higher standards. In addition, the study findings suggested that amongst the OTs at the study setting there is not only the pressure to keep up with the standards of the study setting but also self-competition – an innate striving to improve themselves and be the best they can be. Having expectations of oneself and one another to provide excellence and to strive for improvement might not in itself be unhealthy. However, if not carefully nurtured and controlled it can lead to a stressful negative spiral where people push themselves too hard, are critical of colleagues and a general atmosphere of intolerance develops. Thus, while the general ambiance of excellence is commendable, members of the executive management team at the rehabilitation centre must ensure that the focus and organisational attitude remains that of ensuring every patient receives high quality care. . In what seems like a highly task-orientated environment, managers (both executive and line) must not forget that the therapists and other members of staff are indeed part of their "task", and that through nurturing them, there can be the content, self-confident staff complement essential to providing services of excellence.

5.3   Management, supervision and support

A lack of managerial support and the challenges involving supervisors, which was identified in this study as a major cause of stress, was also found to be a cause of stress and/or burnout in various other studies (Balogun *et al* 2002; Du Plessis 2012; Lloyd *et al* 2005). Balogun *et al* (2002), Du Plessis (2012), Edwards and Burnard (2003), Lloyd and King (2001), McGilton *et al* (2007) and Obasohan and Ayodele (2014) found that supervisors can play a critical role in reducing work-related stress. Current study participants said they would feel more supported at work and might thus experience less work-related stress if managers were more visible and actively supportive. The participants in this study thought their supervisors might not be aware of the magnitude of the problem of work-related stress. Du Plessis (2012) found that the managers were too rigid and lacked understanding and thus caused more stress amongst employees, whereas in this study it was not that the managers were too rigid but rather the lack of the presence, support, guidance and understanding from mangers that created stress.

Balogun *et al* (2002), Harris *et al* (2006) and Lloyd *et al* (2005) found that if managers did not clarify roles there was a lack of certainty and value in the profession, resulting in increased

stress. Current study participants did not specifically highlight a lack of role clarification on the managers' side but felt their roles were blurred, due to the nature of the work, and that managers were lacking in communication and mentorship skills. Although participants seemed to think that blurred responsibilities stemmed from the fact that professions overlapped, it could also have been due to managers not clarifying their roles adequately. This is an area that can be explored further in future research.

Sweeney *et al* (1991) describe the importance of institutions providing mentorship. And in this study, the participants felt that they did not receive mentorship from their supervisors and that they could not turn to their managers for assistance and guidance as regards patient care. Participants said that they would rather access their OT colleagues, who had skills similar to theirs, or colleagues from a different profession, such as physiotherapy. The impression received was that participants found their managers to be ineffectual and lacked the strong leadership and clinical skills needed to provide guidance. The possibility exists that the line managers of the current study participants were neither clinically nor managerially sufficiently adapt to provide the guidance regarding core roles, clinical skill development, support, representation and leadership that therapists working in a specialised rehabilitation environment require and expect. If this is the case, it might also partly explain why the OTs felt they did not receive the necessary respect and recognition for their work. If line mangers do not use the platform of various meetings to point out the valuable contribution made by the people they supervise, the OTs' contribution might go unnoticed and unpraised.

A further cause of work-related stress in this study was the lack of appraisal, recognition, appreciation and gratitude for services rendered. Participants, although striving to improve themselves, learning on the job and giving their all, didn't feel that was enough. They stated in jest that they only realised how good they were once they resign. On resigning, you are thrown a farewell party that is generally organised by your colleagues, and at the event, normally one or two people will thank you for your contribution to the facility, team and patients – which might be the first time that you feel appreciated or are acknowledged by your manager. Participants made a strong plea that they wanted to be acknowledged throughout, with a word of encouragement here and a compliment there, instead of only on leaving the employment of rehabilitation centre or once a year during their performance appraisal. A consequence of never receiving any acknowledgment or recognition is that the therapists questioned whether they were liked and wondered whether their managers thought they were good at their jobs – which can have a very negative effect on one's professional stamina as well as morale. Such lack of approval is a negative burden to carry

and can easily cause disillusionment in the workplace. Sweeney *et al* (1991) stressed that it was the responsibility of the manager to ensure that staff feel appreciated for good work.

The study participants did not report increased pressure from the managers to perform as did participants in the Balogun *et al* (2002), Du Plessis (2012), Harries *et al* (2006) and Lloyd and King (2001) studies. It was more a case of the rehabilitation centre as a whole exerting pressure to perform. This might be due to the fact that managers seemed to be quite absent from their day-to-day functioning, but it could also be that managers were not strong leaders in effectively encouraging their staff to perform.

Mutkins *et al* (2011) found that if supervisors acknowledged stress, employees' chances of experiencing work-related stress are reduced. The current study findings stressed that participants just wanted to feel that their managers acknowledged the stress that they were enduring. Tourangeau *et al* (2009) point out that the participants in their study also wanted to feel supported by their supervisors. Managers should be easily accessible so that should problems arise they are available to deal with them, but managers should also praise good performance and provide constant constructive feedback (Sweeney *et al* 1993b). In this study it was stressed that more appreciation is sure to help reduce work-related stress. In order for managers to be supportive and visible, they need to be trained in these areas (McGilton *et al* 2007; Wood & Killion 2007).

Management should also be approachable (Moore *et al* 2006b), which would ultimately mean that they are more visible and supportive. As highlighted in this study, participants wanted to be able to confide in their manager confidentially, knowing that they would be supported. Moore *et al* (2006b) also state that managers should support their staff in advocating for their staff needs.

Other areas of support where it was felt that management could be more involved include the treatment of patients. This was not really stressed in the available literature, which could be due to the fact that the managers in earlier studies were involved in the cases or that the caseloads in those studies were of a more manageable size. However participants in this study indicated that it would be beneficial if supervisors could be involved in the assessment and treatment of patients, and in so doing the managers would keep their clinical skills honed and help to alleviate the caseload.

5.4 Role of the occupational therapist

The core role of the OT in the physical rehabilitation team is to improve the patient's ability to function and participate in life roles, including being productive and in the workplace. In this context, participation includes *everything* that an individual would normally do on a daily basis, from waking up and going to the toilet, to preparing food and taking children to school, being productive at work, developing and maintaining relationships, to name just a few areas. Each of these tasks consists of multifaceted physical, cognitive, perceptual, personal and environmental components which the OT must address. Both the number of tasks that each individual engages in on a daily basis, and the complexity of each task, mean that OTs often experience time pressures when trying to address each task optimally during in-patient rehabilitation. There is not much that can be changed in this regard – rehabilitating people to participate again in social roles is the general function of occupational therapists. However, OTs can and should prioritise with the patient to identify the areas that are most important to the patient and address these first. Thereafter, if the patient is being discharged and there are still aspects that need to be covered, the OT would be required to refer onwards.

A common experience amongst the participants of this study was that they felt responsibilities of various professional groups were blurred. This might be partially due to the fact that the role of a rehabilitation therapist is to incorporate aspects of other professions. Thus one might find in a rehabilitation setting physiotherapists working on function, including the activities of daily living, and occupational therapists ensuring correct mobility. Moore *et al* (2006a) and Sweeney *et al* (1993a) also found that a close relationship amongst health professionals can lead to blurred boundaries. The blurring of responsibilities might cause challenges with regard to role definition. It is crucial however that OTs hold onto their core role as this is what identifies them and sets them apart from other rehabilitation specialists. OTs need to be mindful that they are working on functional ability within all spheres of daily living. If they do so, they will not have the same problem as the participants in Edwards and Dirette's (2010) study who struggled to define their role and felt they were 'gap filling' (when therapists fill in for each other). It was evident that some gap-filling occurred in the current study, as participants mentioned how they covered for colleagues from other professional groups when they were on leave, thus incorporating the roles of other professions into their therapy sessions. This might be a result of working in functional teams rather than discipline-specific teams. Functional teams have distinct advantages in a rehabilitation setting and should be continued. However, it is critical for the functioning of a team that within the functional team, OTs and other professional groups should establish and maintain their core role and identity. The occupational therapists in the study setting do not work according to a

specific theoretical model. This lack might increase the challenges regarding professional roles. The students who are placed at the center make use of the Person-Environment-Occupational model so most therapists are aware of this model. Management should try and encourage a use of a model of occupational therapy that will guide the therapists' interventions and roles.

OTs in the studies by Gupta *et al* (2012) and Moore *et al* (2006a) felt disrespected, that their roles were misunderstood and unaccepted, and that they needed to justify their role constantly. Study participants described similar challenges. The problem might in part, be attributable to nursing staff that often confuse physio- and occupational therapy. This is understandable because there are many aspects that overlap within these two professions, especially in the rehabilitation field, but OTs should be assertive and explain how their role differs and what makes their profession unique.

Generally speaking, assertiveness might not have been one of the participants' strengths, with some of them describing how they were unable to say 'no' to additional tasks that would add to the work-related stress. This might be closely linked to the fact that participants generally showed a high level of commitment to the job – they did not want to be seen as slacking or unable to cope and so they pushed themselves further. A concern regarding this dedicated type of person is that, as Espeland (2006) explains; pushing oneself constantly may actually result in poorer performance, which will cause further stress, a lack of self-worth and decreased confidence in the ability to deliver a service of quality. Du Plessis (2012) also found that when therapists were not able to reach their goals, they were susceptible to burnout. Therefore it is important that the OTs and their managers set realistic goals and that the therapists also learn to be more assertive through training or self-awareness.

While Moore *et al* (2006a) found that OTs perceived their profession as having lower worth than other professions, the participants in this study emphasised that they believe they have an important role to play in the field of rehabilitation. However, a common feeling amongst the participants was that while they believed in their role, they were undervalued by the rest of the team as well as service users. They felt other health professionals were not aware of their contributions and that the public often didn't realise the difference between physio- and occupational therapy. This could have huge implications for the profession of occupational therapy and needs to be addressed in order to ensure that the profession is understood and that confident therapists are produced. Without confident therapists the profession is going

to dwindle, as the OTs won't be able to promote the profession. Again, the need for assertive therapists who are supported and encouraged is highlighted.

An interesting finding from this study was the notion that OTs provide a more qualitative approach to health care delivery than, say, physiotherapists, but that this approach was somehow seen as lesser. Participants explained that it seemed to them as if it was required that they develop a more quantitative outlook and assess their work through statistics and measures of numerical outcome. According to them, the importance of numbers or outputs as a way of assessing services is stressed at an institutional, provincial and national level. At the rehabilitation centre the main measure of outcome used is that of outcome levels (Landrum, Schmidt & McLean 1995). This is a multi-disciplinary outcome measure that focusses on ensuring that all aspects which might impact the patient's ultimate ability to participate in life-roles are addressed. While patients progress through levels on this outcome measure, it is not numerical as such and no numerical measurements are taken. Outcome levels were not taught to OT undergraduates by Universities in the Western Cape at the time of this study, although the rehabilitation centre provides training on the concept to all staff. However even with this on-site training and given that it's a tool that does not focus on numbers, therapists still felt that the quantifiable requirements of the rehabilitation centre did not sit well with them and caused stress. This could be due to a lack of familiarity, because in my experience performance measurement is not taught in any depth at undergraduate level. As evidence-based practice is more prevalent at a student level, I feel the aversion to this outlook will dissolve. In time, with more training and with more exposure to occupational therapy-specific, quantifiable methods of which there are many available, this cause of stress in this area may become greatly reduced.

That said the use of outcome measures is only a small aspect of what OTs were adverse to. My impression was that it was more about needing to prove their service delivery through the use of numbers. It seemed as though the greater the number of patients who could be accommodated, the higher the approval from management. However numbers do not guarantee quality service or that patient goals are met. Management need to ensure that with head counts there is a focus on achieving patient goals and providing service of good quality. If not, OTs might continue to feel inadequate and frustrated.

5.5   Support structures

The study participants emphasised the need for debriefing avenues so that the burden related to treating patients does not build up. Literature states that with counselling, therapists' self-esteem improves and they are less susceptible to stress (Flett *et al* 1995). ICAS is a counselling service available to therapists and other staff, although despite all participants being aware of the service, only those who had attended a once-off ICAS session at work had made use of the service. Participants were reluctant to use these services, as were participants in the study by Du Plessis (2012). The exact reasons are unknown, but I suspect that it has to do with one of the following: a, it means that the problem is individual and not on an institutional level; b, councillors are allocated by ICAS and not according to the choice of the individual therapists; and/or c, it's an additional thing that then needs to be done on top of everything else they are expected to do.

Team-building events were highlighted as a strategy already being used to support the therapists. Du Plessis (2012) stated that the use of team building within her study setting assisted with relieving therapists from stress, and in the current setting participants indicated that team-building activities could be expanded on. However it is important that should team building be used to alleviate stress, the responsibility of organising such events should not fall to the therapists as the extra burden can negate the advantages.

Group therapy sessions were another team initiative that participants suggested may assist with stress relief. Allan and Ledwith (1998) and Sweeney *et al* (1993a) found that the group support helped to lift the burden of stress experienced at the workplace as therapists were able to express their feelings. Attending group therapy sessions should be voluntary. The composition of groups must be carefully considered to ensure optimum benefit to each group member and an external mediator should facilitate the sessions.

Participants also suggested the implementation of strategies to improve communication amongst all levels of staff, within and across functional teams. It seems as if existing strategies to improve communication, such as a communication book in the wards, were not used optimally. The reasons for this should be addressed, or, if the strategy is found to be not feasible, it must be abolished and replaced. Participants weren't sure exactly how to practically improve communication. It is an area that needs exploration by the rehabilitation centre management and, since communication is essential to the optimal functioning of any service (Donohoe *et al* 1993), they should consider consulting with an outside expert.

Also supportive in helping to deal with work-related stress and ultimately reduce burnout are the therapists own coping skills (Devereux *et al.* 2009; Edwards & Burnard 2003; Leonard & Corr 1998). OTs learn how to develop coping skills to some degree during their undergraduate training, but the focus of this training is more about developing the coping skills of the clients, rather than those of the therapists. Additional training in coping skills more applicable to OTs might be beneficial.

Gupta *et al* (2012) and Mutkins *et al* (2011) also stress the importance of personal support structures such as family; friends; spirituality and leisure activities including exercise. Although this was often mentioned as an initial go-to point for the participants and a strategy they were already using, they didn't seem to stress the need for support from their families and friends. What could be considered by the rehabilitation centre management is dedicated time for therapists to exercise at the facility, as there is equipment available. It could form part of the employee wellness programme that staff be allowed to exercise say for 30 minutes three times a week. This might help to alleviate stress and staff members would not feel that exercising is an extra thing that needs to be done after a long day of work.

CHAPTER 6

Conclusion and Recommendations

6.1   Conclusion

The study determined that occupational therapists at the study setting experienced high levels of work-related stress. Multiple factors including a personal and organisational attitude of excellence, big caseloads, administrative duties, lack of managerial presence and support as well as role challenges led to stress amongst the OTs in this study. Existing support structures offered by the institution were limited and not optimally utilised. Therefore debriefing was mostly done on an informal basis amongst staff and with 'significant others'. This strategy seemed to assist therapists to function from day to day, but did not seem to produce positive long-term results.

It is essential for the well-being of participants and the institution that work-related stress amongst OTs is addressed on an institutional level. Both line managers and top management should realise the extent of the problem and actively seek solutions. Participants in this study were fairly sure about what strategies they would put in place to relieve work-related stress and were willing to share their ideas.

The following recommendations might assist in supporting therapists and decreasing work-related stress.

6.2   Recommendations to the study setting

These recommendations are based on study findings and recommendations by participants in the study. It might not be feasible or necessary to implement all of them. The management at the rehabilitation centre are encouraged to explore the options and implement those that are found to have the biggest impact on reducing work-related stress.

6.2.1 COUNSELLING

It is recommended that individual counselling sessions are made available to staff members. Participation should be on a voluntary basis. The counsellor should be someone external but who understands the nature and requirements of a rehabilitation centre.

6.2.2 TEAM BUILDING AND GROUP THERAPY

Team-building events should be encouraged from an institutional level and should be organised for rather than by the therapists. The aim of these events should be both enjoyment and a chance for colleagues to get to know one another outside of work.

A voluntary group therapy session by an external mediator is another suggestion. These sessions could provide debriefing opportunities and a realisation that others are in similar situations. It is recommended that these sessions address the OTs and guide them on how to market themselves and their occupation. Thus therapists will learn how to be assertive and not feel they need to constantly prove themselves.

6.2.3 MANAGEMENT

Recommendations refer to both top management and line management, unless specifically referring to a particular level of management.

- Managers should be more visible and supportive. They must show more appreciation for the work their employees are doing through continuous encouragement.
- Managers should also clarify their roles and responsibilities so that everyone is aware of them.
- Line managers should continually attend training to improve their managerial and clinical skills as needed. These training sessions should include how to identify problems with staff, support staff and conflict resolution. Line managers could be more involved with patients by assisting with smaller caseloads.
- Line managers should seek therapist opinion on policy-related issues and should represent them at meetings in this regard.
- A lot of responsibility falls on top management. It is recommended that they monitor the management skills of their line managers more attentively.

6.2.4   DECREASE EXTRA RESPONSIBILITIES

Extra responsibilities over-and-above the OTs' core responsibilities, and especially those that are administrative in nature, could be alleviated so that therapists can focus on their patients. This might include:

- Hiring additional administration clerks to help deal with statistics and paperwork.
- Contracting an events coordinator to help organise events held by the institution – events such as awareness days.

6.2.5   SMALLER CASELOAD OR MORE STAFF

A smaller caseload will enable therapists to provide more comprehensive treatment to every patient while addressing the feelings the OTs have of being overwhelmed by having to treat too many patients. This could be done by reducing admissions and/or having managers assist with the caseload. Alternatively, increasing the number of OT staff employed would also result in a smaller caseload per therapist.

Another possibility is staggering the onset of OT intervention. That is, only once patients are strong enough to start engaging in ADLs would they then be referred for OT.

6.2.6   IMPROVE COMMUNICATION

All staff could be required to go on training to improve communication skills. Someone skilled in communication practices could be employed to assess the communication at the institution and put systems in place to improve it.

6.2.7   PERFORMANCE MEASUREMENT

Throughout the multidisciplinary team, each member should have a clear understanding of their colleague's contribution and what their focus is. It should also be clear to everybody on the team as to how progress is measured with, for instance, improvement in the quality of life as explained subjectively by a patient. OTs should identify ways in which they could better measure performance of the patients. The inclusion of a Model of Occupational Therapy may help to provide across-the-board therapeutic intervention. This is something that is required at an academic level and therapists are aware of these models due to their exposure with the students so implementing this at the rehabilitation centre should not cause much resistance.

6.3　Recommendations for further studies

- Should any of the above recommendations be implemented, their impact must be studied.
- It is recommended that a study involving a quantitative methodology is done to quantify work-related stress amongst all members of staff at study setting.
- It is recommended that all members of staff and management at the rehabilitation centre be included in further studies on work-related stress in order to make comparisons between allied health professionals.
- A study that explores the norms of staffing and caseload distribution in settings such as the study setting would help to provide a benchmark.
- Options for further study include exploring the roles of home-based carers and non-governmental organisations involved in rehabilitation.
- The influence of managers on role definition and responsibilities in the workplace can be studied.

6.4　Limitations

The following study limitations were identified:

- The qualitative data was collected and analysed by me as the researcher. I have also worked as a therapist at the physical rehabilitation centre. With this is mind, there is the potential for there to be various sources of bias. During the interviews, for example, I could have sub-consciously directed participants to answer how I would have answered, and in analysing the data I could be searching for what I would like to find, to support what I believe.
- Not making use of a standardised scale to measure work-related stress.
- The interviews were all conducted in English, although some of the participant's first language is Afrikaans or Xhosa. The consent form was also only in English. With hindsight, it would have been more beneficial and ethical to have had the consent forms and interviews also available in Afrikaans or Xhosa. Especially since people were asked to express their feelings, they might have been more comfortable in their first language.
- Not seeking the managers' opinion on the topic of the study was a limitation especially as many support structures related to the managers. Including the managers would have allowed for a broader knowledge of the topic.

- During final write-up I realised that in a few instances I had failed to explore answers in enough depth for instance not exploring the reasons for not using ICAS as a supportive measure.

6.5   Dissemination of findings and recommendations

The findings and recommendations will be disseminated to the management of the rehabilitation centre. This will hopefully help management to put strategies in place to reduce work-related stress and ultimately improve service delivery. Managers need to be made aware of the fact that they have a critical role in influencing the work-related stress experienced by their team and specific strategies for example open-door policy and improved relationships with subordinates, needs to be reviewed. If requested to do so, I would be willing to present these findings to the rest of the staff at the rehabilitation centre once management has received them.

I feel it is important for colleagues outside of the rehabilitation centre to also be aware of the reality of work-related stress. This awareness will hopefully help with the provision of more support in other environments. I also feel it's important that OTs realise their need to be more confident therapists and to define their roles and hopefully, writing an article for the South African journal of Occupational Therapy will make more OTs aware in this regard.

6.6   Reflection

Almost three years after experiencing my own bout of work-related stress, I'm grateful for the opportunity to have completed this study. It has allowed me to realise that I'm not alone in experiencing what I did and that many therapists require the same tools that I would have liked in place back then. It was emotionally draining to speak to colleagues, some of whom had become friends, and to realise how they were suffering. But I'm hopeful that there will be a greater awareness of work-related stress and that it will be addressed, not overlooked.

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APPENDIX 1

Information Leaflet

TITLE OF RESEARCH PROJECT:

An exploration of work-related stress and support structures experienced by occupational therapists working at a physical rehabilitation unit.

ETHICS REFERENCE NUMBER: S12/11/295

RESEARCHER: Ms Jennifer Clarke

CONTACT DETAILS: Tel 021 370 2340, Cell 071 352 0989; jenclarksa@gmail.com

You are being invited to take part in a research project. Please read carefully through the information presented here detailing the above-mentioned project. Please feel free to ask the researcher any questions in order to fully understand the study. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you have already agreed to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

The study aims to explore and describe work-related stress experienced by occupational therapists working at a physical rehabilitation unit and to determine whether current support structures are addressing work-related stress experienced by them. The nature of this study will be qualitative and the method of data collection will be that of individual interviews conducted by the principal researcher. A sample of ten informants, all qualified occupational therapists, will be ideal. Informants will not be paid for their participation. Informants should not incur any expenses related to the study. Each willing informant will be allocated a time-slot convenient to them and a venue will be decided upon between the researcher and informant. Suggested venues will be the home of either the researcher or informant. The

interview aims to be between one to two hours. Each interview will be recorded using a Dictaphone. After each interview has been transcribed, the researcher will contact the informant with the participant's data analysis for the member to check the data is correct. At all costs confidentiality will be upheld and no personal information will be used unless willingly revealed.

You have been asked to be a part of this study as you meet the inclusion criteria, primarily being an occupational therapists working in an intensive rehabilitation centre. You will be required to give up your time and participate in an informal interview. Questions will be related to your profession and the use of support structures. Post the interview, you will also be required to correspond with the researcher to ensure quality of the data collected. This will be done through electronic-mail and should not require constant correspondence. Should the need for a second interview arise, if you are willing, you will be requested to participate in a second interview.

The researcher hopes to establish what support structures are in place and what structures are still needed to provide better support in the work environment. This may have a direct benefit on you as better support structures, if needed, may be implemented. However, with the results of the study no strategies may be put in place and then other than speaking of your experience, this study will have no benefit to you. The results of the study will be made available to the institutions where you work in an attempt to bring awareness of the support structures available. The interviews pose the possibility of being emotionally driven. The interviews may evoke emotions that you are unaware of, however the researcher will be aware of this and provide support and resources where necessary.

You will be asked to sign a consent form, which allows the researcher to use your information in this study. You will receive a copy of this information, as well as the consent form, for your own records.

Thank you for your willingness to participate in this project.

APPENDIX 2

Consent Form

Declaration by participant

By signing below, I ………………………………..…………. agree to take part in a research study entitled: An exploration of work-related stress and support structures experienced by occupational therapists working at a physical rehabilitation unit.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (place) ....…….......……………. on (date) …………..………….. 2013.

Signature of participant   Signature of witness

Declaration by investigator

I (name) …………………………………………..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (place) ....…........……………. on (date) …………...……….. 2013.

Signature of investigator   Signature of witness

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APPENDIX 3

Interview Guide

Introduction Key Components: *Switch on Cellphone	• Thank for willingness to participate • Introduce self and purpose of study • Explain confidentiality and withdrawal • Explain interview process • Remind about voice recordings • Sign consent form • Ask Demographic questions

Questions:	1. Describe to me how you are feeling right now in general
	2. Describe your work environment
	3. Tell me about your current work situation
	  a. likes
	  b. dislikes
	4. How would you rate your feelings in terms of stress in your work situation? (scale)
	5. Can you explain any stressful situations in your job?
	  a. How do you manage the stress?
	6. Do you think there is another way you could manage your stress? Please elaborate.
	7. Do you find you take your work-related stress into other areas of your life? Please elaborate.
	8. Are you aware of any support structures in your workplace?
	  a. Do you make use of them?
	  b. How helpful do you find them?
	9. Are you aware of the ICAS programme?
	10. Is there anything you would suggest to improve the support systems at your current workplace?

Closing Key Components:	• Provide opportunity for questions or additional comments • Explain next step and follow-up process • Thank for participation

Adapted from the Pathfinder International Tools Series, 1996